Strengthening Adolescent Component of National HIV Programmes through Country Assessments in Swaziland

Initial Report of Rapid Assessment

May, 2015

ALL IN
#EndAdolescentAIDS

Table of Content

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
BSS	Behavioural Surveillance Survey
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
GBV	Gender Based Violence
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HTC	HIV Testing and Counselling
HIV	Human Immuno-deficiency Virus
MICS	Multiple Cluster Indicator Survey
M&E	Monitoring & Evaluation
NERCHA	National Emergency Council on HIV and AIDS, Swaziland
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission of HIV
PEP	Post-Exposure Prophylaxis
PreP	Pre-Exposure Prophylaxis
T/B	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNJT	United Nations Joint Team on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
VMMC	Voluntary Medical Male Circumcision

Section 1: Introduction

Introduction

Globally, adolescents (aged 10-19) are the only age group where deaths due to AIDS are not decreasing - while across all age groups, AIDS-related deaths declined by nearly 40 per cent between 2005 and 2013[1]. Today, AIDS is the leading cause of death among adolescents in Africa[2] and the second highest cause of death among adolescents globally[3]. In 2013, an estimated 120,000 adolescents (10-19 years of age) died of AIDS[1]. Thence the need for a global agenda to end Adolescent AIDS – All In.

This document presents the report of the rapid assessment of HIV and cross-sectoral adolescent programmes in Swaziland. The report highlights the HIV programme context for adolescents in Swaziland, the objectives and methodology for the rapid assessment. It also presents the key findings, priority actions and next steps to strengthen the adolescent component of the national HIV programme, as part of the All In agenda to end AIDS among adolescents.

Overview of All In

All In is a platform for action and collaboration to inspire a social movement to drive better results with and for adolescents (10-19) through critical changes in programmes and policy. It aims to unite actors across sectors to accelerate reductions in AIDS-related deaths by 65% and new HIV infections among adolescents by 75% by 2020, and thus set the global AIDS movement on track to end the AIDS epidemic among adolescents by 2030. The platform is focused on driving forward four key action areas:

1. Engage, mobilize and support adolescents as leaders and agents of social change.
2. Sharpen adolescent elements of national AIDS programmes through improving data collection, analysis and utilization to drive programming and results.
3. Foster innovation in approaches to improve reach to adolescents and increase impact of prevention, treatment and care programmes.
4. Mobilize global, regional and country-level advocacy to firmly position adolescent AIDS on the agenda, communicate needs and successes effectively, and mobilize and direct resources towards effective and efficient programmes for and with those adolescents most in need.

National Programme Context for HIV among adolescents

Swaziland has a generalized HIV epidemic, with a high HIV prevalence rate of 26% among 15-49 year olds[4] and 31% among adults aged 18-49[5]. The HIV epidemic in Swaziland is characterized by gender disparity, with prevalence higher among women (38%) compared to men (23%). Among key affected populations, reported HIV prevalence among female sex workers (FSW) is very high (70%), and slightly lower among men who have sex with other men - MSM (17%) than that of the general male population aged 15-49 (19%)[4,5].

[1] UNICEF analysis of UNAIDS 2013 HIV and AIDS estimates, July 2014.
[2] WHO, 2012. Global health observatory data repository http://apps.who.int/gho/data/view.wrapper.MortAdov?lang=en&menu=hide
[3] WHO, 2014. Health for the World's Adolescents: a second chance in the second decade. www.who.int/adolescent/second-decade
[4] Swaziland Demographic and Health Survey (SDHS) 2006/07
[5] Swaziland HIV Incidence Measurement Survey (SHIMS) 2011

Heterosexual contact is the main mode of HIV transmission in Swaziland[6] and about one in four couples (28%) is discordant[5]. New HIV infections are declining and the HIV incidence rate among adults aged 18-49 was estimated at 2.4%, comprising 1.7% and 3.1% amongst men and women respectively[5]. According to the preliminary report of the Swaziland HIV estimates and projections, the annual incidence rate among 15-49 years is expected to decline from 2.9% in 2011 to 2.1% in 2013[7].

New infections among children at 18 months of age (in 2012) was estimated to be 11% of all exposed children, down from 19.6% in 2009. Programme data indicates that at ages 6-8 weeks, only 2% of children born to HIV positive mother are infected with HIV[8]. Regarding older age groups, there are three high points in HIV incidence among females, i.e. adolescent girls aged 18-19; young women 20-24 and older women 35-39 compared to their male counterparts (figures 1 and 2). High HIV incidence was however recorded among males aged 30-34[5]. The observed high HIV incidence in older man and young women is consistent with age-desperate sexual relationships which is documented to prevent an AIDS-free generation to grow in Swaziland[9], and remains a challenge for the HIV response among adolescent girls.

