

Learning to Live:

**Monitoring and evaluating HIV/AIDS
programmes for young people**

**Douglas Webb and Lyn Elliott,
Abbreviated Version, 2002**

With support from UNAIDS and DFID

CONTENTS

Abbreviations and Acronyms	5
Chapter 1: Introduction	7
Specific aims of this handbook	7
Chapter 2: The Growing Importance of Lesson-learning in HIV/AIDS Programmes for Young People	8
Acting on the need to develop better evaluation methods	8
Changes in approaches to evaluation over time	9
Chapter 3: Stakeholders: Who are they and what do they want to know?	10
Involving stakeholders and ensuring participation	10
Children and young people's participation in programmes	11
HIV-prevention projects	11
AIDS-impact mitigation	11
Participation in practice	13
School-based programmes	13
Youth-friendly health services	13
Chapter 4: Situation Analysis and Objective Definition: Identifying the needs	14
Situation analysis	14
Identification of goals, objectives, activities and outputs	14
Qualitative and quantitative research	15
School-based programmes	15
Case stories and narratives	16
Development and use of problem trees	16
Using a problem tree to develop objectives and indicators	17
Behaviours to encourage	17
Behaviours to prevent	17
Collecting baseline information	19
Chapter 5: Major Strategy Options for Reaching Young People	21
The rationale of school-based education	21
Reaching young people through peer education strategies	21
Clinic-based service delivery (youth-friendly health services)	22
Reaching especially vulnerable children	23
Chapter 6: How to Reach Young People Effectively: Key questions	24
Defining and reaching the target population	24
Estimating the target population-size	24
School-based programmes	26
Peer education targeting	26
How intensive should the project be ?	27
School-based education	28
Peer education	28
Types of peer approaches	30
Youth-friendly health services	30
How cost-effective and sustainable is the project?	32
How integrated is the project with other activities or services?	33

Integrating the key questions into the information systems	33
Chapter 7: The Role of Indicators in HIV/AIDS Programmes	34
What is an indicator?	34
Problems with core indicators	34
Locally derived indicators	35
Problems with locally derived indicators	36
Reaching a compromise: using both types of indicators	36
Chapter 8: Indicator Identification and Use	37
Indicator use in different activity areas	37
Process indicators	37
Intermediate impact	38
Long-term impact	38
School-based programmes	40
Process monitoring and indicators	40
Short-term/intermediate outcome indicators	40
Outcome and impact Indicators	40
Peer and outreach education	42
Process monitoring and indicators	42
Training and activities of educators	42
Intermediate impact indicators	43
Short-term impact indicators	43
Measuring stigma and destigmatisation	43
Process indicators for outreach work involving PLWHAs	44
Outcome indicators	44
Long-term impact indicators	44
Youth-friendly health services	45
The shift from measuring process to measuring change	47
Chapter 9: Data Collection: Where do we get our information and how?	48
Data triangulation	48
Types of evaluation design	48
Knowledge, attitude, practice and belief (KAPB) surveys	48
Focus group discussions (FGDs)	50
Focus group good practice	51
Process monitoring and tools	52
Integrating data sources: the use of clinic-based data	53
Determining attribution in outreach programmes	55
Major points to remember regarding data collection	55
Chapter 10: Evaluating Interventions Assisting Children Affected by HIV/AIDS	56
Using the UNCRC as a monitoring and evaluation framework	56
Indicator development	57
Chapter 11: Data Use in Advocacy Outputs	60
Who are the key advocacy targets?	60
Measuring the impact of advocacy programmes	61
Chapter 12: Bringing It All Together: Monitoring and evaluation plan design	63
The logical framework	63
Health through mosques: AIDS Awareness Programme (AAP), Karachi	64

The logic model	66
Composition of, and terms of reference for, an evaluation team	66
A final word	68
References	69
Annexes	
ANNEX 1: Understanding Incidence and Prevalence	72
ANNEX 2: Key-informant Guide for institutions	73
ANNEX 3: Focus group Preparation and Discussion Guide	74
ANNEX 4: Producing a Problem Tree	76
ANNEX 5: Studying Patient/Clinic Interaction for Youth-friendly Service Development	77

Abbreviations and Acronyms

AIDS	acquired immune deficiency syndrome
ANC	antenatal clinic
ARV	anti-retroviral(s)
AZT	Azidothymidine
BCC	behavioural change communication
BOND	British Overseas NGOs for Development
CAC	community AIDS committee
CBD	community-based distributor
CBO	community-based organisation
CDC	Center for Disease Control
CEDC	children in especially difficult circumstances
CMR	child mortality rate
COPE	Community-based Options for Protection and Empowerment
CSW	commercial sex worker
DACC	district AIDS co-ordinating committee
DFID	Department for International Development
DHS	Demographic and Health Survey
EC/U	European Community/Union
EPI	expanded programme of immunisation
FGD	focus group discussion
FGM	female genital mutilation
GPA	Global Programme on AIDS
HIV	human immuno-deficiency virus
IDS	Institute of Development Studies
IDU	injection drug use
IEC	information, education and communication
IES	Instituto de Educación y Salud
KAP	knowledge, attitude and practice
KAPB	knowledge, attitude, practice and belief
M&E	monitoring and evaluation
MOH	Ministry of Health
MOV	means of verification
MTCT	mother-to-child transmission
MTP	medium-term plan
NACP	National AIDS Control Programme
NACWOLA	National Community of Women Living with HIV/AIDS
NAP	national AIDS plan
NGO	non-governmental organisation
OVI	objectively verifiable indicator
PLA	participatory learning and action
PLWHA	people living with HIV/AIDS
PPI	priority prevention indicators
PRA	participatory rural appraisal
PSI	Population Services International
RCT	randomised controlled trial
RPR	rapid plasma reagen
SAfAIDS	Southern African AIDS Information Dissemination Service
SANASO	Southern African Network of AIDS Service Organisations
SC	Save the Children
SMART	specific, measurable, achievable, relevant and time-bound
STD	sexually transmitted disease

STI	sexually transmitted infection
TBA	traditional birth attendant
UNAIDS	Joint United Nations Programme on AIDS
UNCRC	United Nations Convention on the Rights of the Child (1989)
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
URTI	upper respiratory tract infection
USAID	United States Agency for International Development
VAC	village AIDS Committee
VCT	voluntary counselling and testing
VDC	village development committee
WHO	World Health Organization
YFHS	youth-friendly health services

1: Introduction

Human immuno-deficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) together currently constitute one of the leading threats to human development.

Institutions such as Save the Children UK (SC UK) have been building up much programme experience since the epidemic started having an impact on people's lives in the mid to late 1980s. The severity of the epidemic, with the particular vulnerability of young people, has placed a huge responsibility on child-focused development agencies. They need to reflect on their experiences and take the lead in the promotion of good practices.

To do this, an organisation is dependent on its skills to collect, analyse and disseminate information. With the new challenges presented by the HIV/AIDS pandemic, come new needs for information and the skills to produce it. After some self-reflection, it was clear that projects (on the whole) were not generating the information needed for both programme development and advocacy. Experiences were being shared, but in an unsystematic manner, while information varied in content and method of generation. This meant that good practices were difficult to identify (due to our inability to compare or analyse projects), and evidence of project impact was either weak or non-existent. The root cause of this was a lack of monitoring and evaluation (M&E) procedures within a programme design. This document aims to address that gap and its relevance to SC – although the principles are relevant to all development agencies working in HIV/AIDS-related issues. It aims to help programme and project staff to understand the main concepts behind M&E, and how these can be applied to HIV/AIDS-related projects.

The specific aims of this handbook, therefore, are:

- To introduce the concepts which underlie project M&E.
- To demonstrate how these are practically applied in HIV/AIDS projects.
- To provide an overview of existing good practice in key sectoral areas, and how these practices have been identified.
- To give examples of methods and procedures which can be used in monitoring and evaluating HIV/AIDS projects.
- To encourage the use and adaptation of these methods, (a) to improve programming, and (b) to advocate the adoption and expansion of effective projects by others.

2: The Growing Importance of Lesson-Learning in HIV/AIDS Programmes for Young People

In the global attempt to halt the transmission of HIV, this ultimate goal of a project has evolved into the definition of 'best practice'. HIV prevention is more, however, than just a bio-medical intervention. It is also a social process which includes factors difficult to assess by scientific or rigorous methods. 'Best practice' is thus most useful as a theoretical concept, and the term should not be taken literally. More useful are discussions and sharing of experiences about 'effective practices'. Lesson-learning, then, is a reflection which acknowledges the gradual accumulation of good practices in HIV prevention, and supporting children affected by HIV/AIDS. These practices need to be analysed to a consistent – and high – standard if they are to be confidently promoted.

But defining this good practice is difficult. We don't know, for example, what the situation would have been without intervention. And bad practices also exist, of course: in some cases, a development project or even an HIV-related intervention could actually increase infection rates. Such negative projects need to be identified through good MONITORING and EVALUATION.

Acting on the need to develop better evaluation methods

The truth is that most projects have a combination of outcomes – both positive and negative, intended and unintended. In most cases, the absence of evaluation procedures, or the lack of sensitivity of INDICATORS, means that these changes often remain unrecorded, or are difficult to explain even when recognised. So, developing good practices implies that if and when they are implemented, such changes are recognised. This makes us ask whether currently employed M&E procedures can define what good practice is. In other words, what is the *accuracy of the representation, and recording, of the real outcomes of a project?* To know this, we must first ask what information we need to assess a project's worth.

To begin with, one must understand the important terms involved in lesson-learning:

Impact assessment notes lasting and significant *changes* introduced by a project in relation to its specific objectives (Roche 1999). These changes may be both intended (as defined in the project objectives) or unintended.

Inputs are things required for the project to occur. They include labour, materials, time, infrastructure, etc. All inputs have a cost.

Activities or processes are the events carried out by the project. They include training, materials development, product design and dissemination, education sessions, condom distribution, etc.

Outputs are created when the activities have been completed using the inputs. They may include a set of information, education and communication (IEC) materials, an upgraded health facility, or trained project personnel.

Outcomes/impacts are changes which result from the outputs. They may be short-term (intermediate), or longer-term and more permanent. Intermediate outcomes could be changes in levels of knowledge, or the nature of attitudes and behaviours (both of individuals or institutions). Longer-term change might relate to the health status of communities, the quality of life and/or the status of the HIV/AIDS pandemic itself. As changing people's behaviour, or the quality of service infrastructure and practice, is a continual process, HIV/AIDS programmes must take a very long-term view. In this context, the appropriate

time-scale might be decades – well beyond the span of virtually all projects. This is important. For once the benefits of practising preventative behaviour become less obvious, the more likely are people to abandon or inconsistently practise it. It is vital then to look for both short-term and longer-term impacts.

Monitoring refers to the regular collection, analysis and use of information to help guide a project. The main elements of monitoring are project inputs, performance and progress.

Evaluation is the careful examination of an ongoing or completed project. Evaluations usually include examination of the project design (objectives and plan), IMPLEMENTATION (inputs and outputs) and results (outcomes/impacts) (Barton 1997).

There are important differences between monitoring, evaluation and impact assessment which are worth highlighting (Roche 1999):

Timing: Monitoring occurs frequently and evaluation periodically. Impact assessment, however, occurs infrequently, usually towards, or after, the end of a project.

Analysis: Monitoring is mainly descriptive, recording inputs, outputs and activities. Evaluation is more analytical and examines processes, while impact assessment is mainly analytical and concerned with longer-term outcomes.

Specificity: Monitoring is very specific and compares a particular plan and its results. Evaluation does the same but also looks at processes, whereas impact assessment is less specific and also considers external influences and events.

An important concept is the link between the outcomes identified in the analysis and the contribution of the project (compared to other outside factors) to them (ie, the degree of ATTRIBUTION). The question is, *to what extent do we need to demonstrate that change in conditions or in the status of a target group is because of our work?*

Changes in approaches to evaluation over time

Approaches to project and programme evaluation have changed over time. We are now in a phase where there are very different ways of assessing a project's worth. There is the scientific point of view (emphasising rigorous measurement and objective 'facts') and there is the more qualitative/interpretative method, which emphasises the views of different actors and states that the truth is 'unknowable'.

The scientific/interpretative distinction is, in reality, a continuum rather than a distinct either/or situation, with most practitioners adopting positions along the continuum rather than at either extreme. Within this debate, the importance of data TRIANGULATION becomes evident (using different data sources to address a single question). Different evaluation methods can be used in the same context to give different types of information to answer the same questions.

The debate later switches to the type of information *sufficient* for the purpose, and hence the potential for conflict between *stakeholders*. Chapter 3 looks at who these stakeholders are, and what types of information are desired. After all, the initial question is – *who are we evaluating for?*

3: Stakeholders: Who are they and what do they want to know?

Given that there is a need for improved impact assessment within HIV/AIDS programming, the evaluation must ask several questions. *Whom* is the project actually for? *Who* will find the collected information useful? *Why* is the evaluation being done in the first place? As Table 3.1 shows, potential users of such information are varied, and at different levels in the 'aid-chain' connecting donor to individual. A stakeholder is any person, group of people, or institution, who or which has an interest in a particular project or set of activities. This can include the beneficiaries of a project (such as an adolescent seeking sexual health services), as well as community members, project workers, government staff, donors and academics.

Table 3.1 Benefits of Conducting HIV/AIDS Project Impact Assessment

Stakeholder	Potential Benefit
Beneficiary/ Community	<ul style="list-style-type: none"> ➤ Sense of ownership through participation ➤ Empowerment for change through self-reflection (removal of fatalism through the demonstration of project-effectiveness)
CBO/NGO/ Government counterpart	<ul style="list-style-type: none"> ➤ Information for planning and strategic choices ➤ Development of good practice ➤ Improved reporting to funding agency ➤ Improved information for fund-raising ➤ Capacity building in project planning and M&E techniques
SC: Project Officer	<ul style="list-style-type: none"> ➤ Development of good practice ➤ Assessment of project impact/cost-efficiency ➤ Capacity building in project planning and M&E techniques ➤ Improved reporting to programme officer
SC: Programme Director	<ul style="list-style-type: none"> ➤ Information for programme strategic choices ➤ Development of good practice ➤ Recognition of project impact/cost-efficiency ➤ Improved accountability to government and donors ➤ Improved information for fund-raising
SC: Globally	<ul style="list-style-type: none"> ➤ Examples of good practice ➤ Improved accountability to stakeholders ➤ Demonstration of project-effectiveness to other stakeholders
Donors, international agencies	<ul style="list-style-type: none"> ➤ Sharing of experience as to supervising the monitoring of project-effectiveness ➤ Recognition and implementation of good practice ➤ Reporting to governments/parliaments

Involving stakeholders and ensuring participation

Stakeholder *participation* is crucial and necessitates some kind of dialogue at different levels. A typical example is an advisory board where members represent different interest groups.

