Chapter 4: Determinants (Risk and protective factors) Indicators

Overview

Adolescent behaviours are influenced by a variety of factors which, in turn, are dependent on differences in relationships, settings, cultures, and economic conditions. These factors are called “determinants” as they determine, or influence, individual behaviours. Determinants can be either positive or negative, and, depending on their effect, they are often referred to as "risk or protective factors."

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<th>Definition of Risk and Protective Factors:</th>
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<td><strong>Risk factors</strong> are conditions or variables associated with a lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes. <strong>Protective factors</strong> have the reverse effect: they enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk.</td>
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Jessor, Turbin and Costa “Risk and protection in successful outcomes among disadvantaged adolescents” 1998

In the context of HIV/AIDS prevention, risk factors increase the chances that adolescents will engage in sexual-risk taking or otherwise expose themselves to HIV. Protective factors decrease that chance. An example of a risk factor for early sexual debut is having the perception that one’s friends are sexually active. Youth who perceive that their friends are sexually active are more likely to have had sex themselves. Examples of protective factors include "positive attitudes toward contraception," and "ability to refuse unsafe sex."

Some determinants, such as age, sex, beliefs and attitudes, relate to the individual, while others relate to peer, family, and community influences, and the broader socio-economic environment. The importance of factors external to young people is intrinsic to the WHO/UNFPA/UNICEF Framework for Programming for Adolescent Health and Development ("Action for adolescent health: towards a common agenda, [http://www.who.int/child-adolescent-health.htm](http://www.who.int/child-adolescent-health.htm), which emphasises that the creation of a safe and supportive environment is fundamental to adolescent health and development. It is these indicators that provide information about the determinants that underlie behaviours and HIV transmission in young people, and provide the basis for immediate and long-term responses to the prevention of HIV/AIDS among young people. Programme managers and evaluators responsible for developing and monitoring programmes for young people need to monitor and assess these determinants if their efforts are to be effective and have an impact on the problems that undermine young people’s health and development.

**Why is Collecting Data on Determinants (Risk and protective factors) Important for Managers?**

The routine collection of data about the context of young people's lives is important for programme managers for a number of reasons:

- **advocacy**, so that a compelling case can be made for investing in interventions that decrease young people’s vulnerability, and subsequently the likelihood of them adopting behaviours that decrease the transmission of HIV
targeting interventions such as information, life skills and health services, in order to ensure that those young people who are most vulnerable are not excluded from the provision of key interventions

developing and implementing interventions that are not only directed to individual young people themselves, such as information, skills and services, but that are also directed to the environments in which they live, learn and earn

policies, so that these can include a focus on those factors that increase young people’s vulnerability and ensure that their rights are protected, and to provide a way to regularly assess the implementation of those policies that have been developed

The key indicators that need to be considered by programme managers are outlined in this Guide under three groups: socio-demographic characteristics, vulnerable sub-populations, and the key determinants of HIV-relevant behaviours.

Socio-demographic characteristics describe the target population, such as the distribution of age, marital status, religious affiliations, living arrangements, and urban/rural residence. Much of these data are widely collected through census reporting and through established surveys, such as the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). Details regarding the collection of these indicators are not provided, because new data collection is not required. What is frequently required, however, is disaggregation of existing data by age, sex and marital status so that information specific to young men and women is available. Indicators in this category include:

1. Proportion of the national population aged 10-14, 15-19 and 20-24
2. Proportion of the urban population aged 10-14, 15-19 and 20-24
3. Proportion of the rural population aged 10-14, 15-19 and 20-24
4. Proportion of young men and women in school aged 10-14, 15-19 and 20-24
5. Proportion of young men and women who are currently married aged 10-14, 15-19 and 20-24
6. Median age at first marriage for young men and women
7. Median age at first birth
8. Proportion of young people living on income below the poverty line (nationally defined), aged 10-14, 15-19 and 20-24
9. Distribution of population (adult, and young people) by religious denominations, aged 10-14, 15-19 and 20-24
10. Proportion of population (adult, and young people) expressing accepting attitudes towards people living with HIV
11. The proportion of young men and women who have access to mass media (radio, television, internet), aged 10-14, 15-19 and 20-24
12. Proportion of young men and women working outside the home, aged 10-14, 15-19 and 20-24