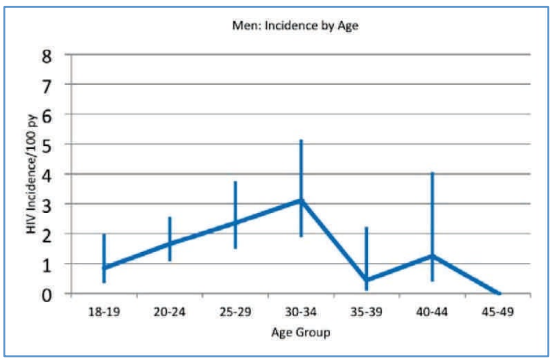


Figure 2: HIV Incidence in Men by Age
Source: Swaziland HIV Incidence Measurement Survey (SHIMS) 2011

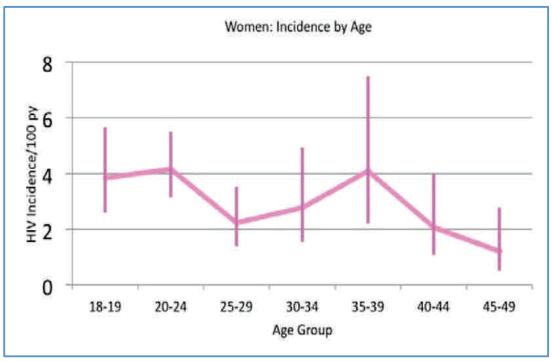


Figure 2: HIV Incidence in Men by Age
Source: Swaziland HIV Incidence Measurement Survey (SHIMS) 2011

Section 2: Objectives of the Rapid Assessment

The rapid assessment is the first of three phases towards strengthening the adolescent component of the national HIV response through a country assessment (See annex B for a schematic illustration of the country assessment process). The specific objectives of the rapid assessment were to:

- Orient stakeholders in Swaziland on the All In agenda
- Assess programme performance on HIV and other related interventions among adolescents aged 10-19 and young people aged 20-24
- Facilitate evidence-informed priority setting on who, what and where to focus HIV programming among adolescents and young people

[6] Swaziland HIV Modes of Transmission Study, 2009
[7] Swaziland HIV Epidemic Estimates, 2013
[8] Swaziland PMTC Impact Evaluation Study 2012
[9] Swaziland HIV Prevention Response and Mode of Transmission Analysis, 2009

Section 3: Methodology

The rapid assessment was a government-led consultative process with participation of various stakeholders including donors and implementing partners, civil society organizations, academia, the United Nations and representatives of adolescent and youth groups. The assessment entailed:

- Review and validation of selected indicators from multiple data sources on HIV and adolescent wellbeing
- Focus group discussions with adolescents and young people
- Synthesis of selected indicator data into a dashboard

The rapid assessment was undertaken using the Adolescent Assessment and Decision Makers (AADM) tool and focused on equity based analysis of the demographic, HIV epidemiologic and programme indicators. See annex C for the selected indicators included in the rapid assessment. The key data sources for the rapid assessment were:

- UN Population Division demographic estimates
- UNAIDS HIV and AIDS estimates
- Demographic and health surveys, e.g. DHS, MICS, targeted surveys (BSS)
- Health information systems
- Qualitative assessments and
- Document reviews

Section 4: Summary of Key Findings

The key findings from the rapid assessment are presented in the Swaziland dash board (see annex A). The key highlights from the rapid assessment include the following:

Adolescent HIV epidemic and programme

Note: Data on young people aged 20-24 was not included in this initial assessment as the AADM tool hasn't been adapted yet, however Swaziland will include this age group in the next phases.

- Adolescents aged 10-19 constitute 24% of the total population in Swaziland.
- HIV prevalence among early adolescent girls and boys aged 10-14 was 3% and the same for both girls and boys. However, in late adolescence (15-19 years), a higher HIV prevalence of 5% was recorded among girls when compared to their male counterparts (3%).
- Very slow decline in AIDS-related deaths was recorded between the periods of 2010-2013. During the same period, there is a slow decline in new HIV infections.
- While HIV incidence among adolescents aged 10-17 is not known, the Swaziland HIV Incidence Measurement Survey (SHIMS 2012) indicates higher HIV incidence among adolescent girls (aged 18-19) at 4% compared to boys (aged 18-19) at 1%; and 4% in young women (20-24 years) compared to young men aged 20-24 (2%).

- Coverage levels are, however, low in all interventions where data were available for adolescents (HIV testing and counselling, antiretroviral treatment, voluntary medical male circumcision, access to media).

Data on programme for adolescents

- Although data were available on 10-19 year old on some interventions, the data were not analysed, disaggregated or reported routinely at a national and sub-national level.
- There were also concerns related to the representation of adolescents in surveys (i.e. ethical issues, sampling).
- There were very limited data on adolescent key populations.
- Overall, there were significant data gaps on progress and targets, limiting the perspective on programme planning and equity in access to available proven interventions for HIV prevention, treatment and care, programme enablers, health, protection, etc. by adolescents.

Adolescent policy and programme environment

Regarding the policy environment:

- There is substantial progress in the enabling policy environment in relation to HIV testing and counselling (HTC), treatment and care; and combination HIV prevention interventions. However, there is a need to strengthen implementation and alignment of policies as some of them conflict in application. For instance, the age of consent for sexual activity is 16, and yet the age of consent to access SRH services is 12 according to the draft SRH policy.
- The policy environment with respect to social and programmatic enablers was particularly challenging with concerns ranging from the protection of adolescent girls from sexual violence, discrimination and the enabling environment for meaningful consultation with and engagement of adolescents.

