Chapter 3: Programmatic Indicators

Overview

Programmatic indicators are intended to monitor key HIV prevention interventions at the national level. They principally focus on inputs, process and outputs, and can be used to track progress in implementing programmes over time.

This chapter begins with two indicators measuring the overall government response to HIV/AIDS prevention among young people – through the existence of policies specifically relating to young people, and through the provision of national funds for prevention programmes for young people.

The following five indicators relating to specific intervention areas were selected on the premise that the minimal components of any national programme for HIV/AIDS prevention among young people should include provision of relevant information and skills through schools, access to condoms, and access to key health services. Key health services for HIV/AIDS prevention are specified as HIV testing, STI diagnosis or treatment, and family planning/contraceptives. This indicator is considered core in any type of epidemic, and any setting. An additional indicator measures specifically the inclusion of young people in Intravenous Drug Use (IDU) programmes. This indicator is core for settings and epidemics in which IDU is a major mode of HIV transmission. (These five indicators focus on programme coverage rather than quality, because assessment of quality must be based on the specific characteristic of an intervention, which differ from setting to setting.)

Finally, as it is recognized that young people should be involved in the design, implementation and assessment of programmes directed at them, the last indicator measures young people’s participation in the design, implementation and assessment of national HIV/AIDS prevention programmes.

These eight indicators include and build upon all programmatic indicators specific to young people included in the UNAIDS publications “National AIDS Programmes: A Guide to Monitoring and Evaluation,” and “United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Monitoring the Declaration of Commitment to HIV/AIDS: Guidelines on Construction of Core Indicators.”

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1. National index on policy relating to young people and HIV/AIDS

Priority:   Core

Definition
Progress in the development of national-level HIV/AIDS policies and strategies in six key areas:

- Identification of HIV prevention among young people as a priority in National AIDS strategic plan
- Application of a multi-sectoral approach to HIV prevention among young people
- Existence of a policy or strategy to promote HIV information, education, and communication to young people
- Existence of a policy that promotes life-skills-based education in schools
- Existence of a policy that provides youth-friendly health services
- Existence of a policy that promotes young people’s access to condoms

Measurement tools
UNAIDS "UNGASS on HIV/AIDS Guidelines on Construction of Core Indicators,” Appendix 3: Country Assessment Questionnaire. (The items proposed in this indicator are to be added to the Country Assessment Questionnaire.)

What it measures
This indicator is a measure of progress in the development of national-level HIV/AIDS policies and strategies in six key areas relating to young people. It complements the National Composite Index Indicator in the UNAIDS "UNGASS on HIV/AIDS Guidelines on Construction of Core Indicators."

How to measure it
The questions pertaining specifically to policies regarding young people should be added to the Country Assessment Questionnaire (Appendix 3 in the UNAIDS "UNGASS on HIV/AIDS Guidelines on Construction of Core Indicators") in the overall areas of “strategic plan” and “prevention.” The questionnaire is conducted with key informants from a designated mix of institutions to give opinions about central areas of commitment and programming. Each item is given a score (yes = 1, no = 0). The items can be incorporated into the National Composite Policy Index (from UNAIDS Guidelines), and they can also be analysed separately as a stand-alone index of youth-specific policies. The items are as follows:

Relating to national strategic plan:

1. Country has identified HIV prevention and awareness among young people as a priority in the National HIV/AIDS strategic plan
2. Country applies a multi-sectoral approach to HIV prevention in young people (at least involving the health and education sectors)
Relating to prevention policies:

3. Country has a policy or strategy to promote HIV/AIDS information, education and communication (IEC), targeted specifically at young people

4. Country has a policy that promotes life-skills-based education in schools

5. Country has a policy of providing young-people-friendly health services

6. Country has a policy that promotes young people’s access to condoms

The indicator is the sum of the scores resulting from this assessment.

**Strengths and limitations**

The indicator is simple to assess, and is designed to complement the National Composite Policy Index. Because of its simple quantitative nature, however, it gives no information on the quality or effectiveness of national policies and strategies; it only tells whether or not they exist. Also, because it relies on the opinions of key informants, the outcome depends entirely on the choice of informants – and these will likely change from year to year. This makes it difficult to detect true differences between countries and changes over short periods of time, as it is likely that any change in the composition of the respondents will lead to a different assessment.

Concern has also been raised about the utility of a single composite score, in which improvements in some areas may be masked by deterioration in other areas. For planning and monitoring purposes, it may be more useful to present the indices separately.

**Methodological considerations**

This is a qualitative exercise: information is collected from a limited number of informants. Respondents for policy assessment are usually not meant to be representative, but are carefully selected for their knowledge and viewpoint. Therefore, the policy assessment can be prone to subjectivity bias of the respondents. In most countries, the selected respondent will be the manager of the National AIDS Programme. However, more than one respondent can be interviewed for a more comprehensive picture, and efforts can be made to retain the same composition of the informant group over a number of years to guard against differential recall bias.