13. Proportion of young men and women who live with their parents, aged 10-14, 15-19 and 20-24

The second group of indicators are related to specific vulnerable sub-populations of youth, such as injecting drug users, young people orphaned by HIV/AIDS, and commercial sex workers. Details regarding the collection of data for these indicators are also not being provided in this guide, as other guides provide detailed information on sampling each of these groups (specifically: “Behavioural Surveillance Surveys: Guidelines for repeated behavioural surveys in population at risk of HIV,” published by Family Health International; and the forthcoming “Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS,” UNAIDS and UNICEF). Indicators in this category include:

1. Number and proportion of injecting drug users who are between the ages of 10-14, 15-19, and 20-24.
2. Number and proportion of commercial sex workers who are between the ages of 10-14, 15-19, and 20-24.
3. Number and proportion of young men who have sex with men (age 10-14, 15-19, 20-24).
4. Proportion of young people (10-14, 15-18) who are orphaned.

The last group of indicators describe the key determinants (risk and protective factors) of behaviours particularly relevant for HIV prevention. Many of them are still in the development stage, but have been included in this Guide to provide programme managers with an indication of the aspects of young people’s lives that need to be monitored. It is anticipated that the experiences gained in measuring these indicators will make important contributions to future versions of this Guide. Below is a list of these indicators, with more details on each in the pages that follow:

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1. Knowledge of HIV prevention among young people

Priority: Core

Definition
Percentage of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV

Target Population
10-24 year olds

Numerator
Number of respondents who gave correct answers to all five questions relating to transmission of HIV and misconceptions about HIV

Denominator
All young people

Measurement tools
Nationally representative general population survey

What it measures
This indicator combines the measures of knowledge of HIV transmission and prevention with the prevalence of most common misconceptions about HIV.

How to measure it
Responses to the following series of questions, recommended by the UNAIDS Guidelines on Construction of Core Indicators, are used to construct this indicator:

1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV infection?
4. Can a person get HIV infection from mosquito bites?
5. Can a person get HIV infection by sharing a meal with someone who is infected?

Items 4 and 5 may be replaced with the two most common local (national) misconceptions about HIV transmission or prevention. For example, “Can HIV in an infected man be cured if he has sex with a virgin girl?”
Items 1 and 2 measure the correct knowledge for preventing HIV transmission. Item 3 measures a common misconception that healthy-looking people do not have HIV infection. This is a widespread misconception among young people, and it can result in unprotected sex with an infected partner. Items 4 and 5 refer to two other misconceptions about HIV transmission. Together the indicator provides programme managers with a measure of the overall knowledge that young people have of avoiding HIV.

Previous knowledge indicators have included abstinence as a "correct" method of prevention used in this indicator. Abstinence is an extremely important prevention option for young people. Research in many settings shows that already sexually active people rarely use abstinence as a primary HIV-prevention method, however, young people in particular may be practising "secondary abstinence" - that is, a prolonged voluntary period of sexual inactivity following sexual initiation. Negative responses on this item may therefore result from people believing that abstinence is not feasible, rather than from belief that abstinence does not provide effective protection. In surveys among adolescents, however, questions about abstinence continue to be important. Programmes focusing on delaying age at first sex among adolescents (ages 10–19) may choose to add a knowledge indicator that includes correct responses to a question about abstinence as a prevention method in the numerator. A suggested question on abstinence might be: “Can the risk of HIV transmission be reduced by abstaining from sexual intercourse?”

This indicator should be presented as a percentage separately for men and women disaggregated by age in the following groups: 10–14, 15–19, 20–24 and 10–24 (eight categories). In addition, this particular indicator should also be presented for the 15-24 age group, as the Millennium Development Goals and the UNGASS HIV Goals are specified for this age group in particular.

The indicator can also be disaggregated by question to show gaps in knowledge and prevalence of misconceptions.