Regarding the coordination mechanism:

- There is a need for NERCHA to strengthen linkages between existing Technical Working Groups on HIV Prevention, Adolescent Sexual and Reproductive Health, Condoms and HIV Testing and Counselling as well as Antiretroviral Treatment

Opportunities to advance focus on adolescents

- The royal call by His Majesty King Mswati III (the King of Swaziland) to end AIDS by 2022 in Swaziland provided the political context to focus on adolescents.
- The Extended National Strategic Framework for HIV and AIDS (eNSF) 2014-2018 prioritizes adolescent girls and young women and calls for the development of programmes tailored to meet their needs. The All In assessment is poised to provide insights that will guide the design of such programmes.
- The new Swaziland Integrated HIV management guidelines prioritize adolescents.
- The All In assessment can be used to inform interventions targeting adolescents supported through partners such as Global Fund.
- All In has added value to existing Geospatial Information Systems (GIS) initiatives: Partner mapping currently allows to see who is doing what and where, such that interventions can be reallocated where there are overlaps or geographical coverage gaps. In addition to understanding how interventions can be better distributed across health facilities, Phase 2 of All

In can be used to understand which interventions should be prioritized for redistribution or scale-up.

- More powerful evidence-based advocacy for improving youth services: Phase 2 can lead to a better understanding of how to target clinical services better for young people including provision of appropriate commodities; availability (commodities and services) and accessibility of SRH/HIV services to young people.

Innovative ways to enhance adolescent participation include

- The use of social media and mobile technology such as the U-report
- Engaging adolescents themselves in the design, implementation and evaluation of programmes
- Collaboration with adolescents as peer providers, peer support groups
- Using edutainment to reach adolescents
- Partnership with churches and faith based organizations
- Comprehensive sexuality education at school and community levels
- Community outreach targeting parents and other significant populations

Section 5: Priority Actions

Based on the findings from the rapid assessment and engagement with key stakeholders, the following key actions were defined to sustain interest on HIV and adolescents.

- **Understand barriers** to access, delivery and utilization of services and interventions on HIV for adolescents focusing on HIV Testing and Counselling (HTC), Antiretroviral Treatment (ART), condom use among sexually active adolescents, comprehensive life skills (sexuality) education in school and communities, economic and family strengthening for vulnerable adolescents and their families and scale-up of voluntary medical male circumcision (VMMC).
- **Improve access and quality** of services and interventions by promoting innovation, integration of services for adolescents and strengthening systems for delivering programmes for adolescents in clinical settings, schools and communities.
- **Strengthen policy implementation** and addressing contradictions in policy affecting access and programme delivery for adolescents.
- **Meaningful engagement and collaboration with adolescents** to better understand their perspectives and jointly define the programme response, including their engagement in monitoring activities.
- Support expansion and decentralization of **platforms for adolescents**.
- **Support for adolescent reporting** in the review of HIV and sectoral M&E plans.
- **Improve routine M&E and data availability** on adolescents aged 10-14; 15-19 and young people aged 20-24:
    - Revise data collection tools at health facility level to ensure they capture data on adolescents and young people.
    - Improve survey sample size, and support adolescent sensitive design, analysis and alignment of indicators across surveys on HIV and adolescents (census, MICS, key populations, SHIMS 2 etc.).

    - Conduct further analysis of concluded surveys, and disaggregate HTC and ART data to look specifically at 10-14, 15-19, and 20-24 in future.
- **Address ethical limitations** to involve adolescents younger than 18 years in studies and research and undertake adolescent focused secondary analysis of existing data from surveys and centralized databases.
- **Strengthen cross-sectoral coordination mechanisms** for adolescent programming across prevention and treatment, and increase cooperation and coordination across ministries and non-governmental actors.
- **Invest in advocacy and communication on policies** to raise awareness and demand among adolescents.
- **Promote the re-strategizing of interventions for maximum impact:** Where analysis shows that resources are being expended on interventions which are not impactful, these are then re-programmed to accelerate adoption and scale-up of interventions demonstrated to be impactful.
- **Leverage and re-programme existing domestic and external funds and programme processes** (e.g. GFATM, PEPFAR, Development Sector Strategies) with focus on adolescents.
- **Build on national and regional commitments** to ensure follow-up actions on HIV among adolescents**.**

Section 6: Conclusions and Next Steps

The rapid assessment of selected indicators on HIV and adolescents in Swaziland highlighted progress and key gaps in the national response. Immediate next steps agreed with partners to operationalize the findings and priority actions highlighted in this report are as follows:

1. **Sustain political commitment and coordination mechanism on All In**
    - Establishment of high level oversight committee comprised of permanent secretaries of the ministries of health, education and youth and office of the Deputy Prime Minister together with the Executive Director of NERCHA and representatives of the UN country team. The oversight committee will be responsible for high level engagement with the Prime Minister, address contradictory policies and maintain engagement of partners, as well as, mobilise internal and external resources for the HIV response among adolescents.
    - Constitute a task team of middle level technical managers to coordinate the partnership on HIV and adolescents using the All In agenda. Track progress of priority actions, coordinate Phase 2 (in-depth analysis) of the country assessment and report to the oversight committee. The task team will have representation from NERCHA, ministries of health (Adolescent Sexual and Reproductive Health Unit), education, planning, youth and justice; Office of the Deputy Prime Minister, representative from Clinton Health Access and the UN.
    - Collaborate with the Adolescent Sexual and Reproductive Health technical working group (led by the ministry of health) to provide technical leadership for Tinkhundla selection for the in-depth analysis of key interventions on HIV among adolescents – under Phase 2 of the country assessment.
    - Integrate findings of the All In Initiative into the 2015 World AIDS campaign and ensure focus on adolescents and young people.