**Links to other indicators**

1. National AIDS Programmes: A guide to monitoring and evaluation (UNAIDS). Link to Policy indicator #1: “AIDS Programme Effort Index (API).”

2. National funds spent by government on HIV/AIDS prevention programmes for young people

Priority: Core

Definition
Amount of national funds spent by governments on HIV/AIDS prevention programmes for young people

Measurement tools
UNAIDS/UNFPA/NIDI survey on financial resource flows (This survey does not currently include disaggregation of the financial data to specify spending on programmes for young people; such disaggregation is an additional measurement task proposed to gather data for this indicator.)

What it measures
This indicator complements the core indicator (Indicator 1) proposed in the UNAIDS “Guidelines on construction of core indicators.” The UNAIDS indicator consists of measures of expenditure in four areas: STD control activities, HIV prevention, HIV/AIDS clinical care and treatment, and HIV/AIDS impact mitigation. This indicator, however, is concerned only with the economic commitment to enhance the prevention response to HIV/AIDS for young people, including life-skills-based education through schools, information-education-communication campaigns targeted at young people, and condom provision programmes.

How to measure it
Survey of national government expenditure on HIV/AIDS programmes, and within them, if possible, expenditures particularly for programmes targeting young people. The estimates should exclude the cost of any multilateral or bilateral or international donor-funded government programmes. In addition, all local NGO programmes should be excluded, except programmes (or parts of programmes) that are funded by the national government.

Strengths and limitations
In some settings it may be difficult to obtain even general government expenditure figures relevant to HIV/AIDS programming. Where general figures are available it may be difficult to isolate, within them, expenditures on specific programmes, such as youth prevention programmes. Nevertheless it is important to attempt to capture the government's financial commitment to HIV/AIDS programming for young people.

If the necessary information is available, the main weakness of this indicator is that it does not capture the financial commitment to all relevant programming for young people. For example, it does not include the provision of youth-friendly health services as these tend not to be defined within prevention activities. In addition, it is not intended to be used as a measure of resource availability, but as an indicator of political commitment to responding to HIV among young people. All governments reflect their political priorities in their allocation of internal resources. Changes in funding allocated to HIV prevention among young people is therefore a good indicator of the importance that governments are placing on the epidemic.
Links to other indicators


3. Provision of life-skills-based HIV/AIDS education in schools

Priority: Core

Definition
Percentage of schools with at least one teacher who has been trained in participatory life-skills-based HIV/AIDS education and who taught it during the last academic year.

Target Population
Primary and Secondary Schools

Numerator
Number of schools with at least one teacher trained in, and regularly teaching, life-skills-based HIV/AIDS education

Denominator
Number of schools

Measurement tools
School-based survey

What it measures
This indicator is a measure of the progress in implementing life-skills-based HIV/AIDS education in schools. It is a measure of coverage by school – that is, estimating the proportion of schools that report having such programmes. It is not a measure of the quality of such programmes. For this indicator to be most meaningful, it should be combined with measures of quality.

How to measure it
Principals/heads of a nationally-representative sample of schools (to include both private and public schools, and primary and secondary schools) are briefed on the meaning of life-skills-based HIV/AIDS education and are then asked the following questions:

1. Does your school have at least one qualified teacher who has been trained in participatory life skills-based HIV/AIDS education in the last five years?
2. If the answer to question 1 is “yes”: Did this person teach life-skills-based HIV/AIDS education on a regular basis in your school throughout the last academic year? ("throughout" meaning at least 5–15 hours of life-skills-based HIV/AIDS education programming per year per grade of pupil)

A qualified teacher is one that has participated in, and successfully completed, a training course focusing on the skills required to conduct participatory learning experiences that aim to develop knowledge, positive attitudes and skills (e.g., interpersonal communication, negotiation, decision-making and critical-thinking skills and coping strategies) that assist young people in maintaining safe lifestyles.

The criteria of teaching on a regular basis is grounded in research findings that show that high-quality programmes can produce good outcomes with 5–15 hours of life-skills-based HIV/AIDS education programming per year per grade of pupil.

The time dimension of the last academic year will be, in each country, defined according to the educational calendar (usually 9-10 months within one calendar year, designed to allow students to complete one educational level, or grade).

If the sample was selected to represent different strata, the results can be disaggregated by school type (i.e., female and male, large and small, urban and rural, private or public, and primary or secondary). Where a school is both primary and secondary, information should be collected and reported separately for each level.

In addition, primary and secondary school attendance rates for the most recent academic year available should be stated.

Resources permitting, the following additional four questions can also be included (in the case of the answer to question 1 above being “yes”):

3. How many teachers at your school have received training in participatory life-skills-based HIV/AIDS education in the last five years?

4. How many of these teachers taught life-skills-based HIV/AIDS education programme in your school during the last academic year?