**Strengths and limitations**

Sound knowledge of HIV transmission and prevention is a prerequisite, although alone insufficient, for adoption of behaviour that reduces the risk of HIV transmission. Correct knowledge of false modes of transmission is as important as knowing correct modes, and correct basic understanding of how to protect oneself is critical to young people. Disaggregated data on this can provide meaningful guidance for national health-promotion programmes.

This indicator is easy to measure in a survey, and is especially informative in countries where overall knowledge of HIV/AIDS is low, because it permits easy measurement of incremental improvement over time. In countries where knowledge is high, the indicator can tell whether the high levels are maintained.
2. Knowledge of a formal source of condoms among young people

Priority: Additional

Definition
Percentage of young people who know of at least one formal source of condoms

Target Population
15-24 year olds

Numerator
Number of young people, aged 15-24 years, who can name at least one formal source of condoms

Denominator
All young people

Measurement tools
Nationally representative general population survey

What it measures
Studies in sub-Saharan Africa have demonstrated that adolescents who know of at least one source of condoms are much more likely to use them. This indicator measures the proportion of young people who can name at least one formal source of condoms.

Note that there may be many acceptable answers to the question on sources, including health centres, pharmacies, stores, outreach clinics, vending machines, or any other formal structure or setting where condoms can be purchased or obtained free of charge. The exact range of acceptable sources is best defined in each national setting.

How to measure it
This indicators is assessed by asking respondents to name at least one source where they can obtain condoms. The question should allow for more than one source to be listed (the maximum number can be defined in each national setting, but three sources is an acceptable option). In a surveyor-administered questionnaire, the surveyor should simply record the sources listed, probing the respondent to think of another source until the set number of sources is listed, or until the respondent cannot name any additional source. In a self-administered questionnaire, a number of blank spaces should be provided into which the respondent writes his/her response. At the analysis stage, certain stated sources may be considered unacceptable, or “incorrect” (for example, “friends” or “family members” may not be considered formal sources of condoms).

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1 Meekers and Calves, 1999; Kamya et al., 1997
This indicator should be presented as a percentage separately for men and women disaggregated by age in the following groups: 15–19, 20–24 and 10–24 (six categories).

**Strengths and limitations**

In many parts of the world, the vast majority of young people will know of at least one formal source of condoms. To obtain a meaningful answer in this case, one option is to increase the minimal number of sources that must be listed for a “correct” answer. That is, the numerator is composed of respondents who are able to list, for example, at least two formal sources of condoms.

While knowing a source of condoms is the first step in obtaining them, it is not the same as actually being able to do so. Numerous barriers prevent young people from accessing condoms: among the more common are their cost, and the stigma associated with obtaining them. Programmatically, it is very important to examine these barriers, as interventions can be targeted at addressing them (e.g., subsidizing condom cost, or targeting media campaigns at reducing stigma).

This indicator can be interpreted together with Indicator 6 in the Programmatic chapter of this Guide -- Condom availability for young people.
3. Sexual decision-making among young people

Priority: Additional

Definition
Percentage of young people who believe they have the ability to refuse unwanted sex

Target Population
Unmarried, 15-24 year olds

Numerator
The number of young people who feel that they have the ability to refuse unwanted sex

Denominator
All young people

Measurement tools
Nationally representative general population survey

What it measures
This indicator measures whether young people feel confident that they have some degree of control over their sexual lives and activities. Related to “self-efficacy” at the individual level, this indicator measures the extent to which young people feel capable of protecting themselves. If young people feel that sex is something that happens to them over which they have little control, they will likely be unable to avoid unwanted sex.

How to measure it
For the numerator, culturally-appropriate questions about young people’s perceived ability to refuse sex should be developed. For example:

If you did not want to have sex, how confident are you that you would be able to refuse sexual intercourse?

(0) Definitely could not, (1) Probably could not, (2) Probably could, (3) Definitely could.

In an interviewer-led survey, the interviewer would read these options to the respondent, and ask him or her to choose one of the options.

To calculate the indicator as a percentage, those answering “probably could” or “definitely could” can be classified as a “yes” answer, while all others can be classified as a “no” answer, and the proportion calculated accordingly. Alternately, the distribution of the full answers could
also be presented (each answer category a percentage, adding up to 100%), for each of the sub-groups of interest (e.g., male and female, different age groups, etc).