2. **Strengthen adolescent engagement and participation**
   - Formalize a mechanism for linking adolescents and young people (10-24) with the national HIV coordination structures responsible for programme design, implementation and evaluation (ASRH, HIV Prevention, HTC, Condom, ART, etc.).
   - Facilitate the involvement of adolescents and young people (10-24) in innovative programme design, implementation and monitoring such as accelerating the use of social media and mobile technology to reach and involve them in more in-depth ways.
   - Improve the participation of adolescents and young people in the subsequent phases of the All In process and ensure information is provided in ways that will improve their understanding and enhance engagement.
   - Convene a youth-friendly forum for the dissemination of national reports and continuous engagement of adolescents and young people.

3. **Strengthening adolescent focus in the national programme**
   - Undertake in-depth analysis of priority interventions – HTC, ART, condom, comprehensive life skills (sexuality) education in school and communities, economic strengthening and VMMC in 8 sentinel sites[10] to understand bottlenecks/barriers (supply, demand, quality, social norms and enabling environment) affecting delivery, access and utilization by adolescents. It is planned that this exercise will be completed by October, 2015 as part of the on-going programme performance review and improvement.
   - Disseminate findings from the rapid assessment to partners to influence on-going programme design especially the PEPFAR DREAMS and Global Fund grant making; and ensure adolescent and youth participations in on-going programme planning processes.
   - Mobilize technical assistance to develop a national HIV programme and data improvement plan based on the findings of the country assessments and other existing information. The national programme will adopt a life cycle approach and bring additional focus to adolescents and young people.

4. **Experience sharing**
   - Considering the fact that Swaziland was the lead country to implement the rapid assessment, the country team is committed to sharing their experience on the country assessment with others as may be required.

[10] In the inaugural meeting of the task team on All In, it was agreed that eight sentinel sites (i.e. one urban and one rural Thinkundla in each of the four regions) will be identified for the in-depth analysis. The Thinkundla will be selected based on a composite index comprised of adolescent population density, HIV prevalence, vulnerability assessment mapping, distribution of sexual and reproductive health and adolescent friendly health services and distribution of out-of school adolescent population.

Section 7: Lessons learnt

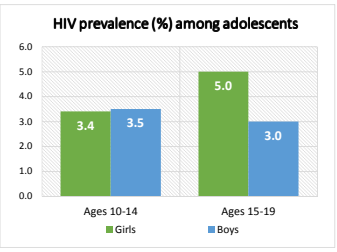
- Initial scoping is important to understand how the All In initiative can best fit within the country context and response such that it adds highest value to current country needs and requirements.
- Prior engagement and preparation of the country teams is crucial for ownership and an efficient running of the process. For instance, AADM tools and data requirements (indicator list) should be shared beforehand, such that the country teams can initiate the data gathering process.
- Methodology and tools should be flexible and easily adaptable to specific country context and needs, for instance the AADM tool should allow adding additional age groups or programme interventions to best fit country needs.
- Ownership at the highest level facilitates advocacy at all levels for the All In initiative and the continuous engagement and commitment of partners in all phases.
- Engaging policy makers early in the process facilitates ownership by government and civil society and allows for easy transition to address advocacy issues to be addressed for establishment and or implementation of policy.
- Engaging and planning with programmers and adolescents ensures that the necessary and most appropriate changes are made at the programme level.
- Clear guidance for each phase should be provided, including a detailed breakdown of the process to guide further steps and a list of specific outcomes for each phase.
- Continuous support from the multi-agency team and the in-country UN teams accelerates progress of the assessment.
- Ensuring the in-country UN agencies have bought into the All In is crucial for coordination and assuring country ownership. Also, all adolescent assessments to be conducted by the UN should be fitted into the All In process to avoid duplication of effort and efficient use of both human and financial resources.

Adolescent Overview Dashboard: Swaziland

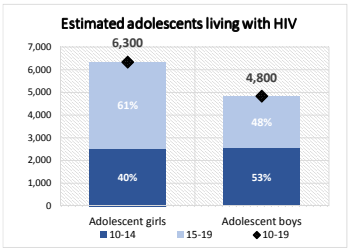
Demographic and Epidemiology Overview

Demographic Indicators: Swaziland	Value
Estimated total population (all ages), 2013	1,106,168
Estimated population of women of reproductive age (ages 15-49), 2013	174,415
Estimated population of adolescents (ages 10-19), 2013	257,850
Estimated population of adolescent girls (ages 10-19), 2013	130,976
Estimated population of adolescent girls (ages 10-14), 2013	65,542
Estimated population of adolescent girls (ages 15-19), 2013	65,434
Estimated population of adolescent boys (ages 10-19), 2013	126,874
Estimated population of adolescent boys (ages 10-14), 2013	64,685
Estimated population of adolescent boys (ages 15-19), 2013	62,189
Percent of the estimated population that is adolescents (aged 10-19)	24%

Source: CSO, Population Census projections for 2014, Swaziland



Sources: UNAIDS 2001-2013 HIV and AIDS estimates, via Spectrum, August 2014



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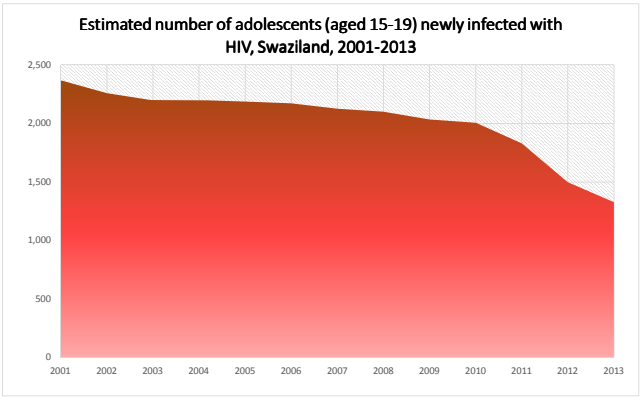