5. How many classes and students in each grade in your school received life-skills-based HIV/AIDS education last year?

6. How long was the programme/course for each grade in hours?

With information on the overall school-age population and on the above questions, it is possible to estimate the proportion of all young people, as well as the proportion of school-going young people, who actually receive life-skills-based HIV/AIDS education.


Strengths and limitations
This overall measure of coverage of the life skills-based programme in schools is fairly simple to collect, though it does require a national sampling frame of all schools. Vocational schools and work-school programmes should be included in the sample.

The life-skills programme should be implemented in primary schools and continued through secondary schools, with content and methods adapted to the age and experience of the students. This indicator tells whether life-skills-based education is taught at each level of schooling, but nothing about the quality of the content, approach, or materials used.

When making comparisons across countries – or even between regions of a country – the differing rates of school attendance and enrolment must be taken into consideration.

The indicator is concerned with the provision of life-skills-based HIV/AIDS education through schools and specifically, through the curriculum taught by teachers; programmes conducted by outside agencies or facilitators should be excluded. The indicator might not capture the total effort of providing HIV education through schools, as students could obtain some information through non-curriculum sources (e.g., distribution of educational pamphlets, posters, special assemblies on the topic, etc). However, such efforts are likely to be ad-hoc, while this indicator purposefully focuses on a systematic inclusion of HIV education into the curricula.

Methodological considerations

For this data to be representative at the national level, the sample of schools must also be nationally representative. First, a complete listing of all schools is needed, both public and private, as well as schools with special curricula or programmes (e.g., vocational schools, boarding schools, etc). For the results to be valid for each sub-group of schools as well as at the national level, the sampling must be done by each group of interest. If a particular sub-categories of schools includes less than twenty schools in total, then there is no advantage to randomly sampling this group. In this case, a “representative” sample of schools can be selected purposefully, with regard to factors such a size, location, socio-economic level of the student body, etc. There is no need to sample within schools, as the information for this indicator is collected from a head administrator or similar.

Links to other indicators


4. Institutionalising youth-friendly health services

Priority: Core

Definition
Estimated number of health facilities that have arrangements in place to provide youth-friendly services
Target Population
Selected health facilities

Numerator
Number of health facilities that have specific policy on treatment of young clients, and who have at least one health care provider trained in the provision of youth-friendly services

Denominator
Number of health facilities

Measurement tools
Interviews with directors/heads of selected health service delivery points.

What it measures
This indicator measures two key characteristics in institutionalizing youth-friendly services: existence of facility-based policies and guidelines for treatment of young clients, and the training of health providers in youth-friendly approaches and methods. Both the existence of youth-friendly policies and youth-friendly health care providers are key elements of the WHO recommended generic characteristics of a youth-friendly health service.¹

This is a facility-based indicator (it does not assess national-level policy). It is an estimate of the effort to institutionalise youth-friendly services, but does not measure service delivery at the health facility, nor the quality of the services provided. For tools which are focused on operationally improving health services at facility level, refer to guides such as NAFCI², or FOCUS³.

How to measure it
A nationally representative sample of health service delivery points is preferred for this measurement. Depending on the setting, the sample may include primary, secondary and tertiary-level facilities. The sample should be limited to facilities which offer one or more of the three essential services related to HIV/AIDS prevention: STI diagnosis and treatment, contraceptive/family planning services, and HIV testing. If possible, both public and private facilities should be included.

In addition, in cases where intravenous drug use is a major factor in driving the epidemic, substance abuse prevention and treatment programmes could also be included. If such services are included, the type of staff trained is likely to change (e.g., may not be doctors and nurses, but other types of professionals). The questions below should thus be tailored accordingly.

² "Going for Gold: A clinic guide to the National Adolescent Friendly Clinic Initiative," the National Adolescent Friendly Clinic Initiative (NAFCI), South Africa, November 2000;
Directors/heads of a nationally-representative sample of health service delivery points are asked the following questions:

1. Does your facility have written policies and/or guidelines for health professionals specifically on how to treat young clients?
   - "Young people" are aged 10-24; the relevant facility policies may include the entire age range, or only a sub-range, e.g., up to 19 years of age
   - Experience indicates that it is important to ask to see the written guidelines, in addition to asking whether they exist

2. Does your facility have at least one qualified health professional (doctor, nurse, counselor, etc) who has been trained in the provision of youth-friendly services in the last five years?

**Strengths and limitations**

This measure of institutionalising youth-friendly health services is simple to collect, though for it to be representative, a national sampling frame of all health service delivery points is required. This indicator is useful for national programme managers to keep track of the proportion of health settings that are making efforts at becoming youth-friendly. Tracking changes over time in this measure can provide useful overview of the trend of implementing such services. It must be kept in mind, however, that for a health setting to qualify as fully “youth-friendly,” a series of characteristics and functions must be in place (e.g., convenient opening hours, treating young clients with respect, affordability, effectiveness of the services provided, etc), of which written guidelines and trained health professionals are only the most basic. To be most useful for individual service delivery points, quality of services are best assessed in-depth at the level of each health facility through a quality improvement approach, or similar process.