This indicator should be presented separately for men and women disaggregated by age in following groups: 15-19, 20-24 and 15-24 (6 categories).

**Strengths and limitations**
This indicator is useful in that it measures an essential attribute of the context in which young people live, and their perceptions of it. If young people perceive that the context or cultural environment in which they live limits their power to refuse or negotiate sex, efforts in HIV prevention must be tailored to address this issue, and evaluation of existing prevention efforts must consider this limitation.

In some cases, more in-depth information of the types of sexual relationships and situations young people are in may be desired. If so, this question can be expanded to cover a variety of relationships and situations. For example, it can be expanded to cover ability to refuse sex with a long-term partner, with someone who offers money or gifts, or with someone who holds power over the respondent (like a teacher or employer). An additional question can also be added that asks about whether they are confident they can negotiate condom use. This question could also further be expanded to cover the ability to use a condom after drinking or taking drugs, to insist on condom use even if partner is reluctant, and to refuse sex if a condom is not used. For further insight into how such questions are formulated, refer the FOCUS guide.  

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4. Perception of peers' sexual activity (peer norms)

Priority: Additional

Definition
Percentage of young people who perceive their friends have had sex

Target Population
10-24 year olds

Numerator
Number of respondents aged 10-24 years who perceive their friends have had sex

Denominator
Respondents aged 10-24 years

Measurement tools
Nationally representative general population survey

What it measures
It seems common sense to state that peer attitudes and norms are an important influence on the behaviours of young people. Yet attitudes and norms among young people are important to track as studies conducted both in developed and developing countries have demonstrated that when adolescents believe their friends are engaging in sex, they are more likely to report having had sex themselves\(^3\). This indicator measures the extent to which young people believe their friends are sexually active.

How to measure it
In a general population survey respondents are asked the following question, and the possible response categories are read out loud by the interviewer (asking the respondent to choose one of the options):

- About how many of your friends do you think have had sex?
  1. None of them
  2. A few of them
  3. About half of them
  4. Most of them
  5. All of them

Each of the possible answers can be presented as a percentage (all adding up to 100%). This is particularly insightful if calculated separately for major sub-groups of interest (males and

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\(^3\) See for example Kirby, 2001; Murray et al., 1998; Magnani et al., 2001; Park et al., 2002; Magnani et al., 2002; Kiragu and Zabin, 1993; Karim et al., 2000; Selvan et al., 2001; Laguna, 2001; Isarabhakdi, 1999; Podhisita, 2001
females, and for age groups 10-14, 15-19, 20-24), as differences in perceptions among different groups can thus be uncovered.

Alternately, each of the given answers can be given a score (increasing with the proportion believed to be sexually active; e.g., from 0 to 4). The scores of all respondents can be summed up, and divided by the total number of respondents to obtain an average score. This average should also be calculated separately for males and females, as well as for different age groups (10-14, 15–19, 20–24 and 10–24).

Generally, as the perception that a large number of friends are sexually active increases, so too does the likelihood of reporting having had sex. This indicator should therefore be interpreted in conjunction with the indicators measuring reported sexual activity (refer to the Behavioural chapter in this guide).

**Strengths and limitations**
This indicator is most insightful among a population of young people who have not yet begun to have sex. Both theory and empirical research demonstrate a relationship between peer norms of sexual behaviour and actual sexual activity (Bearman et al., 1999; Kirby, 2001). Correspondingly, interventions such as peer education programmes often focus on changing norms.

However, since most of the studies that have analyzed the influence of the perception of friends' sexual behaviour on actual behaviour are cross-sectional, it is still not clear whether the relationship is causal. For example, it could be that adolescents mimic the actual or imagined behaviour of their peers, or it could also be that once adolescents initiate sexual activity, they are more likely to assume that their peers are also sexually active.