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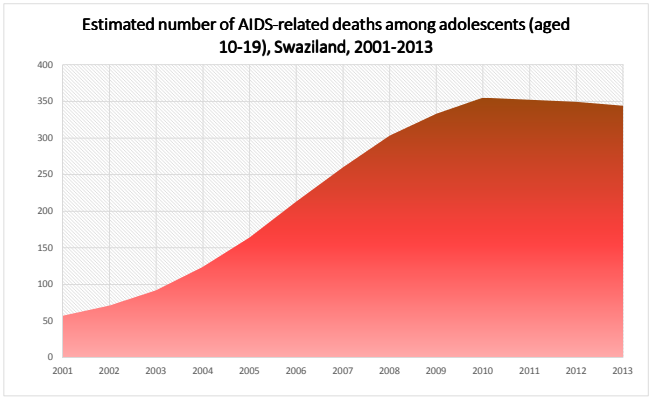
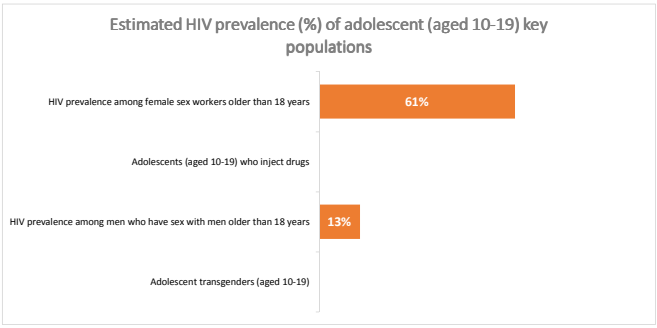
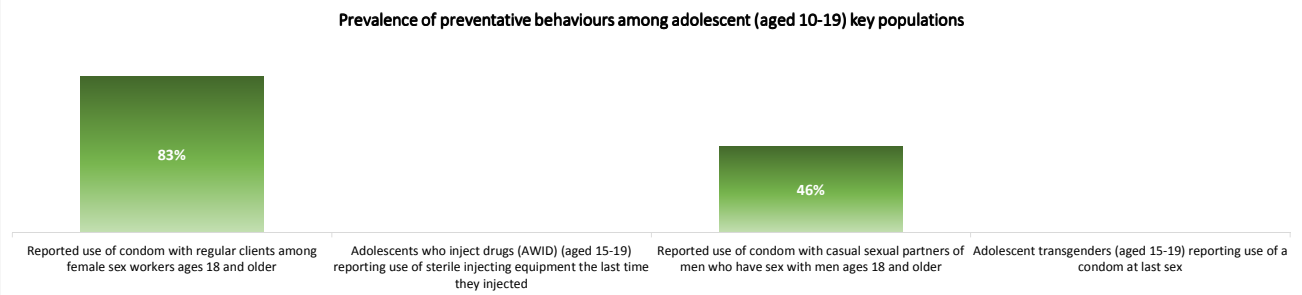


UNAIDS 2001-2013 HIV and AIDS estimates, via Spectrum, August 2014

Adolescent Key Affected Populations

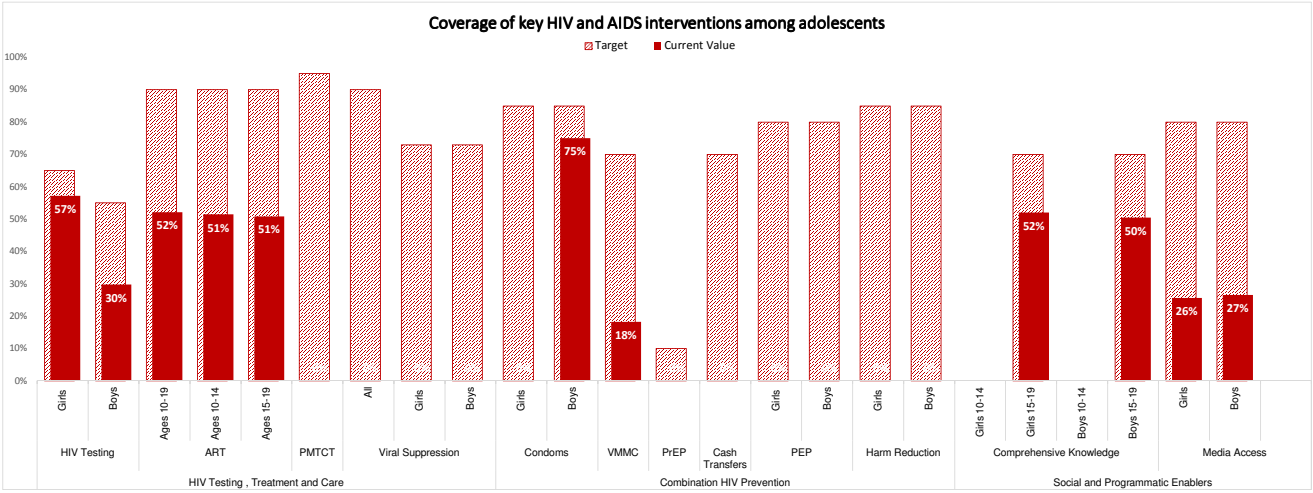


Source: Baral, S et al. 2013. Examining prevalence of HIV infection and risk factors among female sex workers (FSW) and men who have sex with men (MSM) in Swaziland. USAID Project SEARCH