**Methodological considerations**

For this data to be representative at the national level, the sample of health facilities must also be nationally representative. First, a criteria must be established which types of facilities will be considered (e.g., primary- and secondary-level care, both public and private, etc). It is very important to differentiate between facilities that are aimed at young people and those which are targeting the general population, as those targeting young people specifically are more likely to have staff trained in youth-friendly services. Once the criteria are established, a complete listing of all eligible health facilities is needed. For the results to be valid for each sub-group of facilities as well as at the national level, the sampling must be done by each group of interest. If a particular sub-category of facilities includes less than twenty facilities in total, then there is no advantage to randomly sampling this group. In this case, a “representative” sample of facilities can be selected purposefully, with regard to factors such as client volume, location, socio-economic level of the catchment area, etc. There is no need to sample within facilities, as the information for this indicator is collected from a director, head doctor, or similar.
5. Use of specified health services by young people (facility-based and population-based)

The use of specified health services by young people can be measured either through facility-based records (which measures service utilisation only), or through population-based methods such as surveys (which can give an estimate of coverage of health services).

Priority: Core

Definition
1) Facility-based: Number of young people seeking specified health services and the proportion of all clients at health services that are young people
2) Population-based: Proportion of all young people receiving specified health services

Target Population
10-24 year olds

Numerator
1) Facility-based: The number of young people using a specified health service in a defined period of time. Health services that are of particular interest include: HIV testing, STI diagnosis and treatment, and family planning/contraceptive use.
2) Population-based: The number of young people who report receiving any of the specified health services (HIV testing, STI diagnosis and treatment, and family planning/contraceptive use) in the last 12 months

Denominator
1) Facility-based: All clients using a specified health service in a defined period of time
2) Population-based: All young people surveyed who report being sexually active (have ever had sex)

Measurement tools
1) Facility based: Facility-based surveys, routinely collected facility-based data
2) Population based: Nationally representative general population survey

What it measures
1) Facility based:
This indicator tracks the total number of young people seeking health services, and the proportion of all at health-services clients that are young people. It can be an estimate of the changes in care-seeking behaviour among young people.

It is well known that young people do not access health services in proportion to the health problems experienced in this population. A basic aim of an HIV/AIDS prevention programme,
therefore, is to increase service use by young people, specifically for STI testing and treatment, family planning/contraceptive use, and HIV testing. This indicator provides the crude numbers (and the proportion) of all clients (per specific service, if possible) that are young people.

Generally, an increase in the number and proportion of young clients is considered positive. However, the number and the proportion of young clients must be interpreted together, as a proportion of all clients that are young people may decrease if clinic use by adults suddenly increases, although the number of young clients may actually be increasing as well.

In addition, to correctly interpret these numbers some population-based estimates must be available, as the magnitude of the need must be known to correctly interpret the increase (or decrease) in service use. For example, if it is known that 40% of the population served by a particular health service are young people aged 20–24, and also that in this population the prevalence of chlamydia is 20%, this provides an estimate of the maximum number (and proportion) of young clients that could ideally be expected to seek STI testing and treatment. That is, it provides a “ceiling” against which to gauge the increase (or decrease) in young clients.

2) Population based:
This indicator estimates the proportion of sexually active young people who report seeking specified health services. In addition, if there are data available on the proportion of young people who are in need of specific health services (either through epidemiological estimates, or through other surveys), this measure can be an estimate of coverage of the specific health services. For example, if it is known that in a region X the proportion of sexually active females in the 15-19 age group is 50%, this provides a benchmark against which to gauge the number and proportion of 15-19 year old girls who report seeking health services to obtain contraceptives. If more detail is known about sexual risk behaviours (e.g., if, of the 50% who are sexually active, 40% report more than 1 partner in the last year, and only 30% report frequent use of condom), these can be benchmarks for the proportion of girls aged 15-19 that would potentially need HIV testing services.

How to measure it
1) Facility based:
The minimal data required for this indicator is a disaggregation of all clients by age and by sex. It is focused on primary care facilities, but, depending on the setting, the use of other types of facilities can also be tracked.

Data can be collected from a nationally representative sample of health facilities. Refer to the Methodological Considerations section of the previous indicator (“Progress in institutionalising youth-friendly health services) for a brief discussion on sampling health facilities.

Data can be obtained from record books, log books, or other similar mechanisms used by the facility to keep track of clients. In a defined period of time the number of all clients who are young people is added up. In facilities that are youth-specific, the time period chosen may be short (e.g., one month); however, in facilities in which young people are a small proportion of the overall client load, the time must be extended to capture a sufficient number of young clients. The proportion of all clients in a chosen time-frame who were young people can also be easily calculated by dividing the number of young-people clients by the total number of clients in that
time. These data can be summarized at several points in time to provide an idea of the trends of service use.