Nevertheless, this indicator provides important insight regarding young people’s beliefs of how common it is for their peers to be sexually active. This is important as studies have shown that young people often over-estimate the proportion of their peers that are having sex (Robinson, Telljohan and Price 1999; Kinsman et al 1998; Romer et al 1994). In this case, peer norms act as a risk factor, possibly contributing to early sexual activity. However, peer norms can also have a positive effect: adolescents who believe that their peers were using condoms have been found to be more likely to use condoms themselves (Romer et al 1994).
5. Connection to a parent or primary caregiver among young people

Priority: Additional

Definition
Percentage of young people who feel connected with their parent and/or primary caregiver(s)

Target Population
10-19 year olds

Numerator
1) The number of young people aged 10-19 in each of the three connection “categories”
   (low, medium, and high)
2) As a mean score: the sum of all answers

Denominator
1) All young people aged 10-19
2) As a mean score: all young people aged 10-19 multiplied by 45

Measurement tools
Nationally representative general population survey

What it measures
This indicator measures the percentage of adolescents (aged 10 to 19) who feel connected with their parents or primary caregivers. Evaluators measure the connections in terms of the closeness of relationships between young adolescents and parents or primary caregivers.

This is a set of items compiled from a careful review of theory, empirical work, and existing programming in many developed and developing countries\(^4\). The list is a synthesis across many sources. Thus any one or two sources would not sufficiently cover the breadth. Therefore, it represents a comprehensive assessment of the supportive behaviours caregivers engage in that help create a positive connection with adolescents. It is limited, of course, to the adolescent perceptions of the occurrence of these behaviours, which may or may not be consistent with how the caregiver would assess the same behaviours.

How to measure it
This indicator is measured by calculating proportions or a mean score from 10 attitudinal items in a survey that includes young people. The items for measuring connection have been tested and validated in 12 different cultural settings. The 15 statements that comprise the connection indicator are about the young person’s relationship with parents or primary caregivers.

Respondents are asked to choose from a list of adults (e.g., mother, father, grandparent, aunt/uncle, guardian, etc.) the one adult who they spend the most time living with. Then, in relation to this caregiver, they are asked to choose their answer for each statement from a three-point Likert-type scale, rating how much the primary caregiver does each of the stated things: (1) not at all, (2) sometimes, (3) often.

1. ‘Supports and encourages me’.
2. ‘Gives me attention and listens to me’.
3. ‘Shows me affection’.
4. ‘Praises me’.
5. ‘Comforts me’.
6. ‘Respects my sense of freedom’.
7. ‘Understands me’.
8. ‘Trusts me’.
9. ‘Gives me advice and guidance’.
10. ‘Provides for my necessities’.
11. ‘Gives me money’.
12. ‘Buys me things’.
13. ‘Has open communication with me’.
14. ‘Spends time with me’.
15. ‘Supports me in my school work’.

The results are calculated as the proportion of young people who feel little, somewhat, or very connected to their parents or caregivers. As the scale has only three items, the results can be categorized into “low,” “medium” and “high” connection. This categorical interpretation may be useful in some cases – for example, to make the message clearer and more appealing for advocacy purposes.

The outcome can also be calculated as a mean score: summing up all answers, and dividing by the number of respondents*45.

All answers
(All respondents * 45)

In addition, the outcome can be correlated with the health behaviour (or health outcome) of interest – for example, sexual initiation, condom use, etc. This yields a measure of the importance of positive connection between young people and parents or caregivers, and its effect on behaviour and health outcomes.

This indicator should be presented as a percentage separately for men and women disaggregated by age in the following groups: 10–14, 15–19, and 10-19 (six categories).

If suitable data are not available this indicator should not be reported.

Strengths and limitations

There is substantial research that demonstrates that adolescents who perceive that their caregivers support them in the ways measured in this indicator have statistically higher levels of well-being and lower levels of risk behaviours (e.g., Barber et al., 2003; Rohner, 1996; Rollins & Thomas, 1979). Adolescents who live in a family where there is conflict are more likely to experience depression and use illicit substances (WHO “Broadening the Horizon” 2001). HIV is, ultimately, driven by individual sexual behaviour, and the context in which young people grow up and make decisions – including sexual decisions – contributes greatly to the types of decision taken (i.e., engaging in risk behaviour or not). Connection describes one aspect of that context – in this case, the family context, and its contribution to adolescent health and development.
Often it is difficult to address contextual factors through programmes. Connection to parents is, however, one contextual factor that can be, and has been, addressed programmatically. Most often, such efforts have focused on improving the communication between parents and adolescents - particularly on sensitive issues such as sexual and reproductive health - through information/communication campaigns targeted at parents, and through school-based efforts at involving parents more actively in communication with their children. While connection is certainly composed of different aspects of the parent-child relationship, an open and positive communication is an important aspect of connection, and one that can be successfully promoted through interventions. Where the level of connection is low, programmes for parents or primary caregivers, or the provision of alternative mentors, may be called for. In such programmes, evaluators may also use this indicator as an intermediate outcome indicator to measure improvements in the social environment for young people in the programme’s intended population.