The evaluator may talk to the different stakeholders – if appropriate. Each stakeholder may, however, have their own conflicting position.

In response to this stakeholder-participation dilemma, some have found it useful to adopt the principle of *utility* (Peers and Johnston 1994) which identifies several ‘ideal’ emphases:

- Potential users should be identified and involved from the outset – and at every stage.
- The content of the evaluation should be agreed between the various users (or stakeholders).
- The evaluators should make user-participation their goal, and should see their role as training stakeholders in the use of evaluation.
- Consideration should be given to all the possible forms of evaluation impact.
- The cost of user-participation (in money, time and other resources) should be accepted.

These may not all be practical or feasible, but they are valuable as principles of both programme planning and evaluation design.

CHILDREN AND YOUNG PEOPLE’S PARTICIPATION IN PROGRAMMES

A major challenge for HIV/AIDS and young people is the inclusion of children and adolescents in the design, implementation and evaluation process. Not only should young people be viewed as the primary stakeholders, the UN Convention on the Rights of the Child 1989 (UNCRC) emphasises that children have the *right to be heard* and that all actions concerning children should be *in the best interests* of the child. It is worth examining the specific mechanisms and challenges of this inclusion in both HIV prevention, and AIDS-impact mitigation.

1. HIV-prevention projects

The primary issue here is whether children are the *subjects* or *objects* of the evaluation. If children are simply studied, they become the subjects. If they actively participate, then they become the objects of evaluation. For child-focused agencies, this child perspective is central to the understanding of the real impacts of projects.

Letting children express their opinions should therefore be a main aim when assessing the influence of behavioural development programmes. The best techniques for this are focus group discussions and other participatory evaluation exercises, ie, participant observation by children; art work; storytelling; social mapping; diary-keeping; or looking at changes in norms and levels of peer pressure (Feuerstein 1986; Barton 1997; Theis 1996; Feldman and others, 1997; Solim and others, 1997). These qualitative approaches must complement more quantitative techniques such as knowledge, attitude and practice (KAP) surveys, or sexually transmitted disease (STD) surveillance, in a single evaluation framework. Evaluations which harness the interest and experiences of children themselves, as objects of the study, provide a better understanding and more holistic picture of the situation (Colling and others, 1998).

2. AIDS-impact mitigation

When analysing an intervention which aims to alleviate the impacts of HIV/AIDS on children, we need to be clear which children we are concerned with, and how this may differ according to context:

- children living with HIV (asymptomatic)
- children living with HIV (symptomatic)
- children (uninfected/HIV status unknown) of seropositive parent(s)

- maternal orphans
- paternal orphans
- double orphans
- relocated children
- abandoned/destitute children
- child/adolescent-headed households
- children who are 'unaffected'/control children

Children's involvement in a project evaluation is partly dependent on their age and overall situation.

In a developing context, evaluations involving children often face cultural restrictions. The level of child participation in the evaluation of the Community-based Options for Protection and Empowerment programme (COPE) in Malawi, for instance, was limited. Community members involved in the project stated that the children would not open up to insiders, though they might, on a one-to-one basis, with an outsider – so long as confidentiality was assured. Group work with children was deemed unfeasible, and if it were to be conducted, only generalised views would be given. Children are presumed to be reluctant to talk for fear of (a) being chased away from the house by guardians, and (b) being considered 'rude'. The point to be learnt here is that if children were involved in planning and monitoring from the outset of a project, there would be less resistance from adults to 'including' them in an evaluation later on.

So far as the author knows, no evaluation of a project to alleviate the impacts of HIV/AIDS has yet been documented with children as the objects of the evaluation. Certain principles of participation, however, have been defined, and it is worth listing them here (Box 3.1).

Box 3.1 Questions to ask in evaluating children and young people's activities

- Have children and young people, and their families, been involved in deciding the measure for the evaluation?
- Can children and young people benefit from the evaluation, and how?
- What have been the risks and costs for children of their involvement?
- Have confidentiality and privacy been respected at all times?
- Do the children involved know that they are free to refuse, or withdraw at any stage, and that this will not be held against them?
- If certain children have been excluded from participating, can their exclusion be justified?
- Have the children concerned and/or their carers, helped to plan, implement, analyse and evaluate the activity?
- Are the children concerned aware of the purpose and nature of their participation, methods, timings, benefits, consequences and outcomes?
- What have project workers learnt from the participation of children and young people?
- Will the children, young people and their families be told of the main findings?
- Apart from the effects of the activity on the participants, how might the conclusions affect other children and young people?
- What are the constraints on the participation of girls, disabled children, orphans or children living with HIV/AIDS? How can these constraints be overcome?

Based on Colling and others, (1998), *Children living in a world with AIDS: Guidelines for children's participation in HIV/AIDS programmes*, The Children and AIDS International Non-Government Organization Network (CAINN)/UNAIDS.

PARTICIPATION IN PRACTICE:

1. School-based programmes

The highly contentious nature of sexual health education for young people makes it important that sources of potential conflict are actively acknowledged from the start. Points of agreement can be used as a basis from which to negotiate further, for example, 'no child should be sexually abused'.

If stakeholders are involved from the beginning in curriculum design and production of educational material, extra flexibility is possible if pamphlets or a series of booklets are used. For instance, sensitive issues can be left out if necessary, rather than the whole educative tool being rejected. Consultation with the community and religious authorities can give a sense of wider ownership from the outset, and addressing the fears of parents is crucial. Often the results of FORMATIVE RESEARCH can be used to make a community aware of the need for school-based (and other forms of) sexual health education, especially in areas experiencing high levels of denial (as may be the case in low-PREVALENCE countries, particularly in South-East Asia [Tewari 1998]). Within the school itself, the support of the head teacher is vital, and he or she needs to be constantly updated on the progress of the work. Problems occur when these key gatekeepers are marginalised from the overall process. Similarly, a big challenge for the teachers is allowing more participation of parents in school-based events.

As with school-based education, peer education has the challenge of identifying the relevant stakeholders, and then involving them in programme design and implementation. They might include government agencies, the police, organised crime, brothel owners, teachers, parents, community leaders and clinic workers.

2. Youth-friendly health services

Clinics often represent the focal site for many different actors: health workers, neighbourhood health committees, Ministries of Health (and the various departments within them), provincial and district health authorities, women's groups, youth groups, NGO interventions, and research institutions such as universities or foreign study teams. Within the clinic itself, all departments (primarily antenatal, out-patient, and maternal and child health) need to be involved. Only such a wide involvement can ensure that services (which may have different distribution sources and supply lines) are co-ordinated effectively. These include the supply of drugs, education materials and condoms.

Because so many actors are potentially involved, the feedback loops within the system need to be well defined and consistent, thus allowing rapid identification of problems and ease of project monitoring. This implies regular meetings of the relevant actors and sensitivity of project co-ordinators. Clear definitions and project objectives are vital from the start— all must understand, for example, what is meant by the term 'youth friendly'. And all the actors should know from the outset their roles and responsibilities. A common problem in this type of project is the often blurred role of the peer educators, both in and outside the medical environment. The training of the medical staff and the educators must clearly define these roles (which must be agreed with them), to avoid any build-up of resentment between actors.

The process of stakeholder identification and consultation is a continual one throughout the life-span of a project. A key event for both the identification of these groups, and their involvement in the programme design, is the SITUATION ANALYSIS stage. This forms the subject of the next section.

4: Situation Analysis and Objective Definition: Identifying the needs

Before any project begins one must do a situation analysis. This is sometimes referred to as a 'NEEDS ASSESSMENT' or 'formative research': the terms mean the same thing and are interchangeable. There are two major steps involved in any initial project/programme development, namely the situation analysis (which itself has two stages), and then identifying the main objectives.

Situation analysis

Research should focus on situations relevant to HIV, and the factors favouring or impeding its spread. What are the most serious obstacles to reducing the spread and impacts of HIV/AIDS? Attention should be given to children and young people at risk and their experiences should be the key source of data. Who is at risk? Where are they? Why are they at risk? What factors protect against HIV infection? The differences in the situation as it affects males and females should be clearly identified. A SURVEILLANCE DATA review is essential. This information is usually provided by the national AIDS programme, or sometimes by provincial/district health authorities.

The second part of this process is the RESPONSE ANALYSIS – looking at who is doing what in relation to children and sexual and reproductive health (including HIV/AIDS). This covers all government policy positions and strategies, as well as development of the National AIDS Strategic Planning process. If such positions exist, how are they being encouraged and implemented? Are actors aware of them? Also needing assessment will be the activities of other, relevant, non-governmental and community-based organisations, and where, and whom, they are targeting. What are the most important gaps, and what opportunities are there to fill them? (Annex gives an example of a key-informant interview-guide to research these issues.)

The identification of goals, objectives, activities and outputs

This is the second major step: what should be done, by whom, in what time-frame? The specific role of Save the Children (SC) within a larger (national and/or provincial) response (to the epidemic) should be clearly outlined as well as the areas of competence which SC wishes to build on, including special expertise in children's participation. Central to this process is the participation of stakeholders (especially the project beneficiaries and gatekeepers.

At programme level, there are distinct elements which need to be looked at before moving on to the identification of goals, etc, (eg, SC [UK] 2000a):

- SC's own existing situation (objectives, strategy, target groups, partners, studies, community-based training, training materials)
- needs assessment of HIV/AIDS and reproductive health and young people in the country/target areas
- institutional profile – who is doing what and where?
- activities – HIV prevention, care of infected and affected children, after-care, mitigating social impact
- unmet needs
- vulnerable groups
- operational research needs.

A good situation analysis should generate both qualitative and quantitative information. This distinction is an important one and needs to be understood.

Qualitative research: a flexible and open-ended method of building up an in-depth picture of an institutional profile, situation, community, etc. The emphasis is on questions of *how* and *why*. PLA methods commonly used are:

- focus group discussions
- in-depth interviews
- time lines
- body mapping
- gender workload analysis
- community resource mapping
- ranking and wealth
- venn mapping
- transect walks
- social mapping
- force field analysis
- problem trees
- seasonal calendars
- health matrix
- income and expenditure tree

Quantitative research: this method is used to collect data which can be analysed in a numerical form. Behaviours, occurrences of events, perceptions, socio-economic data, etc, are therefore either measured or counted, or questions are asked according to a defined questionnaire so that the answers can be coded and analysed *numerically*.

Then there is also the important distinction between a needs assessment and baseline data. Baseline data is data collected using a set of methods and indicators which can be later replicated. Such data is directly comparable, thus enabling any trends to be identified: this implies the use of a numerical or quantitative baseline. However the collection of baseline data cannot begin until it has been decided what changes the project is aiming for. These aims, in turn, cannot be identified until the information gathered from the needs assessment has been analysed. Such information should never itself be considered baseline data: though sometimes it may be directly comparable to data produced later in the project.

It is worth looking at some questions and methods used in situation analyses of different programmes.

School-based programmes

Good formative research is crucial in designing an appropriate school-based programme. This exploratory data can be used in the development of education materials. Or the link can be made between materials to be used and the design of the baseline survey itself. New education materials may not always be needed as much is already available. (However, involving young people in a participatory process to generate materials virtually assures that the materials will be relevant and understandable). Formative research in this case must look at the appropriateness of different material options, and the generation of baseline data related to the messages and objectives of the education materials (AIDSCAP n.d).

Knowledge, attitude and practice (KAP) surveys are a reliable method of baseline data production, but they must be combined with qualitative techniques. Potential formative research questions for school-based programmes are many and varied (Box 4.1).

Box 4.1 Formative research questions for school-based programmes

- When do boys and girls become sexually active?
- What is known about HIV and STD prevalence in the community by health workers or by parents?
- How do youth perceive their risk of HIV/STD infection?
- What are their main health concerns?
- What are their attitudes to sex?
- What is known about the most common sexual practices in adolescence?
- What do parents think about sex education?
- What does the community of which the school is part think about sex education?
- What do teachers think about sex education, and are existing teaching methods appropriate?
- Is there any room for expanding out-of-school activities to support the school-based programme?
- What type of organisational structure is available to support the programme?
- What is the approach of the official curriculum? Is it necessary to supplement the deficiencies in the top-down approach of a national curriculum?
- How could a peer-health-educator programme be set up to supplement the official curriculum?
- Do teachers have sexual relations with students?
- Do school counsellors or guardians need to help protect students' sexual health?

Source: Schapink and others, 1997.

A question crucial throughout a project is, 'How do we know that the project is responding to the main concerns of the adolescents?' Focus group discussions with young people are important here, and they can be repeated with different community-based stakeholders at various stages throughout the project.

Important to note are the different perspectives of the various stakeholders. It is vital to consider these differences when designing the intervention so that none of the stakeholder groups feel alienated or isolated.

Case stories and narratives

Another qualitative method, which can yield a rich blend of information, is to produce case studies with young people. This may be most appropriate with groups who are not organised, or accessible, through survey techniques.

Development and use of problem trees (see annex)

A useful analytical method in these formative group discussions is the problem tree. This allows participants to focus on a central problem, identify its causes and impacts, rank these factors, and define objectives for an intervention. Problem trees can be conducted separately with boys and girls to determine the gender elements of a specific problem. In this way project activities can recognise, and respond to, different needs.

If many problem trees are used with different groups around a central problem, the aggregation of findings can give an overall picture of how young people see an issue. Ranking responses in this way will not show how important these factors are in *causing* a problem, but it will indicate how common or widespread a particular factor or perception is.

Using a problem tree to develop objectives and indicators

Problem trees can be the first step to developing objectives and indicators within a programme. An example is shown from the Children First project which works with out-of-school youth in Spanish Town, Jamaica, providing education and vocational opportunities and outreach education in local communities. A focus group was conducted with teachers and some of the elder students, and a problem tree constructed with 'risky sex' as the central problem (Figure 4.1).

In attempting to define objectives for the project regarding the sexual and reproductive health of young people, and ultimately finding ways of assessing the impact of the project, various important questions need to be addressed:

What behaviour is the project trying to (a) encourage, and (b) prevent?