Whenever possible, the type of service provided should be specified. For HIV prevention programmes for young people, at the minimum the following services should be specified: STI testing and treatment, family planning services, and HIV testing. Depending on the setting (both the level of the epidemic as well as the existence of a facility-based tracking system), PMTCT and antenatal care services can also be specified, as well as needle exchange services. In most resource-constrained settings, however, these specifications will not be possible. In such cases, simply recording young clients (specifying age and sex) by type of service sought is a valuable measure.

In settings with more sophisticated tracking systems, first-time visits should be distinguished from follow-up/repeat visits. First-time visits measure the increase in “uptake” of the services. Follow-up/repeat visits may capture successful treatment episodes (e.g., first visit for HIV test, second visit for obtaining the result), or they may capture a recurring health problem (e.g., returning for an STI that had not been successfully diagnosed or treated).

In addition, other important characteristics of young people using the services should be measured (e.g., rural/urban status), as this can provide useful information on the portion of the population not using the services.

2) Population based:

Data are collected through a population-based survey, asking respondents whether they have received specified services. Most often, such question will get asked only of respondents who report being sexually active (have ever had sex). If the question of service utilisation is asked of all young people, those who have never had sex should be excluded from the denominator.

A defined time limit must be part of the service utilisation question. This can be defined on a national level (12 months is proposed here), although less than six months is probably not realistic in most settings, as young people do not tend to use health services frequently.

For HIV prevention programmes among young people, at the minimum the following services should be specified: STI testing and treatment, family planning services, and HIV testing.

1) In the last 12 months, did you receive any of the health services listed below:

- STI diagnosis or treatment
- family planning/contraceptives
- HIV testing

The numerator is composed of all respondents who report having used health services, and the denominator of all respondents. As before, the disaggregation of the respondents (if possible) by sex and age group is crucial to learning insight into what part of the population is not using the services.

To estimate coverage from these data, population-based estimates of the need for such services must be available. These can be sociodemographic estimates (for example, proportion
of sexually active adolescents, by age and sex), epidemiological estimates (of STI/HIV prevalence, pregnancy or birth rates, contraceptive use, etc), or estimates of perceived need for services collected by other surveys. For example, if it is known that in a region X the proportion of sexually active females in the 15-19 age group is 50%, this provides a benchmark against which to gauge the number and proportion of 15-19 year old girls who report seeking health services to obtain contraceptives. The difference between the two can be an estimate of the unmet need for a particular service.

Strengths and limitations

1) Facility based

The strength of this indicator is that it uses existing service-based mechanisms of data collection and record-keeping. In settings with sufficient resources, a simple coding scheme can be established both to code the type of service received and to distinguish first visits from repeat visits. Where this is not possible, however, simply tallying the total number of adolescent clients is a valuable source of information.

As these data build on monitoring systems, they are ideally collected continuously throughout the year. Trend data should be observed at intervals (e.g., quarterly) and not only at specific points in time, because service utilization is affected by seasonal events. In each setting the important socio-cultural events need to be recognized, but at a minimum the local school year and major religious holidays must be taken into account when collecting and interpreting the data.

It should be kept in mind that an increase in the number of young people seeking services need not mean an increase in the proportion of young people with health needs/issues. The increase may well be due to other factors, such as an Information-Education-Communication (IEC) campaign to advertise the services, or a health promotion programme that enables more young people to recognize the need for services (e.g., recognize symptoms of a sexually transmitted infection (STI), or increase the demand for contraceptives).

However, one of the major weaknesses of this indicator is that it depends on facilities to have well-maintained and accurate records and log-books, which include age-specific records (or at least in age brackets which allow for disaggregation of young people from adult clients). For many countries, this may not be the case at all, or there may be no standardization in how facilities record their services (i.e., some of the clinics may keep updated and well-maintained records, others may not). Even where well-maintained clinical records exist, the way in which the information is recorded may limit the ability to collect data for this indicator. For example, some facilities that include STI diagnosis and treatment under the overall heading of “Outpatient Services” but do not break it down into further categories or causes. In this case, it would not be possible to collect data on the number of young people who were diagnosed and treated for sexually transmitted infections. Thus, it is very important to find out how facility records are maintained and what type of information is recorded in the medical/service records before data on this indicator is collected.

In settings where majority of facilities do not keep age disaggregated data this type of information would be impossible to collect. In such cases the feasibility of first improving the record keeping system to include young people-specific age brackets would have to be explored.
2) Population based

The strength of this indicator is that the question to measure it can be incorporated into a population-based survey. The questions should be carefully formulated to include a realistic time dimension, as in most settings adolescents seldom seek these services.

As with facility-based estimates, an increase in reported need for services need not mean an increase in health problems, but may be due to IEC programmes, or other factors that increase awareness of health issues and can prompt preventive (or curative) behaviour. Also, measuring service utilisation provides no information about the quality of services; as stated above, to better understand the trends observed in utilisation, these data should be complemented with measures of quality and effectiveness of health services.