NOTE: this indicator should be interpreted together with the measure for parental regulation of adolescent behaviour (see following indicator). That indicator focuses on parental knowledge of adolescent actions, which is an aspect of parental “regulation,” related to structure and boundaries particularly around young people’s behaviours. Recent literature has shown that it is both the positive connection with parents/caregivers, as well as positive regulation by parents/caregivers, that contribute most effectively to young people’s positive health and development outcomes.
6. Parental (or primary caregiver) regulation of young people's behaviours

Priority: Additional

Definition
Percentage of young people who report low, medium or high level of regulation of their behaviours by their parent or primary caregiver

Target Population
10-19 year olds

Numerator
1) The number of young people aged 10-19 in each of the three regulation “categories” (low, medium, and high)
2) As a mean score: the sum of all answers

Denominator
1) All young people aged 10-19
2) As a mean score: all young people aged 10-19 multiplied by 15

Measurement tools
Nationally representative general population survey

What it measures
This indicator is a measure of the percentage of adolescents (aged 10–19) who report a high level of one aspect of regulation by their parents or primary caregivers. “Regulation” is composed of expectations (e.g., in relation to behaviour, school work, etc), monitoring the adolescent behaviour, and enforcement of limits of behaviour. This indicator is limited to the monitoring aspect – specifically, to the young people’s own perception of how much their parents or primary caregivers know about their behaviours.

An indicator which measures all three aspects of regulation is presently being tested, and will replace the current indicator when it becomes available. The indicator in this guide, though limited, still clearly relates to one aspect of regulation, has been validated in 12 different cultural settings, and has been shown to perform precisely as other indicators which ask more directly about monitoring of behaviour and enforcement of limits of behaviour.

How to measure it
This indicator is measured by calculating proportions or a mean score from 5 items in a survey that includes young people. The items for measuring regulation have been tested and validated in 12 different cultural settings. The 5 statements that comprise the regulation indicator below are about the parental knowledge of young adolescent behaviour.
Respondents are asked to choose from a list of adults (e.g., mother, father, grandparent, aunt/uncle, guardian, etc.) the one adult who they spend the most time living with. Then, in relation to this caregiver, they are asked to choose their answer for each statement from a three-point Likert-type scale, rating how much the primary caregiver "really knows" about each of the stated things: (1) does not know, (2) knows some, (3) knows a lot.

1) Where you go at night
2) Where you are most afternoons at school
3) How you spend your money
4) What you do with your free time
5) Who your friends are

The results are calculated as the proportion of young people who report that their parents or caregivers engage in “low,” “medium” or “high” regulation. This categorical interpretation may be useful in some cases – for example, to make the message more appealing for advocacy purposes.

The outcome can also be calculated as a mean score: summing up all answers, and dividing by the number of respondents*15.

All answers

(All respondents * 15)

In addition, the outcome can be correlated with the health behaviour (or health outcome) of interest – for example sexual initiation, condom use, etc. This yields a measure of the importance of positive regulation by parents or caregivers, and its effect on young people’s behaviour and health outcomes.

This indicator should be presented as a percentage separately for men and women disaggregated by age in the following groups: 10–14, 15–19, and 10–19 (six categories).

If suitable data are not available this indicator should not be reported.