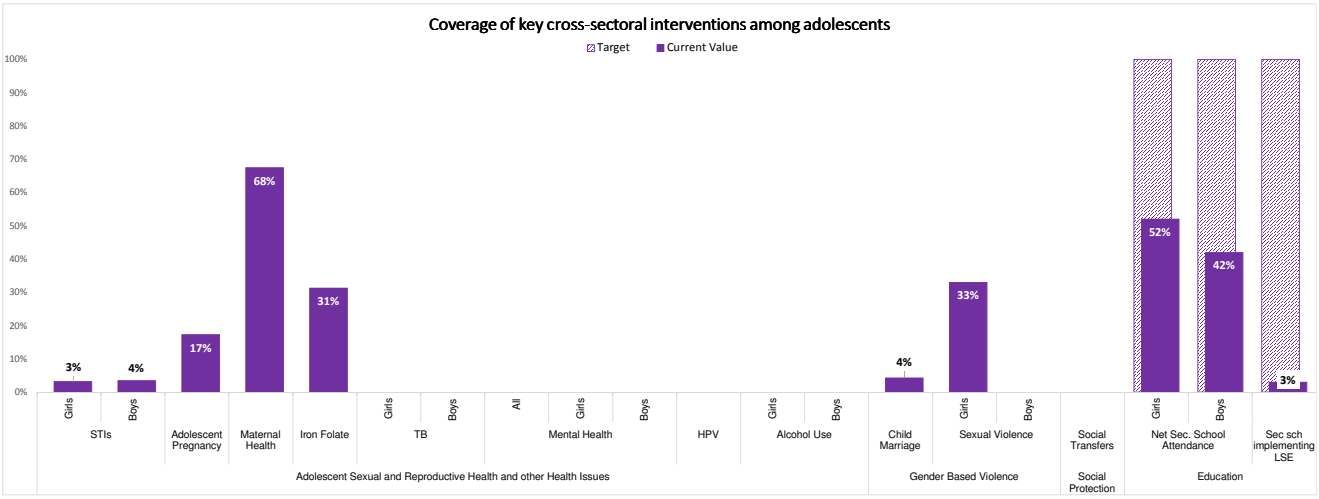
Source: Baral, S et al. 2013. Examining prevalence of HIV infection and risk factors among female sex workers (FSW) and men who have sex with men (MSM) in Swaziland. USAID Project SEARCH

HIV-Specific Adolescent Interventions



Sources: MICS 2010, SHAPMoS, SDHS 2007, HIV Guidelines and Targets from The Extended National Multisectoral HIV and AIDS Framework (eNSF) 2014 - 2018 and Global Targets

Cross-Sectoral Adolescent Interventions



Sources: SDHS 2007, MICS 2010, MICS 2010, UNICEF Violence Study 2007, Education Annual Census 2012

Programme Environment for Adolescents

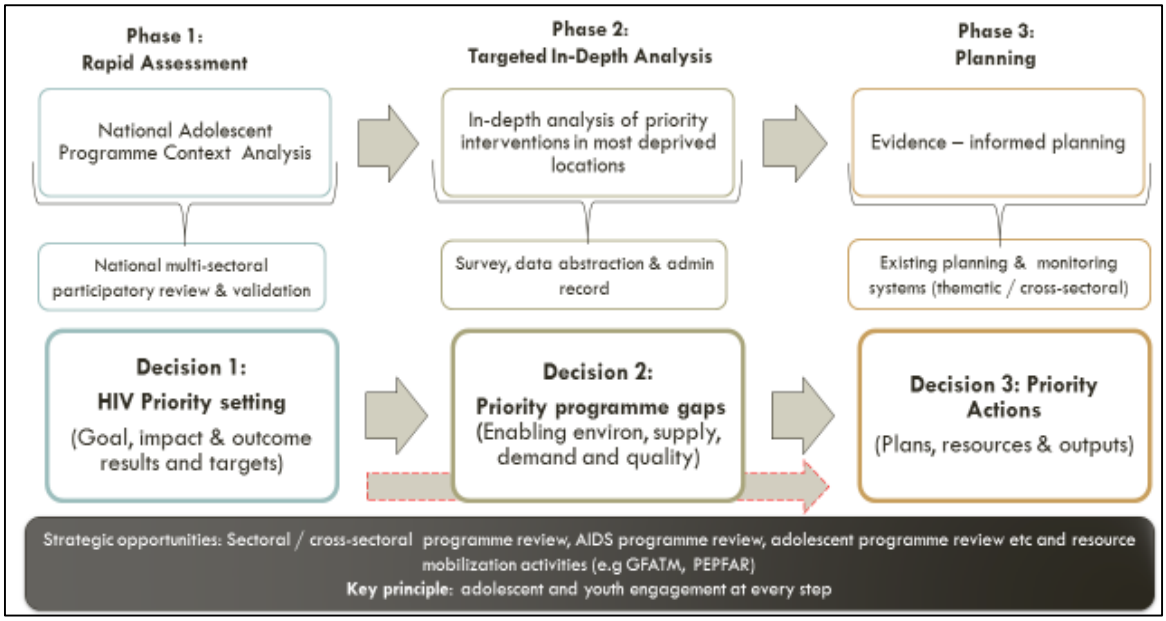
On Track | Substantial Progress | Very Little Progress | Off Track

Programme	Interventions	National Programme Environment for Adolescents		
		Policy	Coordination	Stigma
HIV Testing, Treatment and Care	HCT, ART, PMTCT, Viral Suppression	3	3	
Combination HIV Prevention	Condoms, VMMC, PreP, PEP, Harm Reduction	3	3	
Social and Programatic Enablers	Protective laws, Comprehensive life skills education, innovative communication / mobilization	3	3	

Source: Qualitative assessment by workshop participants (Government, Civil Society Organizations, Adolescent and Youth Networks and United Nations Joint Team)

Annex B: The Country Assessment Process

The country assessment is premise upon the HIV investment framework[11], the *"All In!"* strategic framework[12] and the UNAIDS modelling for the fast track initiative to end AIDS by 2030[13] and will be implemented in 3 phases at country level.