6. Condom availability for young people

Priority: Core

Definition
Percentage of randomly selected retail outlets and service delivery points typically accessed by young people that have condoms in stock at the time of the survey

Target Population
15-24 years

Numerator
Number of retail outlets and service delivery points that are typically accessed by young people* and that have condoms in stock at the time of the survey.

* Sites and venues that are typically accessed by young people must be identified either through key informants or from responses of a youth survey to questions on where young people get condoms or where they prefer to get them.

Denominator
Number of retail outlets and service delivery points typically accessed by young people

Measurement tools
MEASURE Evaluation/WHO/PSI Compiled Condom Availability and Quality Protocol, retail survey (http://www.cpc.unc.edu/measure). The statistical departments or finance ministries of many countries conduct regular (usually quarterly) retail surveys that include price and availability data for a wide variety of commodities.

What it measures
Actual distribution of condoms at designated points, *typical of youth access*, at any one point in time. It highlights programme efforts to broaden the distribution of condoms so that they are available at the location types that young people prefer.

**How to measure it**

Sites of different types are randomly selected for a retail survey. The sampling frame should be stratified to ensure geographic and demographic spread (e.g. rural/urban, Christian/Moslem, etc.). It is better to limit the type of venue that "could or should" provide condoms to young people, and focus on a defined set that *must consistently* provide them (e.g., youth centres, health clinics, school clinics, etc). Accordingly, this indicator should foremost be focused on the priority venues, and include additional ones as resources permit. These additional sites could be as diverse as bus stops, motor parks, barber shops, hair salons, night clubs, bars, fast food shops, kiosks, pharmacies, markets, petrol stations, etc. However, it may be difficult - and costly - to obtain a full list of all possible sites where young people obtain condoms. For this reason, criteria should be developed for what type of venues will be included, focusing on venues that, in the particular national context, must consistently provide condoms to young people.

The data should be disaggregated by condom type (male/female), geographic location as relevant (e.g., by region, state, district, county, ward, etc.) and outlet type. Disaggregated data by outlet type provide invaluable information for programme managers and for those seeking to improve the marketing of condoms.

**Strengths and limitations**

The statistical departments or finance ministries of many countries already conduct regular retail surveys that include price and availability data for a wide variety of commodities. They typically use a well-established sampling frame covering a wide variety of venues nation-wide. Where such surveys exist, condoms can simply be added to the box of commodities for which data are collected. Certain venues, where young people typically access condoms, are not traditionally covered in retail surveys. In this case, special surveys of these extra venues can be undertaken to provide the necessary additional data.

This indicator focuses on static sites and venues and therefore in countries where a special effort is being made to distribute condoms through non-static outreach sites, this indicator would have limited usefulness.

Another limitation of this measure is that it only gives a "snapshot" of condom availability at a particular point in time. In countries where the supply of condoms varies significantly, data collected on this indicator may show an invalid conclusion about the true availability of condoms. In such countries, data collected for this indicator would show a high availability of condoms (when, in fact, condom availability may actually be low for the rest of the year). Moreover, low availability in such a case would not be due to poor distribution but rather to problems at the central level.

This "snapshot" limitation can be partially addressed by including an additional numerator item: number of retail outlets and service deliver points that are typically accessed by young people *that have experienced a stock-out in condoms for 5 or more consecutive days in the previous three months*. This additional numerator item can give a longitudinal dimension to the indicator,
which is otherwise limited only to the time of the survey. The methodology for collecting this additional item must include a brief interview with the venue manager. This can consist simply of asking the manager to recall whether there have been stock-outs, or, for a more rigorous assessment, could include the review of merchandise log books and records. For this information to be most useful programmatically the reasons for the stock-out should also be ascertained, so that interventions may be designed to address the problem.

**Methodological considerations**

As with other indicators in this chapter which require a sample of institutions (schools – indicator 4; health facilities – indicators 5 and 6), this indicator first requires deciding on the criteria of what types of sites will be considered eligible, as it may be very difficult (and costly) to obtain a full listing of all sites where young people could access condoms. Once the criteria is set, a complete list of all such sites is required if the sample is to be representative. If the data is to be disaggregated by venue type, then the sampling must be conducted for each type separately. If a sub-group of venues includes less than twenty venues total, then sampling is not needed, and a number of venues can be selected purposefully.

The availability of condoms at time of the survey is verifiable by the surveyor. However, the additional part of the numerator asking about stock-outs requires consulting with a key informant - e.g., interviewing the manager of each venue surveyed, or reviewing the merchandise log books and records - and therefore presents additional planning and work necessary to obtain the information. Interview-type data collection is also prone to recall and response bias of the informant interviewed.