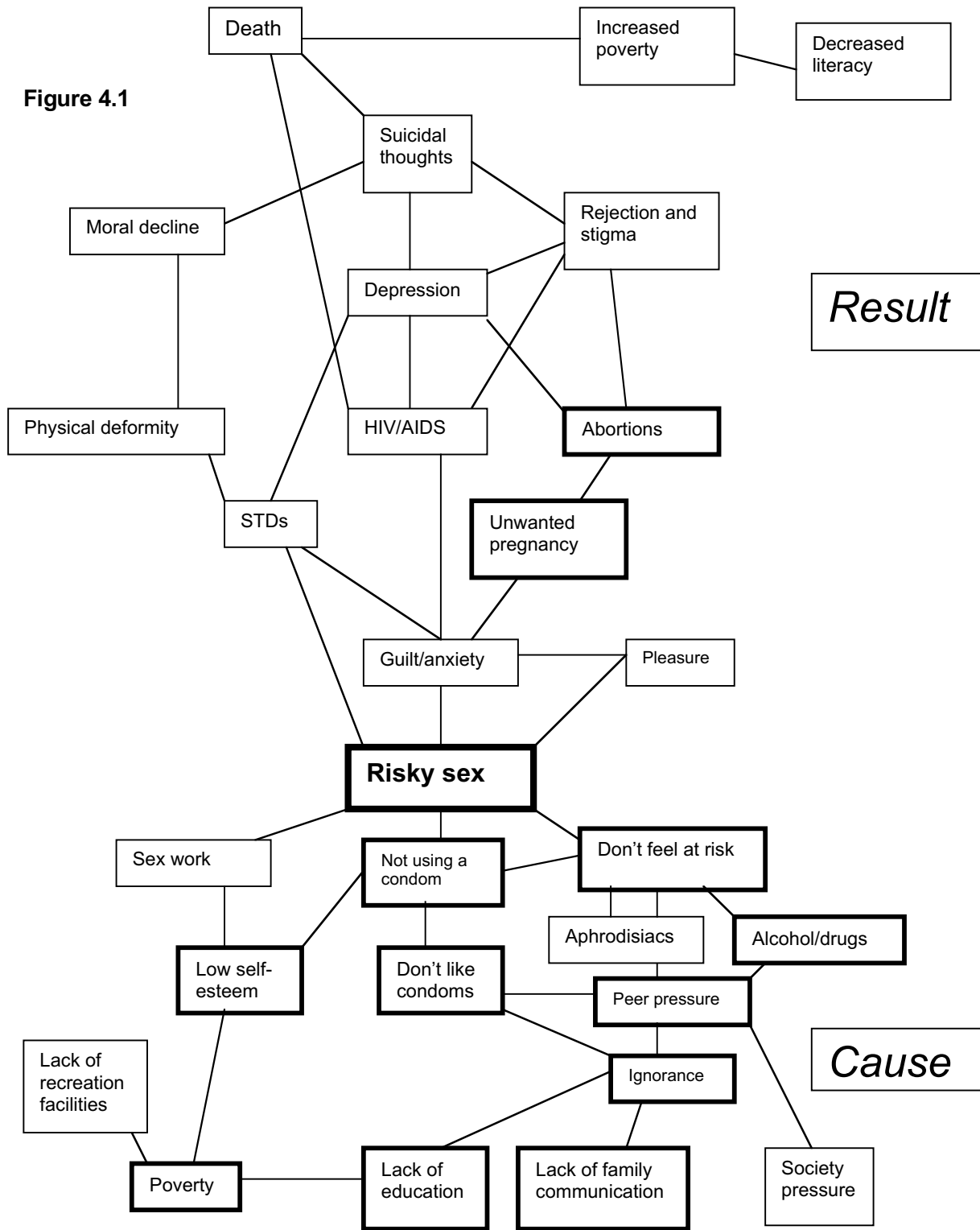
Children First identified various behaviours to encourage:

- respect – for self, life, others, etc
- abstinence
- condom use (responsible choices – normalisation of safe sex)
- seek education
- use services available
- correct treatment
- positive peer influence.

And discourage:

- early sex (delay until 'mature')
- irresponsible behaviour
- multiple partners
- unwanted pregnancies
- drugs' use
- unemployment – dependence
- illiteracy
- succumbing to negative peer pressure
- discrimination/homophobia
- self-treatment for STDs/home remedies.

Figure 4.1



From the problem tree (Figure 4.1), and other discussions and exercises, objectives can be identified which the project can monitor:

Changes in the context or environment:

- reduction in poverty of target group – reduction of female economic dependence
- increase in literacy and education.

Changes in individuals:

- increased ability to deal with peer pressure
- changes in alcohol and drug-taking behaviour
- increase in self-esteem.

Intermediate impacts:

- increase knowledge of condom use
- reduce feelings of invulnerability
- raise awareness of condom use
- increase family communication on SRH issues.

Behavioural outcomes:

- increase condom use.

Long-term impact:

- reduction in unwanted pregnancies.

An important step in the planning process is recognition of what the project can and cannot achieve. Projects should consider two important points: (1) What factors have most influence over a certain behaviour? (2) Which factor is the project best placed to influence? Realistic assessment of these two points can help define the objectives, and will ensure that the project does not attempt too much. The factors influencing young people's behaviour are very complex, and no one project should feel that they have the responsibility to change the behaviour of all the beneficiaries.

Collecting baseline information

Baseline data information is essential to assess the impacts of a project, and its collection should be planned at the beginning of the project cycle. Without baseline information, projects are forced to rely on recall methods and retrospective techniques. To address these concerns, a number of organisations use a 'rolling baseline' which allows changes in people's lives and priorities to be regularly recorded. This is generally done by using 'panel groups' or 'COHORTS' (groups of individuals or households) who are tracked over the lifetime of the project (Roche 1999). It is important – if using a rolling baseline – to measure the same indicators or benchmarks at each stage. Too often the indicators, and other measures, change over time which makes comparison between different stages of the project difficult.

In collecting baseline information, a key lesson is to only gather information which is actually going to be used. This should reduce wasted time and resources and ensure the relevance to the project of the collected information. The link between the baseline data question, the indicator and the objective should be clear (Table 4.1). All baseline data should be disaggregated by age, gender and other differences as appropriate.

A challenge with baseline data collection is that sensitive information is sometimes required. Here, the evaluator must balance the need for such information with the fact that a respondent may not feel at ease in answering some questions. There may be some 'padding questions' to establish a rapport, before the crucial questions are asked. It may, then, be

important to recognise the padding questions and not waste too much time in their analysis after the data has been collected. Evaluators should be able to pinpoint the crucial questions in a baseline survey, and link them back to the project objectives. Once again, the importance of using different tools and methods is emphasised to give a comprehensive picture of any one situation. The next step is implementation which is the focus of the next few sections.

Table 4.1 Linking Objectives with Indicators

Objective	Indicator	Example Question
Increase HIV-related knowledge	Understanding of HIV latency period	How long is it before someone who has HIV shows symptoms?
Increase safe sex behaviour	Condom use at last intercourse (unmarried person)	On the last occasion you had sex, did you use a condom?
Harm reduction regarding injection drug use	Prevalence of needle sharing	Would you say that you (a) always share needles, (b) very often share, (c) share about half the time, (d) rarely share, (e) never share?
Reduce stigma associated with people living with HIV/AIDS	Willingness to care for someone with AIDS	If a family member or a close friend became ill with AIDS, who would care for them?
Reduce stigma attached to children affected by HIV/AIDS	Degree of rejection experienced by orphans in the school environment	Do orphans get teased at school? Why is that?

5: Major Strategy Options for Reaching Young People

Once a situation analysis has been done, strategies to reach young people are devised. It is worth focusing on four of the major strategies employed for HIV prevention: (a) school-based education, (b) peer education, (c) youth-friendly health service development, and (d) outreach work with especially vulnerable children. These four are not the only options available to project designers, but the focus on them is deliberate. They are the programme approaches most commonly adopted by practitioner organisations, as they have been effective in achieving project aims and objectives. This section looks at understanding their rationale and the key concepts underpinning them. Following sections look at what we understand by 'good practice' within these strategies.

The rationale of school-based education

No other institutional system worldwide reaches as many children as the school system. Its potential for sexual health education of children and young people is therefore vast. And UNAIDS have specified the overall aim to significantly increase the number of countries with detailed policies and implemented programmes for non-discrimination and HIV/STD prevention in the school setting (UNAIDS 1997).

As well as a wide coverage, also important is the pre-existing body of educators, ie, teachers, who are in regular contact with these children. The pre-existence of a group of trained educators, however, does not presuppose that the teachers are sufficiently equipped to play the role of sexual health educators. The notion that teachers can simply add a certain teaching component to an existing curriculum, and use the existing didactic teaching style, has proved extremely naive.

The added complication of the contentious nature of sexual health education as seen by some teachers (as well as parents and opinion leaders outside school), makes programme design a diplomatic as much as a technical process. Participation by these actors is thus especially crucial throughout the design, implementation and evaluation cycle.

Reaching young people through peer education strategies

There are many reasons why peer education is a logical approach (Kathuria and Wilson 1995; Peers and Johnston 1994; Fee and Youssef 1993; Feldman and others 1997; Newton 2000; UNAIDS 1999b):

- In areas of high unemployment, peer education taps the large pool of human resources in a cost-effective way.
- Peer educators are able to reach marginalised groups denied access to formal structures.
- Peer education, by definition, requires community participation and is an integral element of wider community development processes.
- It provides training and resources to marginalised communities.
- Young people are ready-made experts in communicating with other young people, especially where adult-adolescent communication on sexual health issues is taboo or limited.
- Peer education is a means whereby the effectiveness of a single, trained educator can be multiplied (cost-effectiveness).
- Empowerment: it is right that young people themselves should control the process of education.
- Young people feel more at ease than older adults in challenging traditional norms or practices, such as female genital mutilation or 'dry sex'.

Peer education is also very important in that it reaches young people outside institutional settings, such as youth who are not in school. These young people are especially vulnerable to HIV infection, and other sexual and reproductive health problems.

Clinic-based service delivery (youth-friendly health services)

The provision of adequate and appropriate sexual and reproductive health services to young people has taken on a new urgency in the light of the HIV/AIDS pandemic. The whole premise of youth-friendly health services is that current, formal health systems are somehow deficient in providing adequate access to young people. The reasons young people tend not to seek sexual health care in the formal sector are complex, but can be summarised:

- lack of information about services
- lack of understanding of the importance of sexual health
- possible easier access to non-formal (traditional) services
- fear of stigmatisation
- fear of lack of privacy and confidentiality in clinic
- lack of trust in ability of health workers
- services not affordable
- service not geographically accessible
- poor attitudes of health workers towards young people
- long waiting time in clinic
- lack of drugs
- low self-esteem, especially in girls and young women.

The clinic's potential in reducing HIV transmission has not been fully realised – especially in relation to antenatal care for young mothers (most importantly *PRIMIGRAVIDAE*), which represents a significant contact between young sexually active females and sexual health services (Webb and Fleming 1996; Box 5.1).

Box 5.1 The roles of antenatal clinics and out-patient departments in HIV/AIDS prevention and care

Antenatal clinics

- sero-epidemiological surveys
- the identification, care and support of infected adolescent women
- the identification of AIDS-affected families, with counselling of infected women, partners and families
- reduction of sexual transmission through provision of education and condoms
- reduction of vertical transmission
- prevention of nosocomial transmission
- diagnosis and treatment of STDs

Out-patient departments

- prevention of STD and HIV transmission through the provision of education and condoms
- treatment of STDs
- prevention of STD and HIV transmission through partner-tracing and treatment of infected adolescents
- prevention of unwanted pregnancy
- referral of suspected HIV patients to counselling and testing services
- diagnosis of pregnancy and referral to antenatal clinic services

Reaching especially vulnerable children

The area of HIV-prevention work amongst especially vulnerable children is perhaps the most challenging. Included in this category are street children, child sex workers, abandoned children, refugee children, children in war situations, domestic workers and child-headed households.

The principal difficulty in addressing the sexual health needs of these children is their overall vulnerability and degree of marginalisation. In summary, marginalised young people are vulnerable to STD/HIV because:

- High risk sexual behaviour is very common despite high levels of knowledge of HIV/AIDS.
- Psychologically, the risk of HIV infection is not an 'immediate' problem.
- Sexual exploitation, and even rape, by adults is common.
- Economic vulnerability forces many children into commercial sex with adults, eg, female, adolescent heads of households.
- Sex is seen as a recreation for many, enhanced by drug use.
- Despite the presence of sexual health services, awareness and utilisation is generally low.

To develop good practice in these major strategy areas, we have to return to the elements that make a programme 'good' in the first place. In reality, multiple strategies can be used to reach various groups of young people. For instance, peer education or developing clinical services can be used, whatever the target group. The analyses in the following sections will concentrate less on the specifics of the target groups (although these are still crucial), but will address good practice within the strategies themselves.

6: How to Reach Young People Effectively: Key questions

As activities are designed for the main strategy areas, some more important questions arise – about the way the project is delivered. Here, we look at refining these questions in relation to the activities, and what has been learned to date. Each project can be (1) assessed against lessons learned, (2) developed according to previous experience, and (3) designed to ensure that the monitoring systems include these fundamental questions.

These are the key process questions which need asking, and the issues which the project monitoring system should cover:

- Have we defined the target population and do we know how many there are?
- Are we actually reaching this population?
- Are we spending enough time with the target group?
- Are the methods we are using appropriate in reaching them?
- How cost-effective and sustainable is the project?
- How integrated is the project with other activities?

Defining and reaching the target population – the importance of COVERAGE

In defining the target population, there are three major elements; age, gender, and the location (both geographical and institutional) of the group. If a needs assessment has been properly done, this should have identified the relevant services, behaviours and their causes, where these behaviours are most likely to happen, and indeed *when*.

Estimating the target population-size of the project

Knowing the target population-size, such as the catchment population of a clinic, is important to assess the amount of coverage needed, and then the project impact. If the project area is defined by district boundaries, then census data should suffice. If it is out of date, then an easy method to estimate current population size is to use the existing figure, the date of that figure, and the estimated population growth-rate for the country. Using the chart in Box 6.1, read down the left column to find the required number of years since the last census, then multiply the number in the right hand column by the population figure. This will give the current population estimate for the district.

If the project area does not conform to district boundaries, or census data is not available for the district, a community mapping exercise can be conducted. With a group of community members or project staff who know the area well, draw diagrams of the area on the ground or on flip-chart paper. Then, identify key landmarks or boundaries, and distinct clusters of households. For each distinct area identified, estimate the number of households. As a group, estimate the average number of people per household (this may be provided in other surveys, or nationally by the Demographic and Health Survey) to give a household total for the area. Finally, multiply this by the agreed average number of people per household to give an overall population estimate.