Source: UNICEF, 2015. Guidance Document for Strengthening Adolescent Component of National HIV Programme through country assessments [unpublished]

- **Phase 1 : Rapid assessment is the national adolescent programme context analysis** which focuses on the validation of existing data on HIV and adolescent wellbeing and aims at defining priority populations and programmes to accelerate HIV results in adolescents

- **Phase 2: In-depth analysis of priority interventions at sub-national levels** offers an in-depth examination of gaps and barriers limiting the impact of priority programme interventions identified in Phase 1. It will focus on low performing interventions in limited geo-settings to enable understanding of core supply, demand, quality and structural challenges.

- **Phase 3: Evidence-informed planning** will harmonize decisions and outputs from phases 1 and 2 into multi-sectoral plans for adolescents and HIV, and facilitate actions to operationalize set priorities.

[11] *Schwartländer, B. et al. 2011. Towards an improved investment approach for an effective response to HIV/AIDS. Lancet, 377:2031 – 41*
[12] *UNICEF and UNAIDS, 2015. All In! to End Adolescent AIDS. Launch document*
[13] *UNAIDS, 2014. Fast tract initiative to end AIDS by 2030. Online Available UNAIDS website* *http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report*

Annex C: List of Demographic, HIV Epidemiologic and Other Adolescent Indicators included in Phase 1 of the Country Assessments

Category	Indicator		Data Source
Demography	Estimated population (all ages)		UN population Division
	Estimated population of women of reproductive ages 15-49		UN population Division
	Estimated population of adolescents (aged 10-19)		UN population Division
	Estimated population of adolescent girls	10-14	UN population Division
		15-19	
	Estimated population of adolescents	10-14	UN population Division
		15-19	
HIV Epidemiology	HIV Prevalence (National / sub-national)	General Pop.	Modelled HIV estimates/surveys
		15-24	
	HIV prevalence (%) among adolescent girls	10-14	Modelled HIV estimates / surveys
		15-19	
	HIV prevalence (%) among adolescent boys	10-14	Modelled HIV estimates / surveys
		15-19	
	Estimated number of adolescent girls living with HIV	All	Modelled HIV estimates
		10-14	
		15-19	
	Estimated number of adolescent boys living with HIV	All	Modelled HIV estimates
		10-14	
		15-19	
	Percentage of adolescents (aged 10-19) living with HIV who were vertically infected		Modelled HIV estimates
	Estimated number of adolescents (aged 15-19) newly infected with HIV		Modelled HIV estimates
	Estimated number of adolescent boys (aged 15-19) newly infected with HIV		Modelled HIV estimates
	Estimated number of adolescent girls (aged 15-19) newly infected with HIV		Modelled HIV estimates
	Estimated number of AIDS-related deaths among adolescents (aged 10-19)		Modelled HIV estimates
	Estimated number of AIDS-related deaths among adolescent boys (aged 10-19)		Modelled HIV estimates
	Estimated number of AIDS-related deaths among adolescent girls (aged 10-19)		Modelled HIV estimates
Adolescent Key Population	Population size estimate of adolescents (10-19 years) who sell sex[14]	Female	Modelled size estimates
		Male	
		Transgenders	
	Population size estimate of adolescents (10-19) who inject drugs	Girls	Modelled size estimates
		Boys	
	Population size estimate of gay and bisexual adolescent		Modelled size estimates
	Population size estimate of adolescent transgenders		Modelled size estimates
	HIV prevalence among adolescents who sell sex[14]	Female	Targeted surveys / programme data
		Male	
		Transgenders	
	HIV prevalence among adolescents (aged 10-19) who inject drugs	Girls	Targeted surveys / programme data
		Boys	
	HIV prevalence among gay and bisexual adolescents (aged 10-19)		Targeted surveys / programme data
	HIV prevalence among adolescent transgenders (aged 10-19)		Targeted surveys / programme data
	Percentage of adolescent who sell sex (aged 15-19)[14] using a condom at last sex	Female	Targeted surveys / programme data
		Male	
		Transgenders	
	Percentage of adolescent who inject drugs (AWID) ages 15-19 reporting use of sterile injecting equipment the last time they injected	Girls	Targeted surveys / programme data
		Boys	
	Percentage of gay and bisexual adolescent boys (aged 15-19) using a condom at last sex		Targeted surveys / programme data
	Percentage of adolescent transgenders (15-19) using a condom at last sex		Targeted surveys / programme data

[14] This definition include adolescents 10-17 years who are sexually exploited in the sex industry through selling sex