**Links to other indicators**

This indicator can be interpreted together with Indicator 2 in the Determinants chapter of this Guide - Knowledge of a formal source of condoms among young people. In addition, it is also linked to:


**7. Young injection drug users reached by HIV/AIDS prevention services**

**Priority:** Core in concentrated epidemics, additional in generalised epidemics

**Definition**

Percentage of young injecting drug users who are reached with HIV/AIDS prevention services

**Target Population**
15-24 year olds

**Numerator**
Number of young injecting drug users who in the past month were reached with outreach prevention services plus the number of injecting drug users in drug dependence treatment, either longer-term drug-free* or substitution therapy.

The numerator should consist of individuals, not events; what should be counted are services during the reference period (30 days) not the number of contacts, including repeat contacts or the number of needles and syringes or condoms distributed.

* For the purpose of estimating the numerator, detoxification-only in whatever form is not considered treatment.

**Denominator**
Estimated total number of young regular injecting drug users

**Measurement tools**
Service statistics from outreach projects and programmes and treatment facilities for the numerator; prevalence estimation methods for the number of young regular injecting drug users for the denominator.

**What it measures**
This indicator is an estimate of the percentage of young injecting drug users who, in the past month, were reached with (outreach) prevention services, plus the number of injecting drug users who are young people enrolled in drug dependence treatment, either long-term drug free or substitution therapy.

Note that prevention services should include the sexual prevention of HIV/AIDS (in addition to clean needles, or drug treatment), as it is through sexual contact that the epidemic spreads to the general population. A comprehensive programme should include both prevention via needle exchange as well as sexual prevention. A programme providing only sexual prevention (i.e., condoms) should not be considered. For clarity and comparability of data, it should be clearly noted which services were included and which not.

The range of services to reduce the risk of HIV among injecting drug users includes:

- HIV information, education and communication (IEC) programmes
- Condom distribution
- Risk-reduction counselling
- Voluntary counselling and HIV testing (VCT)
- Disinfection programmes
• Needle-syringe programmes
• Agonist pharmacotherapy programmes
• HIV treatment and care

How to measure it

The selection of relevant information to calculate the indicator is a consultative process between all stakeholders in the field of HIV/AIDS prevention among injecting drug users. It is necessary, therefore, to discuss information collection and plan for future data-collection in a technical working group specifically dedicated to HIV/AIDS and injecting drug use. If there is no such working group, it is strongly recommended to establish one, which could function, for example, under the UN Theme Group on HIV/AIDS.

Also, the working group must agree on the size of the numerator and the denominator. Often it will discover that essential information is lacking, or that existing information is unreliable. In such cases, the working group should develop mechanisms and standards for monitoring and data collection for the future.

To determine the numerator, it is necessary to review data of all the country’s government and non-governmental treatment and outreach programmes and projects. This usually requires the establishment of an inventory of all ongoing governmental and non-governmental projects and programmes that provide face-to-face services (either information and counselling only, or information, counselling plus clean needles/syringes, or drug dependence therapies such as methadone treatment and abstinence-based programmes); it requires also that data from these programmes and projects are being collated. If a country has no inventory of ongoing programmes and projects, it is strongly recommended that a database be rapidly established, using, for example, the UNAIDS Country Response Information System, often referred to as CRIS or other methods.

Data from all relevant services are combined to calculate the numerator for this indicator; however, when reporting this indicator on a national basis, the types of services available (and the types included in the numerator) should be specified.

It may be problematic to ask for an age breakdown that results in inquiries about possibly illegal activities. A general age bracket of under 25 is recommended, therefore, as a core indicator, and an additional breakdown of under 18 is suggested as optional where appropriate.

A number of methods may be used to estimate the actual size of a specific population vulnerable to HIV infection, in this case the number of injecting drug users in a country. These methods are designed to produce estimates of the size of populations that are hidden or hard to reach.

Strengths and limitations

This indicator gives a strong programmatic measure about availability of harm-reduction services to young IDU. The denominator data could have a considerable margin of error, however, as estimates are derived from different sources, which could be biased, or extrapolated from data from the sub-national level. With different sources of data, the best available estimate will need to be used.
The challenge is to keep track of the number of young injecting drug users reached through outreach, avoiding double counting, and at the same time protecting/maintaining confidentiality of the injecting drug user’s data (identification) especially from law enforcement agencies (where these activities are legally problematic). For example, it may be illegal in some places to distribute needles to people under 18, and many outreach services function on the “no questions asked” policy, therefore not collecting any data at all on their clients. Drug dependence treatment programmes are more likely to keep age data (as these are “institutions”).

8. Young people’s participation in HIV/AIDS prevention programmes

Priority: Additional

Definition
Progress in formally involving young people in the programming cycle of HIV/AIDS prevention programmes targeted at them

Measurement tools
A list of key questions to be included in an interview of national programme managers. (Suggested questions are presented in the “How to measure it” section below)

What it measures
Involvement of young people has been identified as a key characteristic for successful programming for young people. Participation of young people in matters affecting them is a right, included in the Convention of the Rights of the Child. In addition, it has also been recognised that participation can positively contribute to healthy development, therefore acting as a catalyst to attaining other positive outcomes for adolescents. Participation is also important from a pragmatic view: it can increase the relevance and acceptance of adolescent programmes, thereby improving program delivery and effectiveness.