Box 6.1 Estimating the target population size of the project	
Number of years since last census	Annual growth rate of 3%
1	1.030
2	1.061
3	1.093
4	1.126
5	1.159
6	1.194
7	1.230
8	1.267
9	1.305
10	1.334

Due to constant migration, and the fact that people who live outside the area may also access services, a totally accurate figure will never be calculated. Even so, having a population estimate adds meaning to figures of people reached with outreach education, or utilising reproductive health services.

Coverage can be defined as the proportion of a defined population (spatially and socially) who have a specific, defined need, who (1) can access a service and (2) use a service. This definition implies that the service-users know about it and its purpose. To define coverage we need:

- The ability to define the target population (who has a need?). This gives the denominator. When looking at some behaviours (both positive and negative) the entire child (or adolescent) population will be the denominator.
- The numerator, ie, the actual number of cases or individuals who can access, receive, or interact with, a service. The numerator and denominator together give the proportion (usually per cent).
- Clear objectives of an intervention – who are we reaching, with what and why?
- Measurement tools.

Assumptions are often made about coverage measurement: first, that we know the needs of young people (implying that a situation analysis has been done with their full participation); second, that the project adequately addresses the issues or needs identified; and finally, that measurement tools provide accurate data. But in reality, particular problems come up in measuring coverage:

- The denominator may be very difficult to define with any degree of accuracy. Prevalence of an issue may be unknown, or vary over time. This may especially be the case with hard to reach groups, or in dealing with sensitive issues such as depression etc.
- There may be an over-reliance on population-based figures which can be outdated and give an inaccurate denominator.
- The difficulties in providing a denominator often lead to situations where only numerator data is provided (such as use-rates, or numbers of people reached). In other words, coverage is not given.
- Coverage is sometimes over 100 per cent if people from outside the catchment use a service, or when single individuals are counted twice (ie, data is not disaggregated by new or previous user).

Measuring coverage throws up various challenges and some key questions. Pilot projects, for example, usually have a high intensity and low coverage (that is they reach a relatively low number of people compared to the number of people in need). Only by scaling up these projects can their maximum benefits be realised. Pilot projects must be evaluated carefully, to ensure that the scaling up which occurs is based on sound principles and experience.

In some circumstances, it may be sufficient to provide only a numerator as evidence of impact (ie, actual number of people receiving a service/interacting with a project). If the objective of a project is to increase use of a service, than absolute numbers will be sufficient. Difficulty here arises when the project objective relates to the improved health status of a community – increased use does not necessarily mean an improvement of overall status of the catchment population. For example, condom-distribution data is important but does not necessarily mean that the prevalence of STDs will drop.

School-based programmes

For school-based programmes, most commentators agree that education prior to sexual debut is most effective in achieving programme aims, and that reaching the 10-14 age group is especially crucial (Grunseit 1997; Gachuhi 1999). The current challenge is to define and develop models of materials for use with different age cohorts. This requires well designed, long-term trials. The key lesson is that life-skills and sexual health education must start early for children.

Peer education targeting

In many peer education projects there may not be any real targeting of younger age groups, despite the messages being designed for a younger audience. This is especially true when education sessions are held in market places, or in house-to-house. This may reduce the ability of the educators to have a real dialogue with the young people and the projects become less effective. Meetings which involve life-skills education, and use of information, education and communication (IEC) materials, are better arranged by word of mouth between the educators and focal youth in the slum areas. A snowball method can be used to lower the age of the target audience, by asking focal youth to bring friends of a certain age (ie, below 18) to subsequent sessions. If need be, sessions can be stratified by age group (eg, under 18 and over 18) to allow for more age-group-specific sessions.

- Reaching high-risk populations in their locations is effective: bars, parks, stroll districts, etc.
- Adults must be involved, and peer education as a concept should not simply be restricted to young people – experience suggests it is needed for all age groups. At the same time, cultural norms can affect targeting procedures, especially in relation to house visits. Here, it may be difficult – or actually impossible – to separate the young people in the house or group from the rest, thus only allowing for a collective meeting and forcing the educator to change the content of the message as the ‘target’ group is diffused amongst the ‘non-target’ group.
- Opportunities for single-sex, peer-learning must be provided. Males ‘dominating’ groups can hamper reaching the young women in mixed-group situations.

How intensive should the project be?

The project INTENSITY looks at how long the optimal length of contact time with the target group should be (ie, hours, days, weeks), and what methods should be used in that interaction (ie, workshops, focus group discussions, one-to-one interviews, etc).

School-based education

The question of intensity of contact is a difficult one to address, and there are no set answers. It depends on the objectives of the project. With regard to programme intensity for school-based education, there are various relevant issues: the timing of the education sessions in relation to pupil age, existing school timetable, and the size and composition of the student groups. The sessions, where possible, should be held in school time, and last at least 14 hours in total, according to Kirby who reviewed evaluations of school-based education in the US.

Evaluators of very short-term programmes continually point to the intervention's short exposure time as an explanatory factor in having little or no impact on behavioural, or attitudinal, changes in target groups (Mitchell-DiCenso and others, 1997; Elliot and others, 1996; WHO 1996). In terms of group composition, an evaluation, in Zimbabwe, of a school-based programme found that teachers considered single-sex sessions to be better for the discussion of puberty, sex, reproduction, or gender-specific relationship problems. At the same time, however, it was felt that mixed-sex sessions fostered respect and communication between girls and boys, and should begin early. It seems that a certain amount of experimenting is necessary to reach an optimal balance and can only be achieved through in-school experience (O'Donaghue 1995).

Principles of good practice have been defined in the various literature reviews, and country-specific reports. Many of these reports are the same as those dealing with peer education, hence a certain amount of overlap in terms of the principles outlined (Box 6.2).

Closely linked to the subject of varying project intensity, is the finding that successful programmes have had inbuilt flexibility. Like peer education, continual monitoring of activities and opportunities for reflection and feedback should ensure that problems are quickly noticed and dealt with.

Box 6.2 Principles of successful school-based HIV/AIDS education

The poor quality of HIV/AIDS curriculum may be due to:

- Omission of important areas of AIDS education, such as non-discrimination and support.
- Inadequacy or non-existence of learning materials Teachers not properly trained to teach sensitive issues.
- Only one option in terms of sexual behaviour being offered, eg, abstinence.
- Poor definition of the course objectives.
- No monitoring and evaluation system in place.
- AIDS not linked with other wider issues in the curriculum.
- No information on referral to other services.

An effective AIDS education programme does all the following:

- Focuses on life-skills – negotiation and decision-making.
- Personalises risk through role-playing and discussion.
- Discusses clearly the possible results of unprotected sex, and the means of avoiding these outcomes.
- Explains where help is available.
- Stresses that skills useful for self-HIV-prevention also help build self-confidence in other areas of one's life.
- Uses social norms which are positive and questions those which are negative.
- Provides sufficient time for discussion and does not rush activities.

The most important HIV-related skills a young person can learn are:

- How to make sound decisions about relationships and sexual intercourse, and stand up for those decisions.
- How to identify one's own personal reasons for resisting pressures for unwanted sex or drugs.
- How to recognise and avoid, or leave, a situation which might turn risky or violent.
- How and where to ask for support, and have access to youth-friendly health services.
- When ready for sexual relationships, how to negotiate protected sex or other forms of safer sex.
- How to show compassion and support for people with HIV/AIDS.
- How to care for people with AIDS in the family and community.

Source: UNAIDS (1997), *Learning and teaching about AIDS in school*, Geneva.

Peer education

In peer-education strategies, there is conflicting evidence regarding the optimal duration of exposure to the intervention. In one study in the United States, high-intensity, small-group programmes (over five meetings) were less effective than low-intensity programmes (one to four meetings) in effecting behaviour change. This was possibly due to the nature of the target group concerned, with women in the high-intensity campaigns being more prone to substance abuse (Ickovics and Yoshikawa 1998). By contrast, in Zimbabwe, self-reported, condom-use rates amongst sex workers and fishermen were strongly associated with the number of education sessions attended (Kathuria and Wilson 1995).

Types of Peer Approaches

Peer education is not a uniform approach. In particular, conflicts appear regarding definitions and targeting procedures, and it is better to think of a spectrum of approaches. A 'peer' should be of the same socio-economic background, status, geographical area and age group as the target audience. Despite the confusion surrounding peer definition, Fee and Youssef (1993), have articulated the three major sub-approaches within peer education (Table 6.1).

Peer information involves promotional activities – organised by groups of young people for a large audience – to spread information, create awareness and distribute materials and condoms.

Peer education is a more structured approach which helps small groups of young people build their knowledge, attitudes and safer-sex skills through organised educational activities by trained young people.

Peer counselling is focused and intensive. This involves the training of capable youth as counsellors to discuss personal problems, and problem-solving strategies, with other young people on an individual, one-to-one basis.

Table 6.1 Types of Peer Education Approaches

	Peer information	Peer education	Peer counselling
Objectives	Awareness Information Attitude change	Awareness Information Attitude change Self-esteem Prevention skills	Information Attitude change Self-esteem Prevention skills Coping skills Psycho-social support Problem-solving
Coverage	High	Medium	Low
Intensity	Low	Medium/high	High
Confidentiality	None	Important	Essential
Focus	Community Large groups	Small groups	Individual
Training required	Briefing	Structured workshops Refreshers	Intense and long
Relative cost	Low	Medium	High
Examples of activities	Drama, special events Material distribution Mobile vans World-AIDS-Day activities	Repeated group events based on a curriculum	Young people living with AIDS Clinic-based youth counselling

Adapted from Fee and Youssef (1993)

Regarding methods used, there are similar principles for both peer education and school-based work:

- A structured, group approach based on a curriculum is the most valuable model for the age group 13-19.
- Small group discussions (defined as 15 people or less) were deemed most successful over 37 projects reviewed (Janz and others, 1996).
- Teaching techniques which personalise the information (rather than a didactic approach) are more effective – role-plays, group discussions.
- Individual counselling and testing is relatively ineffective as a primary prevention initiative.
- Repetition of the essential AIDS-prevention messages is valuable.
- Ensuring that peer educators are able to facilitate referral between various service providers is vital.
- Performing arts are more appropriate for younger audiences.
- The creation of a forum for open, uninhibited discussion is important.
- The visual identity of educators is crucial, through uniforms, tee-shirts or badges.

HIV prevention should be approached from a positive choice viewpoint (eg, ‘there are lots of enjoyable things you can do’) rather than a negative approach.

Youth-friendly health services

In the development and implementation of these services, despite a lack of thorough evaluations, various experiences can be analysed to indicate principles of good practice. Again, these are based mainly on subjective assessments and anecdotal reports of project workers. Characteristics of these projects have been identified in a generic sense, although variations do exist (Table 6.2).

Table 6.2 Characteristics of Youth-friendly Health Services

What are youth-friendly health services?	
<p>Provider characteristics</p> <ul style="list-style-type: none"> ▪ Specially trained staff ▪ Respect for young people ▪ Privacy and confidentiality honoured ▪ Adequate time for client and provider interaction ▪ Peer counsellors available 	<p>Health facility characteristics</p> <ul style="list-style-type: none"> ▪ Separate space and special times set aside ▪ Convenient hours ▪ Convenient location ▪ Adequate space and sufficient privacy ▪ Comfortable surroundings
<p>Programme design characteristics</p> <ul style="list-style-type: none"> ▪ Youth involvement in design and continuing feedback ▪ Drop-in clients welcomed and appointments arranged rapidly ▪ No overcrowding ▪ Short waiting times ▪ Affordable fees ▪ Publicity and recruitment which inform and reassure youth ▪ Boys and men welcome and served ▪ Wide range of services available ▪ Necessary referrals available 	<p>Other possible characteristics</p> <ul style="list-style-type: none"> ▪ Education materials available on site and to take away ▪ Group discussions available ▪ Alternative ways to access information, counselling and services

Source: Senderowitz, J. (1999), Making Reproductive Health Services Youth Friendly, Washington DC, Focus on Young Adults Program.

How cost-effective and sustainable is the project?

A question frequently asked of programmes is how much does it cost? Project managers may give the answer in terms of moneys spent on the project. But that tells us nothing of the project's relative *value*. Most cost-effectiveness studies in HIV prevention have been done in the United States, but techniques are now being made available to address the critical questions in developing contexts also (adapted from UNAIDS 1998f):

- Is it better to invest resources in one intervention strategy rather than another?
- Which type of service, or combination of services, gives the best value from the budget available?
- How should the resources be allocated within the competing needs of AIDS control programmes?
- How can extra investment best improve a project's performance?

Ultimately, the key question is how to maximise efficiency, or how to ensure that a certain output is achieved at the least practical cost. Project designers then have to decide which outputs or impacts they are most interested in. Using sectoral examples can help identify

these indicators. For example, a distinct advantage of school-based programmes is that the existing infrastructure makes the programme relatively cost-effective.

In peer education projects, with intensive training, more emphasis must be placed on evaluation of the training itself to improve cost-efficiency (Vasconcelos and others, 1997).

Also, with peer education, there is the question of whether or not to pay the educators; a dilemma faced by projects in Cambodia for instance, where the issue of payment now lies at the crux of project expansion and cost-effectiveness (Box 6.3).

Box 6.3 Cost-effectiveness and sustainability of different peer education approaches

A central question arose, concerning cost-effectiveness and sustainability, in the review of two peer education projects in South-East Asia. The educators in a project in one site are paid about \$50 per month (a government salary is about \$15 per month). This has raised criticisms from other organisations, who see this as unsustainable and even unethical, as it could undermine voluntarism more generally (typically, an educator is paid in kind or a token amount of \$2 per month). In a separate project, in a rural area, the educators are not paid at all. The dilemma presents an important learning opportunity. Is it actually more cost-effective to pay each educator \$50 a month (overall costs per educator worked out at about \$800-900 per year) than rely on totally voluntary activities? This could be the case, as:

- There is an incentive, and educators have a low drop-out rate, so the turnover of educators is low. With low turnover, recruitment and training costs are less.
- Training costs are also reduced by the fact that the peer educators themselves do much of the internal training.
- Motivation levels are high, which – in principle – should translate into a relatively high quality of service. This was certainly the impression of the project staff.
- Coverage per educator may be higher than when there is no payment. Working hours tend to be much longer and, as a result, more people are met.

Project staff need to identify key indicators to resolve this dilemma, to allow a comparison between the two projects:

- cost of training per educator per year
- average cost of meeting one client
- average cost of educational material distribution
- cost of wages versus number of hours worked
- number of people met per educator per month.