Programme Outcome Indicators			
Category	**Indicator**		**Data Source**
1. HIV Prevention, Testing and Care			
HIV Testing	Percentage of sexually active adolescents (aged 15–19) who were tested and received results in the last 12 months	All	Population based surveys / Programme data
		Girls	
		Boys	
ART	Percentage of adolescents (aged 10-19) living with HIV receiving antiretroviral therapy for treatment	10-14	Modelled HIV estimates / programme data
		15-19	
PMTCT	Percentage of pregnant adolescents 15-19 years living with HIV who received ARVs for PMTCT		Modelled HIV estimates / programme data
Viral suppression	Percentage of adolescents 10-19 years living with HIV on ART who are virologically suppressed (VL below 1000 copies)	All	Modelled HIV estimates /programme data
		Girls	
		Boys	
2. Combination HIV Prevention			
Condoms	Percentage of adolescents (aged 15-19) reporting multiple partners in the last 12 months who used a condom at last sex	Girls	Population based surveys
		Boys	
VMMC	Percentage of adolescent males (10-19 years) who are circumcised		Surveys
Pre-Exposure Prophylaxis (PreP)	Percentage of eligible sexually active adolescents who self-report usage of pre-exposure prophylaxis		Targeted surveys / programme data
Cash Transfer	Percentage of the poorest households receiving cash transfers in the last 3 months		Surveys / administrative data
Post Exposure Prophylaxis (PEP)	Percentage of eligible adolescent for post-exposure prophylaxis (PEP) for HIV that used it within 72hours of sexual violence	Girls	Targeted surveys / programme data
		Boys	
Harm Reduction	Percentage of adolescents aged 15-19 who inject drugs reporting use of sterile injecting equipment the last time they injected	All	Targeted surveys / programme data
		Girls	
		Boys	
3. Social and Programmatic Enablers			
Comprehensive Knowledge about HIV[15]	Percentage of adolescent (10-19 years) who have comprehensive knowledge of HIV	Girls 10-14	Population based surveys
		Girls 15-19	
		Boys 10-14	
		Boys 15-19	
Access to media	Percentage of adolescents 15-19 years who, at least once a week, read a newspaper or magazine, listen to the radio, or watch television	Girls	Population based surveys
		Boys	
Protective Laws	Availability of policy statement reducing age of consent for services below 18 years? (Y/N)		Administrative data
Decision making	Percentage of adolescents 15-19 years that have final say in their health care	Girls	Population based surveys
		Boys	
4. Cross-sectoral Adolescent Programmes (Synergies)			
4.1 Adolescent Sexual and Reproductive Health and other Health Issues			
Sexually Transmitted Infections (STI)	Self-reported prevalence of sexually transmitted infections among adolescents 15-19 years	Girls	Population based surveys / HMIS
		Boys	
	Percentage of pregnant adolescents with a positive Syphilis test that receive treatment	Girls	Facility / Population based surveys / HMIS
		Boys	
Adolescent Pregnancy	Percentage of adolescent girls (15-19 years) who have had a live birth or who are pregnant with their first child (began child bearing)		Population based surveys
Family planning	Percentage of women aged 15-19 years, who are sexually active, who have their need for family planning satisfied with modern methods		Population based surveys

[15] Comprehensive knowledge is defined as Comprehensive, correct knowledge about HIV and AIDS is defined as correctly identifying the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), rejecting the two most common local misconceptions about HIV transmission and knowing that a healthy-looking person can transmit HIV.

Category	Indicator		Data Source
Maternal Health	Percentage of adolescents age 15-19 years with a live birth in the last 2 years who attended ANC during their last pregnancy at least four times by any provider		Facility based or population based surveys
	Percentage of live births to adolescent girls ages 15-19 attended by a skilled health personnel (doctor, nurse, midwife or auxiliary midwife)		Facility based or population based surveys
Iron Folate Supplementation	Percentage of pregnant adolescent girls (aged 15-19) who are malnourished		Surveys / programme data
Tuberculosis	Prevalence of tuberculosis (T/B) among adolescents (10-19 years)	Girls	Facility based survey / HMIS
		Boys	
Mental Health	Number of adolescent deaths due to suicide per 100 000 adolescent population (under discussion)	10-14	WHO Mortality database
		15-19	
Human Papilloma Virus (HPV	Percentage of 15 year old girls in target population who have completed the full dose vaccination schedule for human papilloma virus (HPV)		Measures Evaluation, / HMIS
Use of Alcohol	Proportion of adolescents who had one alcoholic drink at least on one or more days during the past 30 days	Girls	GSHS[16] / HBSC[17]
		Boys	
4.2 Gender Based Violence			
Child Marriage	Percentage of adolescents ages 15-19 years who are currently married or in union		Population based survey
Sexual Violence	Percentage of ever partnered women 15-19 years who have experienced physical and/or sexual violence by an intimate partner in the last 12 months	10-14	Population based survey
		15-19	
	Percentage of adolescent girls who have ever experienced sexual violence	10-14	Population based survey
		15-19	
4.3 Social Protection			
Social Transfers	Percentage of the poorest households receiving external economic support in the last 3 months		Surveys / administrative data
4.4 Education			
Girls Education	Net secondary school attendance (disaggregated by boys and girls)		Survey / EMIS
Sexual & Reproductive Education	Proportion of teachers trained (in-service & pre-service) with quality comprehensive sexuality education curriculum (modified ESA target 2)		ESA Report (UNESCO)
	Percentage of schools with teachers who received training and taught lessons in life skills-based HIV and sexuality education in the previous academic year		

[16] Global School Health Survey
[17] Health behaviour in school-aged children