**Strengths and limitations**

The current indicator, while limited to a measure of parental knowledge of adolescent behaviours, provides a proxy for parental regulation. Adolescents who live in a social environment that provides meaningful relationships, encourages self-expression, and also provides structure and boundaries are less likely to initiate sex at a younger age, less likely to experience depression, and less likely to use illicit substances. Regulation is a measure of the positive structure and boundaries that are necessary for healthy development (i.e., expectations, monitoring, and limit-setting).

HIV is, ultimately, driven by individual sexual behaviour, and the context in which young people grow up and make decisions – including sexual decisions – contributes greatly to the types of decision taken (e.g., engaging in risk behaviour or not). Regulation describes one aspect of that
context – in this case, the family context – and its contribution to adolescent health and development.

Often, it is difficult to address contextual factors through programmes. However, regulation by parents is one contextual factor that can be, and has been, addressed programmatically, most often through information/communication campaigns targeted at parents, and through school-based efforts at involving parents more actively in their children’s decision-making and activities. In settings where the level of regulation is low, programmes for parents or primary caregivers or the provision of alternatives mentors (that is, experienced and trusted advisers) may be called for. In such programmes, evaluators may also use the indicator as an intermediate outcome indicator to measure improvements in the social environment for young people in the programme’s intended population.

NOTE: this indicator should be interpreted together with the measure for “connection” (see previous indicator). The “connection” indicator measures the closeness of the relationship between young people and their parents or caregivers. Recent literature has shown that it is both the positive connection with parents or caregivers and the positive regulation of adolescent behaviour by parents or caregivers that contribute most effectively to young people’s positive health and development outcomes.
7. Adult support of education about condom use to prevent HIV/AIDS among young people

Priority: Core

Definition
Percentage of adults who support young people being educated about using a condom to prevent HIV/AIDS

Target Population
Adults (aged 18 and higher)

Numerator
Number of adults who agree that young people aged 12-14 years should be taught about using condoms to prevent HIV/AIDS*

* NOTE: The DHS version of this indicator limited the question to children aged 12 to 14, and for this reason countries may want to keep this limit. Also, this age group is likely to represent, in most settings, young people before their sexual debut, which is a crucial time to begin education on sexuality. The specific age group could be adjusted to the local situation, however, according to the median age of first sex.

Denominator
All adults (aged 18 and higher)

Measurement tools
Nationally representative general population survey

What it measures
Adult perceptions of HIV prevention programmes for young people are crucial to programme success, given the key role that adults play in shaping attitudes and perceptions of adolescents. If parents and adults in the community disapprove of a programme, their lack of support often influences the attitude and behaviour of young people. The importance of adult perceptions and support is demonstrated in a recent study in Zambia, which found that trends in adolescents’ use of reproductive health services were strongly associated with adult acceptance of the provision of such services to youth rather than with attributes of the services themselves.5

How to measure it
This indicator is based on existing questions addressed in the DHS. It assesses the general level of support among adults for programmes of adolescent-focused information and skills. In a household survey, adults are asked whether young people should be taught about the use of condoms to prevent HIV/AIDS.

The most important group are, ostensibly, parents of adolescents, and depending on the survey, it might be possible to disaggregate the data to provide data specifically for this group. However, adult opinions in general are influential on the programmes and services provided for young people and therefore knowing about "general" adult attitudes is informative.

If even more detailed information is desired on the support (or its lack) by “type” of influential adult, the same information can be measured from interviews with selected key informants. Such interviews can yield deeper understanding of the level of adult support for, or resistance to, HIV prevention programmes for young people, and reveal differences between support for programmes for older and younger adolescents.

**Strengths and limitations**

For the success of any adolescent-focused programme, it is crucial to assess adult support for it. Many interventions that ultimately benefit young people are targeted not at young people but at adults whose values strongly influence adolescents. For example, support of parents or teachers for HIV prevention programmes in schools may positively influence acceptance and interest of young people with regard to the programmes; the support of an important local leader (political, religious, etc) can positively influence the perception of other adults.

If asked in a general population survey, this indicator does not distinguish between different “types” of influential adults such as parents, teachers or health workers. Rather, it assesses the general level of support among adults for adolescent-focused information and skills programmes. If collected over time, the indicator (especially if combined with qualitative follow-up) can provide important data on trends in opinion or support of adults regarding programming for young people.