This indicator captures whether national-level HIV/AIDS prevention initiatives and programmes aimed at young people have formally involved young people in the design, implementation, governance, and/or assessment of the interventions (and whether they have set up formal structures or processes for doing so). What is considered a formal structure or process needs to be defined in each national context, but can include youth advisory boards, opinion polls, participatory consultations, etc. The criteria for inclusion is based on a qualitative assessment: the involvement of young people must not be an ad-hoc activity, but a formal and necessary step in the programming process. The structure or process for promoting participation must also be functional: generally, that means that it has been active in the past 12 months, or in the relevant instances in the programming cycle.
How to measure it

This indicator could be collected simultaneously with the Policy indicator (indicator #1 in this chapter), as the Policy indicator specifies 3 key types of programmes/ interventions particularly relevant to HIV/AIDS prevention among young people:

1. Information, communication and education campaigns focused on HIV/AIDS prevention and targeted at young people

2. Provision of life-skills in schools

3. Provision of youth-friendly health services

Each of the above programme areas should be assessed on whether young people are involved in the following key points of the programming cycle: assessment and design, implementation, governance/oversight, and monitoring and evaluation. Assessment should include both a qualitative description of how young people were involved, as well as a quantitative score that sums up how well the young people were involved. The scores should be based on the following point system: 2=programme fully involved youth; 1=programme partially involved youth; 0=programme did not involve youth at all. For example, if youth were involved in a participatory needs assessment prior to implementing and IEC campaign, then it would be given a “2” for item 1.

1. **Assessment**: Were the needs of young people assessed through participatory methods before the programme was designed? (Conducting a participatory needs assessment would be included as a positive response, whereas conducting a survey of young people where they are merely the respondents does not qualify as “participatory”)

2. **Design**: Was the opinion of the target population actively sought when designing this programme as to the most appropriate methods/approaches of programme delivery? Were young people involved in designing such methods/approaches?

3. **Implementation**: Is young people's participation in the implementation of the programme (e.g., as peer educators, condom promoters) an integral part of the delivery strategy?

4. **Governance/oversight**: Does the governance/oversight structure of this programme include young people? (It could be a separate structure specifically for young people (e.g., a youth board), or it could be incorporated into adult-led structures. In either case, the role of young people vis-à-vis the adult-led oversight/governance structures should be assessed.)

5. **Monitoring and evaluation**: Are young people involved in tracking the progress in programme implementation (monitoring), or in assessing its effects (evaluation)? (e.g., as junior researchers or similar roles, not merely as respondents in surveys or other means of data collection)

Within each of the three key programme types specified above, the points given to each individual item can be summed to an overall score:

- **Sum of scores from each individual item**
- 5 (number of total items)
If there is more than one respondent, the numerator should include the sum of all respondents’ scores, and denominator should be multiplied by the total number of respondents.

These scores are informative for an overall assessment of the extent to which young people have been actively involved in the programmes targeted at them, and can even be used to compare participatory efforts in different programmes (as most interventions, regardless of their topic and means of delivery, go through the stages of the programme cycle specified above). However, as the most meaningful information is actually in the qualitative description of the extent of young people’s participation in each of the programme cycle stages, the overall scores are limited in its use.

Additionally, the three programme-type scores could be combined into a national composite score (which would have a maximum of 15). The interpretation of this composite score, however, may be difficult.

**Strengths and limitations**

This indicator is simple to collect, and if assessed simultaneously with the Policy indicator it will not require any additional data collection efforts. It is a national-level indicator and therefore limited to overarching categories and structures of participation. To truly describe the participatory processes undertaken in a programme, the measurement must occur at the level of the intervention, and it should capture the quantity as well as the quality of the participation (i.e., the proportion of young people that are involved at any stage of the programming cycle, as well as the quality of their involvement). Nevertheless, this indicator is a useful measure of whether, and to what extent, national-level programmes targeted at young people are seeking to involve their constituents.

**Methodological considerations**

This is a qualitative exercise: information is collected through an interview from a limited number of informants. In most countries, the selected respondent will be the manager of the National AIDS Programme. The score of the indicator is dependent on a somewhat subjective assessment of the level of participation in the programme under question. For this reason, more than one respondent should ideally be interviewed for a more comprehensive picture, and efforts can be made to retain the same composition of the informant group over a number of years to guard against differential recall bias. For example, a panel of key informants could be comprised of the managers that oversee the key youth programmes referenced above: (1) information, communication and education campaigns focused on HIV/AIDS prevention and targeted at young people, (2) provision of life-skills in schools, and (3) provision of youth-friendly health services.