Important to a project's sustainability is this cost-effectiveness. A key concern is the selection and retention of peer educators. Experience has shown that:

- Selection of community HIV/AIDS educators must be done with full participation of all community members, so the educator is respected, and appropriate for all.
- Peer educators should be involved in defining their roles and responsibilities.
- Provision of creative rewards and enticements is important, eg, academic credits.
- Material benefits for peer educators need to be considered from the outset. Other incentives could be cash (externally or community-sourced), labour exchange on plots, incentives in kind, such as food, or profits from condom sales.
- Involving participants in all stages of design, implementation and evaluation is important.
- Exchanging visits between educators encourages shared experiences/ideas, develops teamwork spirit/ camaraderie, and helps keep motivation levels high.

- Peer educators can, and do, raise their own funds to pay for transport and food – small collections at outreach performances signify respect from the community and demand for the information.

Emphasis should be placed on the integration of the project into, and acceptance by, the community. Community involvement from the outset is vital to ensure a sense of ownership from within the community, and resistance is reduced to a minimum if the community feels responsible for the project's success. This demands adequate consultation with community leaders, and implies careful selection of volunteers. Educators who don't have the community's respect will receive little support and consequently become demoralised.

How integrated is the project with other activities or services?

As HIV/AIDS programming aims to become 'multi-sectoral' and moves away from what has been called 'vertical' planning, a new important concept is *integration*.

Integration implies four interrelated processes:

- The targeting, by an institution, of previously unreached social groups for specific services, eg, using school-based programmes to reach out-of-school children.
- Reaching an existing target group with an expanded range of services:
 - including HIV/AIDS messages in existing outreach work with street, working, and drug abusing children, and child sex workers
 - sexual and reproductive health education in teacher-training curricula
 - training and awareness-raising of formal and non-formal health providers.
- Increased referral between projects regarding service provision:
 - referral of cases to other locally available service providers.
- Improved co-ordination and communication between actors – effective network development.

Integration is important for a number of reasons:

- In many contexts there is a low coverage of formal institutions, eg, formal school and health structures. Integration would also mean a constructive dialogue with traditional health practitioners.
- Recognition that behavioural change is dependent on more than just knowledge and awareness change, but also on being able to access quality services and being part of a safe and supportive environment.
- In low HIV-prevalence countries the immature stage of the epidemic allows for development of progressive project and programme design. Here, there is also the need to develop interventions for 'low risk' adolescents while HIV prevalence remains relatively low.
- The high mobility of a population is crucial in HIV spread. Reaching this mobile population implies the involvement of a range of service providers.
- The scaling up of pilot projects requires integration at policy level, eg, the institutionalisation of HIV/AIDS education into school curricula.

An often overlooked issue is the relationship between school-based education, and other education initiatives or services available. Teachers cannot perform all the counselling functions needed. Schools, therefore, must find ways of linking their counselling and education to other services the student may require outside school.

At the same time, schools are a suitable venue for other service providers. Many schools have a long association with clinical service providers involved in outreach work, but increasingly there are other opportunities to link schools and organisations of people living

with HIV/AIDS. Too often this occurs on an *ad hoc* basis, but proper consultation at the outset can build in such visits or interactions as a routine part of a school's programme.

Integrating the key questions into the information systems

The questions of identifying and reaching beneficiaries, the nature of the interaction between project and beneficiaries, cost-efficiency, sustainability and integration are relevant to all HIV/AIDS programmes working with young people. The need now is to ensure that these concerns are reflected in M&E systems. It may be that not all the questions can be answered, but it is vital that they are considered and included, where possible, in evaluations or during periodic reflection on the project. In order to do this, some of these questions must be phrased in terms of *indicators*, and the next section deal with this important aspect of project lesson-learning and good practice development.

7: The Role of Indicators in HIV/AIDS Programmes

Central to any evaluation are the role and nature of the indicators used. International NGOs have ambivalent attitudes about using indicators as programme management tools. The debate centres on whether projects in different places should use the same 'core' indicators, or whether they should choose – together with their target community – their own 'internally derived' indicators.

What is an indicator?

There are different definitions of an indicator. In essence, an indicator is a measure of the progress made towards an objective. Other definitions are outlined below (Barton 1997):

- Something which provides a basis to demonstrate change as a result of project activity.
- Can be quantitative (expressed using numbers) or qualitative (descriptive words).
- A marker which shows what progress has been made.
- Can be a target (eg, by the end of the project cycle 80 per cent of the target group will have met with a peer educator).

In HIV prevention, consistent indicators are desirable for the purposes of comparability, and so that trends can be identified. There is great inherent value in having a set of indicators which corresponds with a common, global set of objectives related to HIV/AIDS prevention – the main one being the minimisation of HIV *incidence*. This value is related to the ability to monitor trends in the epidemic and behavioural responses over a wide area and in different settings. The indicators are cross-cultural, objective and 'value free' as far as possible. As well as surveillance, the core indicators also provide means of evaluating programmes and national-level intervention responses.

In identifying core indicators for HIV/AIDS-prevention activities, there are many examples to choose from. A meta-analysis of 33 national AIDS-related behavioural surveys, conducted by Catania and others (1996), divided indicators of sexual behaviour into six categories (Table 7.1).

UNAIDS and WHO (2000) have been refining the core-indicator set over recent years and have identified those indicators which will be 'generally included' for most sample groups, in most countries undertaking national surveillance:

- Percentage of respondents who report at least one non-regular sex partner in the last twelve months.
- Percentage who say they used a condom the last time they had sex with a non-regular partner (in past twelve months).
- Age at first sex.
- IDUs: reported sharing of unclean injecting equipment.
- Sex workers: reported number of clients in the past week.
- Sex workers: reported condom use with last client.

Problems with core indicators

The use of such a set of indicators, however, does have its problems, and it is important to recognise them. First, experience suggests that a single indicator set, with a standardised data collection method, is very difficult to implement due to various factors which distort the data:

- Different agencies/offices will ultimately execute the work, introducing an unquantifiable bias.

- Difficulties in translation will subtly change meanings of words.
- Meanings given to words and phrases are themselves variable.
- Cultural acceptability of discussion of sexual behaviour will make certain topics taboo in some areas but not in others.

Second, despite the wide acceptance of the value of the core indicators, contradictory evidence still appears as to their overall validity. Particularly mentioned are self-reported condom use, number of non-regular partners (Konings and others, 1995) and STD incidence (Clark and others, 1997). For instance, in one study of adolescents, 40 per cent of the sample denied having had an STD over a specified time yet their medical records showed they actually had (Clark and others, 1997).

Table 7.1 Examples of Core Indicators for Sexual Behaviour

Indicator	Specific measure
1. Number of sexual partners	Within lifetime Within last 12 months Within last 4 weeks
2. Type of regular sexual partner	Age Education status Living arrangements Gender Other sex partners Length of relationship
3. Type of casual sexual partner	Age Education status Marital status Residence Gender Other sex partners Length of relationship
4. Frequency of sex	Within last 4 weeks Within last 12 months
5. Extent of condom use	Ever used Used during first intercourse Used with last regular partner Used with last casual partner Currently using Frequency of use Ever seen Able to recognise a condom Intend to use at first or next intercourse
6. HIV testing	Ever had a test Result of test Intention to have a test Date of test

Locally derived indicators

Advocates of participatory research have consistently pointed out that participatory learning and action (PLA) methods, used with communities to generate indicators, have two main benefits: (i) the concerns of the community or beneficiary group are recognised and used in

programme formulation, and (ii) the process of indicator generation is in itself educational and empowering to the beneficiary group.

Examples of such indicators are derived from an ActionAID programme in Uganda (Elsay 1998):

- changes in the way the community treats people living with HIV/AIDS (PLWHAs)
- the number of PLWHAs able to 'go public'
- reduction of risky cultural activities such as wife inheritance
- reduction in night gatherings and discos found after any of these social events
- the formation of support groups
- number of people coming back for test results and asking for counselling services.

Problems with locally derived indicators

These indicators, however, also have problems – linked to both their consistency over time and their comparability. The disadvantages of relying solely on these indicators are:

- The indicators themselves change, so preventing a before-and-after analysis.
- Means of measurement and verification are difficult to ensure at community level.
- The information generated may only be relevant to that community and not comparable with communities elsewhere.
- Using the indicator to measure change relies, in reality, on subjective recall by those involved in the exercise, ie, there is no objective validity of the indicator itself.
- The indicators generated usually relate to non-taboo subjects known to, and interpreted by, all community members, and thus relate to community behaviour rather than (self-incriminating) individual behaviour.

Reaching a compromise: using both types of indicators

Both core and locally derived indicators are equally valid, but only the core indicator is instantly comparable between contexts. Locally derived indicators would need to be viewed together across sites to arrive at a more generalised picture, and many may be unique to one particular community. A combination of the two indicators in any one evaluation framework is a compromise, so long as there is recognition of their relative disadvantages, and also their complementarity. The next chapter looks at these indicators in more detail and how they can be used for developing good practice in HIV/AIDS programmes.

8: Indicator Identification and Use

There are sets of indicators which can be used in any one M&E framework (process, short-term/intermediate and long-term). This section looks at the different indicators which can be used, and gives sectoral examples of their use in the field.

In relation to sexual health in individuals, there are many different indicators which specify different stages of behavioural change (Table 8.1). The specification of indicators should, logically, flow from the objectives and activities, and should be measurable, factual, valid (ie, accurately represent the behaviours), verifiable and sensitive. Above all, when choosing indicators, bear in mind the methods of measuring, and the resources available.

Table 8.1 Activity Stage in the Project and Indicator Type

Activity stage	Indicator type	Thematic Examples
Pre-intervention Participatory exploratory research Existing data review	Baseline	<ul style="list-style-type: none"> ➤ Existing attitudes and self-reported behaviours ➤ Existing service utilisation data ➤ STD/HIV prevalence
Training, participation Information distribution, Service provision	Process	<ul style="list-style-type: none"> ➤ Number of people trained ➤ Number of materials distributed ➤ Number of condoms distributed
Short-term, post-activity	Intermediate	<ul style="list-style-type: none"> ➤ Changes in knowledge and attitudes ➤ Changes in social/peer norms
Medium-term, post-activity	Outcome	<ul style="list-style-type: none"> ➤ Self-reported adoption of positive behaviours ➤ Increased service utilisation
Long-term, sustained	Long-term outcomes/ Impacts	<ul style="list-style-type: none"> ➤ Maintenance of positive self-reported behaviours ➤ Prevented onset of risky self-reported behaviours ➤ Reduced STD/HIV incidence ➤ Changed social/peer norms

INDICATOR USE IN DIFFERENT ACTIVITY AREAS

Process indicators

Appropriate M&E must focus principally on process monitoring, not only to show that activities are indeed being carried out as envisaged, but also to identify (and modify) process difficulties during the project cycle. There may be the problem of determining pre-set indicators as the programme focus may shift during its lifespan. Nonetheless, their initial identification is essential, to allow documentation of inputs, activities, outputs, numbers of beneficiaries and coverage. The key point is that impact assessment is virtually impossible without good information as to what projects have actually *done*.

Intermediate impact

These indicators show the results of interaction between the various components of a project and the beneficiaries. These would essentially be short-term changes in knowledge and attitudes within the target group. They may relate to the acceptance, understanding and internalisation of a message, or the stating of an intention to perform (or not) a particular behaviour. Slightly longer-term would be the adoption of that behaviour, sustained changes in attitudes, and changes in health-seeking behaviour. In terms of impact assessment, all projects must try to address some of these indicators.

Intermediate indicators also cover behavioural changes in individuals, or groups. Key variables regarding behavioural change (eg, the adoption of condom use) can be seen to be connected (Figure 8.1, and Fishbein 1995).

The purpose of intermediate indicators is not to measure the behaviour, but to be predictors of the behaviour. Much experience has shown that projects can have a great impact on certain causes of behavioural change, such as improving communication skills, increasing self-esteem, improving feelings of belonging to family or the wider community, or raising knowledge levels. Rarely does a single project address all the causes of behavioural change, so it is important to recognise these intermediate indicators, which can *contribute* to sustained behavioural change, even if they do not *cause* it.

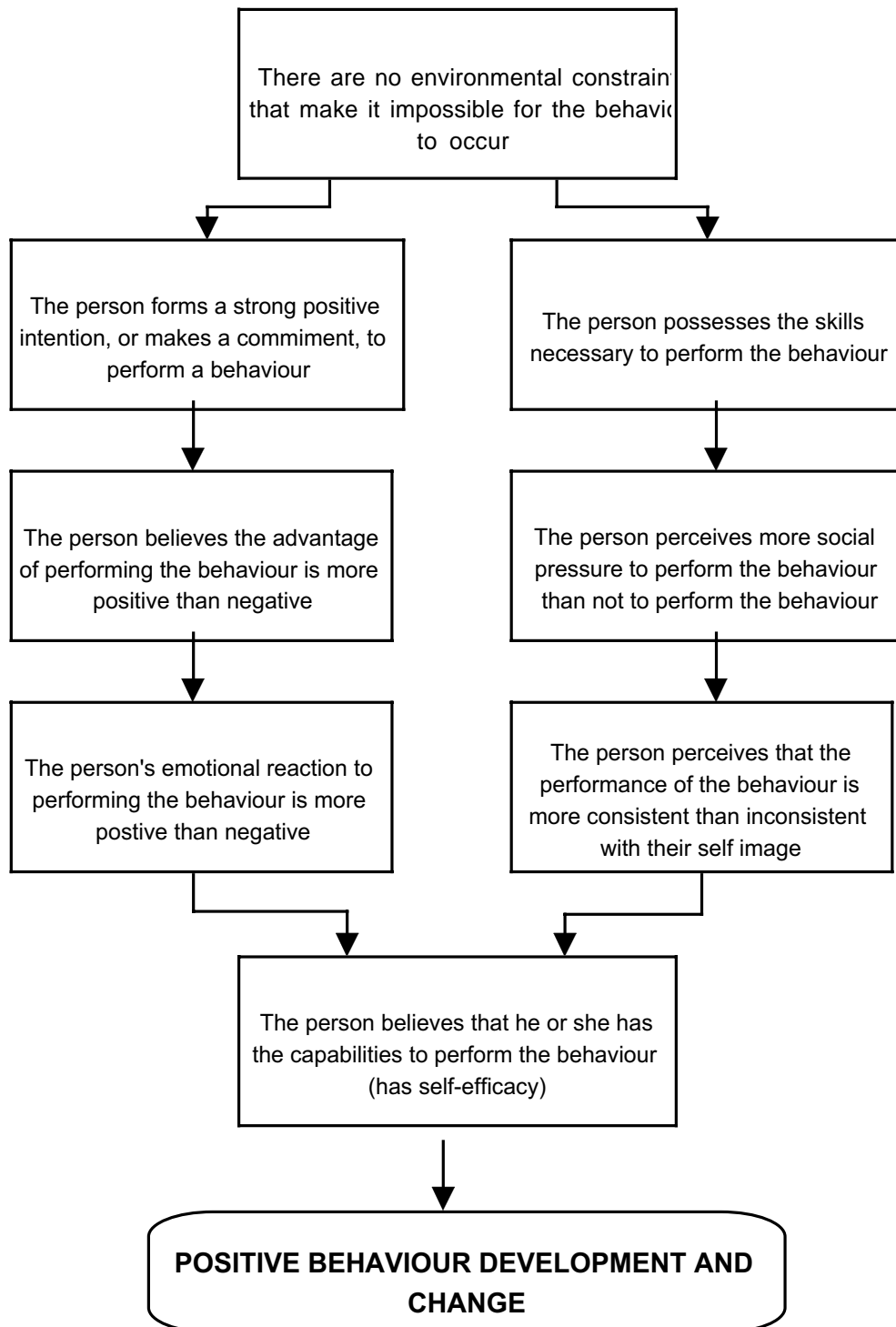
Long-term impact

Measuring the long-term impact of HIV-prevention programmes is not easy. In the long-term, the most direct indicators are HIV incidence and HIV prevalence. HIV incidence, however, is not a viable indicator *per se*, as it requires a well-defined cohort and intensive follow-up, and is too technically demanding for the vast majority of projects. And HIV prevalence is not a viable indicator due to the problems associated with antenatal clinic attenders not accurately representing the wider population.

Using STD data is more feasible as a proxy (substitute) measure of HIV incidence rates. But again there are problems. Using self-reported STD infection is not advisable: given the measurement problems of this indicator, the results cannot be used with any real degree of confidence.

For each of the sectoral areas discussed, examples are given of process, short-term and long-term impact indicators.

Figure 8.1 Conditions and Factors Contributing to Behavioural Change and Development (Adapted from Fishbein 1995)



SCHOOL-BASED PROGRAMMES

Process monitoring and indicators

Experience in programme design and management has highlighted specific areas which need careful attention to ensure that any problems arising during implementation are identified. These can be turned into key process indicators:

- proportion of teachers trained to a predetermined standard (coverage by district)
- proportion of project schools receiving textbooks/teaching materials
- proportion of project schools and teachers using textbooks/teaching materials
- rating by teachers of the materials being used
- rating by students of the materials being used
- timetabling of the education as prescribed or recommended
- proportion of schools integrating the education into the wider curriculum
- proportion of schools using books/materials in the correct sequence
- proportion of schools in target area having *active* anti-AIDS clubs
- proportion of schools implementing HIV/AIDS education.

Short-term/intermediate outcome indicators

The list of possible indicators here reflects: the acceptance of (and reaction to) the project; the perception of the materials and methods used; the level of participation and dialogue; the nature of communication links outside the classroom. In Zimbabwe, teachers reported various outcomes as a result of the education (Woelk and others, 1997):

- Students were better informed about AIDS.
- Students were approaching teachers for advice more often than before.
- Students were interacting more with people living with HIV/AIDS.
- There was increased inter-gender discussion on sensitive issues.
- Fewer girls were thought to be dropping out due to pregnancy.

The latter indicator is, strictly speaking, a longer-term impact, but is still important if accurate. Despite the unverified nature of these indicators (they were generated in focus groups), there is no reason why they cannot be integrated into a formalised KAPB questionnaire.

Outcome and impact indicators

Studies in developing countries have used various outcome and impact indicators, all measured using pre- and post-KAPB questionnaires with the target group:

- age of first intercourse
- number of lifetime partners
- frequency of intercourse over past year
- frequency of condom use.

How different indicators can be used in the same evaluation is shown in Box 8.1, which looks at the Zimbabwe AIDS Action Programme for Schools. Interestingly, the programme designers, assessing the efficacy of the evaluation process after the event, decided that the narrative research method was not the most appropriate (many of the indicators were 'hidden' in the narrative questionnaire). Evaluators, then, are still left with an evaluation package of KAPB questionnaires, supplemented by focus group discussions and key-informant interviews.

Box 8.1 Indicator use in the Zimbabwe school-based programme

Overall goal: empowering the youth with decision-making skills

Objectives:

- Ensure that students have (1) information and (2) skills needed to make healthy decisions.
- Build students' self-esteem, so they feel they have (1) the power and (2) the right to consider their own needs and feelings in relation to sex and abstinence.
- Promote gender equity so that (1) girls feel equal to boys and (2) boys recognise girls as equals.
- Expose girls and boys to each other's feelings.
- Encourage extracurricular activities to (1) build self-worth and (2) develop income generation.
- Encourage positive peer pressure, and normalise 'safe' attitudes.
- Ensure students have someone to talk to about their problems.
- Make health personnel accessible to students.

Activities:

- Design materials.
- Train teachers in their use.
- Integrate materials into school curriculum.

Intermediate impacts: social norm change

- Percentage stating that a boy/girl is most likely to have their first sexual experience with older man/woman.
- Percentage stating that the boy/girl, following their first sexual experience, will feel ashamed/guilty/proud.
- Percentage stating that once a relationship has started, they have sex with someone else.
- Percentage stating that a boy/girl is likely to use condoms.
- Percentage stating that a boy/girl would feel ashamed/guilty/proud about being infected with an STD.
- Percentage stating that somebody would go to the clinic for STD treatment.
- Percentage stating that someone would tell their partner if they had an STD.

Intermediate impacts: knowledge and attitude change

- Percentage correctly stating what can result from STDs.
- Percentage correctly stating that there is an increased risk of getting HIV if you have another STD.
- Percentage correctly stating that a man can suffer from a serious STD without any symptoms on his private parts.
- Percentage correctly stating that a strong and healthy person can be infected by the AIDS virus.
- Percentage stating that condoms often come off inside the woman and get stuck.
- Percentage stating that girls must be sexually experienced when they get married to please their husbands.
- Percentage stating that boys must be sexually experienced when they get married to please their wives.

Age-group-specific, self-reported behaviours

- Percentage ever had sexual intercourse.
- Percentage of boys who have ever forced a girl to have sex.
- Percentage of girls who have ever been forced by a boy/man to have sex.
- Percentage who have ever used a condom.
- Percentage of boys who have ever had sex with a prostitute.
- Percentage of girls who ever had sex with an older man.
- Percentage who have ever had an STD.

Source: adapted from O'Donaghue 1995.

PEER AND OUTREACH EDUCATION

1. Process monitoring and indicators

There are two main sub-components to process monitoring in peer education (i) the process of *training* the educators, and (ii) the actual *activities* of the educators.

a. Training of educators

The impact of the training of educators can be assessed as a predictor of the effectiveness of the educators' own outreach work. Important aspects of training evaluation should be looked at, such as:

- training process
- information received (what have the educators learned from the training)
- strategies learned for negotiating condom use
- changes in their lives as a result of being involved in the project.

b. Activities of educators

This aspect of process monitoring focuses on the production of data showing that educators are carrying out specified activities, and are achieving a (pre-defined) coverage. Examples of activities are: games, dramas, role-plays, poems, songs, video shows, door-to-door visits and group discussion using picture codes. Indicators could measure:

- Proportion of peer educators and educator groups who are active per area.
- Drop-out rate of peer educators.
- Number of young people reached per area. Careful attention is needed here to disaggregate audience by age and gender (if possible).
- Number and frequency of sessions.
- Number of parents' meetings.
- Number of condoms distributed – at no cost to receiver, or through social marketing.
- Unit costs per output, eg, per condom distributed, per person reached, per session held (Kathuria and Wilson, 1995; Mashababe and others, 1998).
- Number of IEC materials (posters/pamphlets) distributed.
- Questions asked by clients/at meetings.
- Number of requests for condoms.
- Number of referrals of case individuals for clinical follow-up.

Indicators for house-to-house visits (to be assessed in follow-up visits by educators):

- comprehension of IEC materials
- questions asked regarding the materials
- what happened to any previously given IEC materials (passed on to a family member or friend, thrown away, etc)

- general questions asked
- requests for further visits, IEC materials
- requests for condoms.

This exercise could take place at any time during the project – where all volunteers are requested to revisit a sample of houses/house clusters one week after the initial meeting and assess, informally, the usefulness of the IEC materials and its reception by the clients.

2. Intermediate impact indicators

The purpose of these indicators is to examine the direct interaction between the project (through the educators) and the target group. They focus on the issues of awareness and acceptance of the project, use and appropriateness of materials distributed, and information concerns of the target group. Routine reporting can also record the number of referrals of young people to clinical services.

3. Impact indicators

These can be divided into short-term and long-term indicators.

a. Short-term impact indicators

In Ghana, the Family Reproductive Health Programme (which has twenty NGO projects) identified its own, most important, short-term impact indicators. In a ranking exercise, the five most important indicators (objectives) across the programme were:

- Increasing knowledge of STD/HIV/AIDS (composite indicator).
- Increasing awareness of condoms.
- Raising awareness of contraception methods in women.
- Reducing feelings of invulnerability amongst people to STD/HIV infection.
- Increasing knowledge of where condoms are available.

The composite indicator of reproductive health knowledge (incorporating STDs/HIV/AIDS) mentioned above includes some or all of the following (Dallabetta and Hassig 1995):

- Correct definition of conception.
- Correct identification of a woman's fertile period as the middle of her menstrual cycle.
- Knowledge that a girl can get pregnant the first time she has sex after *menarche*.
- Spontaneous mention of two or more modern methods of contraception.
- Knowledge of correct use of two or more modern methods.
- Correct naming of two or more STDs.
- Knowledge of two or more methods of preventing STD/HIV.
- Knowledge of two or more symptoms of STDs.
- Knowledge of where appropriate treatment for STDs is available.

The composite indicator is thus a score for each individual based on responses to a series of short questions. Over a whole sample, the score can be averaged and disaggregated by age and gender.

Measuring stigma and destigmatisation

Straddling the prevention and care 'divide' is the issue of stigmatisation, and this is often a specific target of outreach programmes. Tackling stigma is vital in order to allow people to internalise messages regarding risk behaviour (so making behaviour change more likely).

The recruitment and training of PLWHAs to act as educators can be very effective. The impact of such work is that the PLWHAs themselves have improved self-esteem, and their

audiences are impressed in some way by the talk. The aim is to 'personalise' the epidemic and add a human dimension. Indicators to consider would then relate to knowledge-raising regarding HIV/AIDS, understanding the concept of latency period in particular, and destigmatisation.

Process indicators for outreach work involving PLWHAs:

- Number of awareness-raising meetings held and where.
- Number of people attending the meetings.
- Number and type of separate programme meetings participated in by PLWHA.
- Number of meetings jointly held between PLWHA and other peer educators.
- Number of documents produced and distributed.
- Report on the questions asked in the meetings.

All these process indicators can be measured during routine monthly reporting.

Outcome indicators:

- The willingness to talk to a PLWHA.
- The willingness to share a meal with a PLWHA.
- The willingness of an individual to take care of a family member with AIDS.
- The willingness of an individual to take care of a community member with AIDS.
- The right of an individual to keep their HIV status a secret.
- Willingness of personal disclosure of HIV status.
- Agreement that PLWHAs should be able to work.
- Willingness to take care of 'AIDS orphans'.
- Desire to see PLWHA isolated.
- Percentage of people considering children are at risk of HIV infection.
- Percentage of adults believing that children should be educated about sexual health and HIV/AIDS.
- Percentage of people believing that PLWHA can look healthy.

These indicators can be addressed very quickly and easily in a pre- and post-test questionnaire conducted before and after education sessions/meetings.

b. Long-term impact indicators

All long-term impact indicators must be used with caution when evaluating peer education projects. Their short-term nature and other limitations already discussed make the long-term impact very difficult to assess. Perhaps the most viable indicator is clinic-based STD prevalence.

Any one project should aim to identify indicators for all the above project areas. A case study illustrates how projects use indicators in a monitoring and evaluation framework (Box 8.2).

An evaluation can pick out impacts which are unintended, possibly unexpected, or at least not listed in the project objectives. With peer education there may be many of these outcomes which qualitative research can pick up. For instance, the peer educators at the IES were asked how they have benefited from being involved in the project:

- help friends handle problems – themselves and peers – helps build solidarity
- help others 'go ahead' and gain control
- like giving advice
- self-learning
- get information
- self-esteem has improved

- friendly atmosphere – enjoy being part of the team
- one male educator used to be part of a gang before becoming an educator; since then communication with his family has improved and he has taken on responsibility – he now tries to help friends with problems.

Some teachers, in a school attached to the project, were asked what changes they saw brought about by the work of the peer educators:

- less vandalism at the school
- more discipline generally amongst the students
- peer educators more self-confident – this self-esteem is crucial, and academic performance of the educators has improved
- children keen to participate and are enthusiastic.

These findings provide valuable evidence of the impact of the project, and can be used in the assessment alongside QUANTITATIVE INDICATORS.

Youth-friendly health services

Experience has shown, even at this early stage in the development of these services, that monitoring of pilot centres is crucial. The subjective assessments of success outlined above need to be consolidated with more reliable and comparable information.

The monitoring system itself needs to be simple and clear and peer educators, if conducting monitoring, need constant support in the completion of monitoring forms. A limited number of small-scale, qualitative assessments have been done using exit interviews, suggestion boxes and questionnaire surveys of clients. Even these methods report on process and intermediate indicators such as perceptions of service provided, and this is the first essential stage beyond routine process monitoring. Intermediate outcome indicators could be addressed most easily in exit interviews of young people (Box 8.3).

Box 8.2 The IES in Lima, Peru: indicator identification and use

The IES focuses on three indicator areas:

- Performance – functional indicators – in terms of access, quality and image of services (related to training, management and image).
- Service outputs – adequacy of the provision of services.
- Service utilisation – profile of who is using the services.

The IES has a sophisticated process monitoring system, with peer educators, teachers, health care workers and IES staff all contributing to the collection of data.

Functional outputs:

- Number of guidance sessions given by individuals to friends.
- Number and type of activities designed and implemented.
- Number of IEC leaflets designed.
- Number of IEC leaflets distributed.
- Number of trained peer educators.
- Performance of the educators.
- Number of health professionals trained.
- Number of teachers trained.
- Performance of health professionals.
- Performance of teachers .
- Number of schools which have contact with other service institutions.
- Type and number of activities implemented by service institutions in the schools.

- Percentage of schools with a visiting health worker.
- Percentage of schools allowing adolescents easy access to services.

Service utilisation:

- Number/percentage of adolescents who have received advice from (1) peer educators, (2) teachers, (3) health professionals, (4) service institutions.
- Number/percentage of adolescents who have received group help regarding (1) training, (2) information.
- Number and type of activities given by the health workers.

Outcomes and impacts

In addressing project impact assessment, the categories of intermediate impacts and longer-term (behavioural) impacts are used.

Intermediate impacts:

- Number/percentage of adolescents who know about the (1) health centre, (2) peer educators
- Knowledge of one means of preventing HIV/AIDS.
- Number/percentage of adolescents considering themselves at risk of HIV/AIDS.
- Number/percentage not using health centres for psycho-social reasons.
- Number/percentage intending to use a condom.
- Number/percentage of adolescents exposed to messages who (1) retain the message, (2) agree with the message, (3) discuss the message with others.

IES staff themselves identified the most important intermediate impact indicators:

- Communication between partners.
- Intention to use condoms.
- Knowledge of HIV-transmission routes and HIV-prevention methods.
- Recognition of self-vulnerability to infection.
- Intention to use health services in case of STD.
- Intention to ask for appropriate help when needed.
- Ability to recall messages.
- Proportion of respondents agreeing with and advocating messages.
- Proportion of respondents able to name a professional source of help for a specified problem.
- Percentage of respondents who asked for help.
- Percentage of respondents who reported seeking help.

Longer-term Impact Indicators:

- Reduction in the number of teenage pregnancies.
- Detection and treatment of STDs.
- Reduction in number of infections of HIV/AIDS.

In looking at these indicators, the question must be asked how useful they have been in relation to (a) project management, and (b) advocacy? The indicators used have been mainly intermediate (interaction between project and immediate beneficiaries). There has been no examination of longer-term, more impact-orientated indicators. Little information generated to date has therefore been useful for advocacy. Behavioural outcomes of the project are not being assessed within the information system, despite the identification of relevant indicators. An overemphasis has been placed on process monitoring to date, with too little attention paid to the outcomes of the project. Intermediate indicators are used (which is valuable) but the next stages of resulting behaviours are not.

Box 8.3 Examples of intermediate impact indicators for evaluating youth-friendly health services

- Did the nurse/doctor ask you any questions about your condition?
- Did the nurse/doctor give you any information regarding your condition?
- Were you able to ask all the questions you wanted to?
- Were you given or prescribed any medicines/treatments?
- Were the drugs you needed available at the clinic?
- If treatments were given, were they explained to you (what it does, when to take, any side effects)?
- How did you find the clinic staff who saw you (friendly, not so friendly, unpleasant)?
- Did the nurse call you by your name?
- Did you feel that you had enough privacy while with the nurse?
- In general, do you feel satisfied with the service you have just received?
- Would you come back here again if you had a similar need?

A different type of stigma relates to acceptance of young people's sexual behaviour, by their family members and other community adults (Newton 2000). Important indicators may be:

- Percentage of youth who feel that they can seek sexual health information.
- Percentage of families who support their children's access to information and services.

Equally important are the service providers themselves:

- Percentage of clinic workers who agree that young unmarried adults should have access to contraception.
- Percentage of clinic workers believing that a patient's confidentiality should be respected at all times.

Looking at medium and longer-term impact indicators may be beyond the capacity of most health service centres and projects. Co-ordination between projects is crucial to ensure that a community-based KAP survey, for example, can provide information relevant to as many actors in the prevention-care continuum as possible. How to use medical records in collecting data from clinic records is included in the annexes.

The shift from measuring process to measuring change

In the case studies reviewed, there is an overemphasis on process monitoring, at the expense of looking at behaviour changes and longer-term impacts. Not all projects can attempt to measure impacts, but they should all look at what is being measured, and how new tools can be used to ensure that (i) process monitoring is done effectively, and (ii) data is produced providing *evidence* of change. To do this we need M&E methods, and the next section provides some examples to consider.

9: Data collection: Where do we get our information and how?

The identification of objectives and indicators, as previously discussed, is only meaningful if methods of data collection have been identified. This section will not look at the mechanics of the methods, but will show the options available and how they can be used effectively within a M&E framework (with examples from the relevant sectoral areas). Also explained is the importance of using different methods and triangulating the data.

Data triangulation

The current debate about the value of different types of information, means different stakeholders will view the same data in different ways. As a result, we now talk about having *evidence* of impact rather than proof. People may claim to have changed their behaviour but in reality it may be the same, so other methods of data collection are needed to cross-check. Triangulation, which means asking the same question in different ways, then becomes more important. For instance, self-reported condom use data can be compared to condom distribution figures (either free or through social marketing) for the same group.

Types of evaluation design

There are three main types of research design in evaluating behavioural change, with increasing levels of complexity. They are:

- the non-experimental (without a comparison group)
- semi-experimental (with a comparison group)
- randomised control trial ('scientific' trial of an intervention using controlled, randomly chosen, selected groups).

Table 9.1 Evaluation Type (by Level of Attribution) and Resources Required

Evaluation type	Level of 'attribution'	Resources required
Randomised controlled trial (RCT)/ Experimental approach	Very high probability that reported changes are due to the intervention (demonstrated by <i>p</i> value)	High. Considerable and technically very difficult. Beyond the scope of most NGO offices
Semi-experimental (use of comparison group)	Provides a good indication that reported changes are attributable to the intervention. PLA techniques can determine the perceived influence of other interventions	Medium. Technically demanding with small research group required
Non-experimental (no comparison group apart from other surveys)	Provides evidence of behavioural change and the influence of the intervention	Low. Reliance on qualitative information and use of secondary data

Knowledge, attitude, practice and belief (KAPB) surveys

This is a simple way of gathering standardised information from a large number of people. It is a questionnaire with, ideally, both closed and open-ended questions. It is essential to pre-test any KAPB questionnaire with a sample of about 20-30 to ensure that the questions are

relevant and nothing important has been missed out (AIDSCAP, n.d.). The most effective pre-testers of such questionnaires are very often the children themselves.

Pre-coding a questionnaire often makes the implementation faster and data input quicker. In pre-testing, the range of answers to a single question can be estimated which will assist with coding. Coding of answers in questionnaires is more difficult and time-consuming.

In outreach work such as peer education projects, the questionnaires can be asked by the educators themselves, after a short training. This training (to conduct face-to-face interviews) should ensure the following:

1. The educators understand the purpose of conducting the survey and the principles of being objective.
2. The importance of ensuring confidentiality of the respondent's identity and answers.
3. The educators fully understand all the questions.
4. The educators have the skills to probe when an answer is incomplete – without leading the respondent.
5. The educators fully understand the sampling and selection process of the respondents.
6. The educators can answer basic questions about the objectives and activities of the project after completion of the questionnaire.

There are several options in implementing the questionnaire:

1. *Face-to-face, interviewer administered.* The interviewer asks the questions and the respondent is not shown them (or the responses in a pre-coded questionnaire). This maybe time-consuming but will allow for clarification and probing by the interviewer. Most applicable in low literacy populations.
2. *Face-to-face, partly administered.* This is where the respondent is shown the questionnaire and the potential responses, but the interviewer still fills in the form. The disadvantage of this is that seeing the potential responses on the questionnaire may bias the answers.
3. *Self-administered.* Here, respondents complete the questionnaire themselves, either on their own with the interviewer present, or in a small group (focus group size), or large group – such a school class. The advantage of the self-administered method is that a large sample can be reached in a short time. Disadvantages are that any confusion in the respondents may not be picked up by the facilitator, leading to higher levels of error in the responses. Another factor is that not all the respondents complete the questionnaires at the same speed, and some may feel rushed or may not finish at all. These questionnaires need to be simpler and carefully pre-tested, to ensure removal of all ambiguities. Self-administered questionnaires are most appropriate in higher literacy groups or when anonymity is essential.

KAPB questionnaires and surveys do have various limitations, and it is worth being aware of them.

How long the interview lasts may affect the validity of the answers you receive

Konings and others, (1995), trying to validate population surveys for the measurement of HIV/STD indicators in Kampala, found that the proportion of young people reporting sex with a non-regular partner during the previous 12 months was considerably higher when using in-depth interviews than in short survey questionnaires. The difference between the 2 samples

was a considerable 10 percentage points. In explaining this disparity, most of the interviewers indicated a certain degree of discomfort on the part of the respondent during the short questionnaire.

Time-frames for recalling past behaviour should be kept as short as possible, and respondents should be constantly reminded that all answers are anonymous

These two ploys have been found effective in reducing inaccurate recall and avoiding biased answers, in a survey of young people in the United States (Schnell and others, 1996) and a review of the validity of indicators using self-reported behaviours (Catania and others, 1993).

It is important to record all the answers of a respondent

Sometimes respondents may give more than one answer to a question. Recording these multi-responses is important, and the responses after the initial answer should not merely be categorised as 'other'.

Also valuable are 'check' questions. These ask the same question, in two ways, in different parts of the questionnaire. Analysis can compare and contrast these answers and look for contradictions. If contradictory answers are given, respondents either do not fully understand the questions, are deliberately giving false answers, or are genuinely confused about what they have done (or not). Strictly speaking, these questionnaires should be ignored when analysing these particular questions, and recorded 'void'.

Watch out for 'social desirability bias'

An often mentioned criticism of KAPB questions is that respondents will give the answers 'expected of them'. One way to minimise this is to ask respondents to show knowledge. Children are far more likely to answer 'yes' to the question 'do you know what AIDS is?' if they know that an HIV/AIDS project has been operating. It may be better to ask them to describe what HIV and AIDS are, and record the answers.

Pre- and post-test samples should be directly comparable. To be so, they must be selected in exactly the same way, from the same sample group. There may be the possibility of asking the same questions of children in another area (or school), or perhaps part of the community directly involved in the current project (if the project is due to expand). This can provide essential comparison (control group) data as well as a valuable baseline.

Focus group discussions (FGDs)

These can be conducted at any time in the project. They should always be seen as complementary to other (more quantitative) research methods. The discussions can be held following preliminary analysis of the survey data to inform the questioning in the groups, and provide areas of understanding which need developing. Exercises within the groups can be linked to the key questions and indicators in the surveys:

- a profile of the problems of young people in the communities
- health problem ranking exercise
- the level of STD/HIV/AIDS knowledge and exploration of gaps/misconceptions
- the local dynamics of stigma and how this is changing
- knowledge of, attitudes towards, and use/constraints of, use of condoms
- sexual behaviour profile by age and gender
- communication channels (who to, how, what said)
- levels of negotiation skills and assertion levels
- the way which the project has influenced young people in the group/school/community
- the ways in which the project can be improved.

With specific high-risk groups such as IDUs, further group-related topics should be discussed, such as constraints on needle exchange, self-assessment of risk, pressures regarding drug use, the HIV test, and sexual behaviour. In each of the sample sites it is recommended that groups be disaggregated by gender and age (possibly 13-15 and 16-18).

Potential exercises in the focus groups can be:

- Ranking exercises: these assess the priority which young people give to sexual and reproductive health issues, including HIV/AIDS.
- Mobility mapping: this assesses the types of health-seeking behaviour young people employ.
- Venn mapping: to explore the various influences of different service providers and information sources (including peer educators).
- Problem and objective trees : to inform the project of priority areas of attention

When FGDs are written up and the results analysed, the report can contain quotes and extracts from the discussions. These give valuable impact information, to be used in conjunction with other more quantitative methods of reporting. The report should categorise the findings thematically, as are the following, taken from FGDs after the implementation of a project:

1. changes in attitudes towards syringe use
2. changes in attitudes towards domestic work (males)
3. changes in attitudes towards family members
4. changes in attitudes to drugs and drug-taking
5. changes in intra-family communication
6. changes in personal sexual behaviour
7. changes in attitudes towards discussing sexual health issues
8. changes in levels of knowledge regarding the body, especially menstruation
9. changes in self confidence.

Focus group good practice

Focus groups usually consist of about eight to fifteen people, with two facilitators: one to conduct the session, and one to record verbal responses and other reactions, such as facial expressions. A facilitator should ensure full participation and try to prevent any one individual from dominating. Sessions should not last more than about ninety minutes, and there should be time at the end for the participants to clarify any points with the facilitators through questions and answers. For each group the age, gender and number of participants should be recorded.

Try to ensure that the facilitators are appropriate for the group

Where possible, there should not be too much of an age gap between the facilitators and participants. If the facilitators are older, they should have experience of working with young people. Having facilitators of the same gender is also valuable though not always essential.

In the discussion, go from the general to the specific

It may take some time before everyone is comfortable openly discussing their views. It is wise to start with non-threatening topics before moving into sexual health topics. Picture codes can kick-start discussions on the more sensitive issues.

The use of the secret ballot

Even if a good rapport has been achieved, there may be sensitive questions which the facilitators want to ask but are unsure whether the group would feel free to answer. An example may be the age of sexual debut for each of the respondents. Give each of the

participants a small piece of paper and pencil and ask them to put two pieces of information on it: their sex (*m or f*), and then the age at which they first had sex, or put a 'no' if they have never had sex (use the phrase most appropriate to mean intercourse). Pass around a box or bag and ask them to fold up the piece of paper and put it inside. If anonymity is guaranteed, the answers should be honest. The results can be totted up and reported back to the group, to initiate a discussion. If this same exercise is done in a number of focus groups, the results can all be added together to give some quantitative data.

Use fictional stories

Similar in many ways to the narrative research method, this entails the description of a scenario: for instance, how a boy and girl meet, discussion regarding sexual activity etc. The participants can complete the scenario through their own discussion, the facilitators recording the conflicts or disagreements which arise, before a consensus (if any) is reached. Using fictional characters allows participants to talk about others whilst using their own experiences as the frame of reference.

Process monitoring and tools

Ongoing data collection is vital to ensure the project is doing what it set out to do, and that problems in implementation are identified. The key is to keep the system simple, and clearly differentiate roles and responsibilities between project, and between internal staff and external consultants (Youssef 1997). It is worth looking at an example monitoring structure to see how the elements and data sources fit together. The IES project in Peru is given here as the system is comprehensive, and has many different components (Table 9.2).

Table 9.2 Process Monitoring Tools, The IES, Peru

Tool	Purpose
Peer educator, post-project assessment form	Ascertain immediate benefits of project to themselves and to others
Activity recording form (educators)	Record details of events and activities held, such as the fairs (<i>feiras</i>)
Activity recording form (teachers)	Record details of events and activities held, such as the fairs (<i>feiras</i>) – look at levels of involvement, reception and participation
Case reporting form (educators)	Record number of cases in contact with educators, age and sex of the contact, the nature of the problems; one form for each
Case reporting form (teachers)	Record number of cases in contact with teachers, age and sex of the contact, the nature of the problems; one form for each
Monthly reporting form (educators)	Monthly summaries
Monthly reporting form (teachers)	Monthly summaries
Monthly reporting form (health centres)	Monthly summaries on types and nature of attendance at the participating health centre
Profile of CBOs	Educators are asked to keep an up-to- date record of service providers
Monthly refresher course form	Assessment, by the teachers themselves, of the education session held by the teachers
Monthly refresher course form	Assessment, by the IES staff, of the education session held by the teachers
Impact of fairs (<i>feiras</i>)	KAP questionnaire to examine knowledge and misconceptions

Each project must decide what data is essential to record, and what is surplus to immediate requirements. If the system is too complicated it may not function. In this simplifying process, the question can be asked what information is (1) required for accountability purposes, (2) has proved most useful in the past to help programme development, and (3) where has been the most reliable source of information. The premise of a successful monitoring system is that the information is useful for the people who actually collect it.

Integrating data sources: the use of clinic-based data

Having an objective impact indicator is important if it is possible to measure. Medical records can be used to back up KAP survey data. Indicators to consider are:

- (a) proportion (percentage) of out-patients who are adolescent (define ages)
- (b) proportion of STD cases who are adolescent
- (c) proportion of adolescent presentations which are STD.

Health care workers in the project catchment area need to be approached to see if clinical data is accessible, and in a useable form. If so, clinical monitoring forms can be an integral part of the information system and can be even co-designed with the project team. A problem to be aware of here is that adolescents may not use the services geographically closest to the intervention site (especially clinics), due to worries about confidentiality. Mobility mapping of services with adolescents should be conducted during formative research to closely examine health-seeking behaviour.

Box 9.1 Guidelines on medical record review in clinics

The objectives of the review are to find:

- The nature of the records themselves in the out-patients department (OPD), in terms of the type and consistency of the information recorded.
- The number of adolescents presenting at OPD with sexual health problems/queries.
- The proportion of OPD STD cases under the ages of 20 and 25.
- The breakdown by age, gender and condition of OPD attendance. This will give information on the proportion of OPD cases related to sexual and reproductive health (SRH), and the proportion of adolescent SRH cases.
- The breakdown, by age, of the antenatal clinic attendance.
- The breakdown, by age, of the antenatal clinic attendance by syphilis prevalence and TRIMESTER presentation.
- The nature of the catchment population for antenatal clinic syphilis screening, noting idiosyncrasies of referral from other clinics or geographical catchments. This would indicate the validity of this population as a SENTINEL sample for syphilis SURVEILLANCE.
- Data regarding the provision and supply of STD drugs.

Step 1. Randomly select OPD cards over a defined period, eg, the most recent complete quarter. Pick out 100, or more, cards or records and for each note the sex, age and presenting condition of the patient. Record each case and do not ignore cards if there is no diagnosis – record them as ‘diagnosis absent’. You should be able to produce tables such as the following:

Presentations of 100 randomly selected OPD patients, first quarter, 2000.

Condition	no.	(%)
Malaria	23	(23)
gastro-enteritis/dysentery	15	(15)
URTI (upper respiratory tract infection)	12	(12)
Pulmonary TB	10	(10)
Tonsillitis	6	(6)
Measles	2	(2)
Worms	1	(1)
Diagnosis not recorded	31	(31)
Total	100	(100)

OPD attendance of 227 patients in first quarter, 2000, breakdown by age and gender

Age	males no. (%)	females (%)	total (%)
0-5	57 (47.1)	28 (26.4)	85 (37.4)
6-10	8 (6.7)	7 (6.6)	15 (6.7)
11-15	6 (5.0)	5 (4.7)	11 (4.8)
16-20	7 (5.8)	21 (19.8)	28 (12.3)
21-25	11 (9.1)	13 (12.3)	24 (10.6)
26-30	10 (8.3)	13 (12.3)	23 (10.1)
31-35	9 (7.4)	7 (6.6)	16 (7.0)
36-40	3 (2.5)	5 (4.7)	8 (3.5)
41-45	3 (2.5)	2 (1.9)	5 (2.2)
46-49	1 (0.8)	3 (2.8)	4 (1.8)
50-55	5 (4.1)	2 (1.9)	7 (3.1)
total	121 (53.3)	106 (46.7)	227 (100)

Step 2. Next, select at least 100 STD-related OPD cases. Again, record the age and sex of the patient, as well as the specific condition.

Step 3. For each STD case, it must also be recorded whether the patient was administered drugs at the time, or was prescribed drugs to buy elsewhere. This will give information on drug supply.

Step 4. Where syphilis screening occurs at clinics, this is also a valuable source of information. Review antenatal clinic records over six months (if available). Record the

number of new enrolments and their ages, also noting the trimester in which they present, and their syphilis (RPR – RAPID PLASMA REAGEN) result for those screened.

Determining attribution in outreach programmes

Combining methods and indicators in a single M&E framework can show: changes within the target group; the relationship between changes and interventions. Asking respondents where they receive their information, and then looking at the accuracy of that information (or associated behavioural indicators), can help assess the impact of the intervention.

Major points to remember regarding data collection

- *Proof of impact* of an intervention will not be demonstrated, and nor should a project attempt to demonstrate it.
- Mix your methods – an ideal evaluation will have qualitative *and* quantitative data.
- No one method is perfect: remember this when analysing data. Analysis should be thematic rather than by method, ie, when looking at condom use, evidence from different methods used (focus groups, informant interview, PLA techniques, questionnaire, community-based distributor data) should be considered together.
- The general rule regarding questionnaires is that the longer the interaction time between interviewer and respondent, the more honest and reliable the answers.
- Focus group discussions can provide both quantitative and qualitative data.
- Anonymity and confidentiality are essential when discussing sensitive issues.
- Clinical records are a vital source of information.
- Young people assisting in the design of research tools, and collection of information, is empowering to the project, and helps to ensure relevance of the information provided.

10: The Evaluation of Interventions Assisting Children Affected by HIV/AIDS

The development of good practice in projects addressing the impacts of HIV/AIDS on children is a new challenge for project evaluators. Measuring the impact of care programmes cannot be done using existing public health evaluation models. The main reason for this is that the end goal is difficult, if not impossible, to define, as the situation is dynamic and unpredictable in terms of basic welfare indicators of children. The difficulties in evaluation in this area of work can be summarised:

- The situation of children affected by HIV/AIDS is poorly understood in most places.
- The end goal and thus project objectives are difficult to define.
- Local conditions are crucial in determining child vulnerability.
- In resource-poor, high HIV-prevalence contexts, differentiating between the impacts of HIV/AIDS and the impacts of chronic poverty is difficult and, potentially, has unethical consequences.
- Communities with many children affected by HIV/AIDS are usually poor and may not consider project evaluation an important issue.
- There is no common and agreed definition of 'orphan', making comparison of situations, and studies of children affected by AIDS, very difficult.

Evaluations have mainly taken the form of project descriptions and subjective, anecdotal inferences regarding project outcomes. It is worth discussing the UN Convention on the Rights of Child, 1989 (UNCRC) in this context, as it potentially represents a single framework to assist in the evaluation of these programmes.

Using the UNCRC as a monitoring and evaluation framework

The translation of the UNCRC from an advocacy tool into a practical instrument in programming is incomplete. The marrying of human rights and AIDS programming has primarily been a theoretical link until now. The question remains how human rights can be used as a M&E framework. Some progress has been made by the Harvard School of Public Health who have developed a simple matrix, which acts as a progressive implementation framework, covering objectives A-I (Table 10.1). The matrix outlines the responsibilities of governments (through ratifying the UNCRC), and how these relate to children and HIV/AIDS. States have to agree to respect, protect and fulfil the rights of children, including those affected by HIV/AIDS.

Table 10.1 Human rights approach in monitoring and evaluating HIV/AIDS-and-children programmes

Category of Child	Government Responsibilities		
	Respect	Protect	Fulfil
Infected	A	B	C
Affected*	D	E	F
Vulnerable**	G	H	I

*'Affected' could be sub-categorised into children who have been orphaned and children who have seropositive parents.

** Refers to vulnerability to HIV infection.

'Respecting' rights entails their direct non-violation by the state and government actors. 'Protection' implies that the government is obliged to monitor and intervene where necessary regarding private, non-state actions. 'Fulfil' implies the duty of government to ensure the full

realisation of rights through administrative and judicial means (Tarantola and Gruskin 1998). This matrix can be applied to any sectoral issue such as education, health care access, nutrition, and freedom from sexual and/or economic exploitation.

The framework is most applicable at national level but it can be adapted for use by individual agencies and organisations. If the framework is applied to NGOs involved in child-related AIDS care, the most pertinent objectives would be: work within boxes B and E (protecting the rights of infected and affected children in relation to a specific issue, ie, health); advocacy with government in boxes A and D. For NGOs, box H (protecting children from infection) is an implicit activity which may not be the primary focus of the programmes.

As useful as this framework is, it still does not provide us with a complete set of objectives, indicators and measurement procedures.

Indicator development

The question as to why indicators are not commonly used in these programmes relates to poor definition of objectives and goals. Indicators, however, must relate to project objectives, and must never be used without reference to an overall project design.

It has been found easier to monitor activities in these projects – assessing impact is more difficult. Some suggested indicators for impacts are listed in Box 10.1.

Participatory learning and action (PLA) should be the key methodology adopted

Given the importance of context to understanding the vulnerability and needs of children affected by HIV/AIDS, *participatory* M&E must be the key methodology in assessing changes resulting from interventions. PLA can take place against a constantly shifting baseline, as the demography and socio-economic situation of participating communities change. This means the development of tracking systems, and participatory situation analyses must be the first steps in project design.

This does not mean that generic indicators (rights-based approach) have no place in these information systems, but that they must be *locally validated* by the community.

The process of establishing and implementing M&E systems can itself improve project performance and enhance sustainability

The Community Counselling Aides (CCA) Project of the National AIDS Control Programme in Uganda (NACP) developed simple monitoring tools. These were a reporting format for the CCAs, a summary format for monthly reporting, and a supervisor's check-list. A baseline survey was carried out using household interviews, a review of available programme (and other relevant) documentation, observation and questionnaires. This was then repeated at the end of the trial period.

The lessons learned included the following:

- Materials as simple as an exercise book can be used effectively to monitor performance.
- With appropriate training and support, community volunteers with basic literacy skills can understand, make use of, and benefit from the systematic monitoring of their activities.
- Local organisations are better able to give support to the volunteers when provided with data collected through the monitoring system, and if located close to the volunteers.
- The information collected and summarised can be instrumental in attracting additional support for a community programme (from local government, health authorities and the community at large), by creating greater awareness of the work being done, and its impact.

Box 10.1 Indicators for evaluating projects assisting children affected by HIV/AIDS

Community stress:

- prevalence of street children
- proportion of households headed by children (aged under 18).

Nutritional status:

- stunting (height-for-age ratio)
- wasting (upper mid-arm circumference, weight-for-height ratio)
- dietary intake profile.

Educational status:

- primary school enrolment/drop-out
- secondary school enrolment/drop-out
- ownership of uniforms/shoes/school requirements, etc
- comparable educational status of orphans and non-orphaned in same household.

Health status:

- comparable immunisation rates
- comparable incidence of childhood diseases (only valid after controlling for paediatric AIDS).

Protection from abuse:

- level of child involvement in choosing fostering arrangements
- proportion of siblings separated
- comparable domestic workload to siblings and peers (hours worked, work type)
- inheritance rights (land and property) of orphans respected.

Carer status (potentially a function of gender and age):

- primary carer in paid employment or receiving financial assistance
- primary carer involved in some sort of income generating activity (IGA) or assistance programme.

Household status:

- household cultivating all land available to it.

Source: UNAIDS and UNICEF (1999), Children Orphaned by AIDS: Front-line responses from Eastern and Southern Africa, UNAIDS & UNICEF 1999.

Effective training and support for those collecting the data is vital for the success of M&E systems

A further conclusion regarding methods of data collection comes from a review of the M&E system of the Community-Based Options For Protection And Empowerment (COPE) II project of SC US in Malawi (Brown and others, 1999). A CASCADE model was used to train officers at district level in the use of the management information system (MIS). They were then responsible for training at the community and village levels. The review found that members of village AIDS committees (VACs) were enthusiastic about project activities (including orphan monitoring and support, and youth-focused activities), though they were not clear why information gathering was important. Thus, the review found that data collection at all levels was informal and non-systematic, and that most participants at community and village levels did not have adequate training or information to participate effectively, despite their enthusiasm.

The involvement of government employees in the gathering of information can significantly improve the data collection process

This underlines the need to collaborate with local government in designing and planning management information systems since data collection systems, however rudimentary or ineffective, are usually in place already.

Focusing on the family/caring unit in the evaluation provides a more comprehensive picture of child welfare

The welfare of adult carers for children as well as the children themselves should be reviewed in information systems. The growing importance of the 'memory' approach, to assist children in affected households, necessitates developing new monitoring structures which focus on the interaction between the adults and children.

The development of M&E procedures in these programmes is developing fast but will be impeded by the inconsistent approach to programming. The rights-based approach may well, over time, dictate that the UNCRC becomes the evaluation framework. In the meantime, individual organisations should aim to be consistent within their own project evaluation, and not see HIV/AIDS as a 'special case' which is somehow excluded from rigorous evaluation.

11: Data Use in Advocacy Outputs

Different stakeholders want to know different things about a project. It is arguable that no one information system can fulfil all these demands. The data that is produced, however, can be used in two ways: in programme development, and external advocacy. This section focuses on this second area of information use.

Efficient use of information in advocacy outputs will relate to the clarity of advocacy objectives identified. In other words, it should be clear what messages are being given through the use of the data. Typical advocacy objectives might be:

- To raise awareness of policy makers of adolescents' vulnerability to HIV infection.
- To ensure that children and young people are addressed in a national or provincial planning process.
- To highlight rights' violations to the relevant civil and governmental authorities.
- To show that marginalised groups can be reached in effective ways.
- To show to other agencies, donors and the government that a particular intervention model is worthy of scaling up and replication.
- To show the impact of child and adolescent participation in influencing project outcomes.
- To show the Ministry of Education that a school-based programme has beneficial outcomes for children and does not encourage sexual behaviour.
- To highlight the need for sexual and reproductive health education and life-skills programmes for primary and junior secondary school children.

More broadly, the role of advocacy outputs is to show the added value that an organisation such as Save the Children UK(SC UK) has to offer within a national response. There are certain principles of practice, which we use to guide our programmes – but can we convince others of these principles by using research and evaluation data? There are important questions to consider regarding advocacy information (Roche 1999, adapted from Davies 1997):

- Who is supposed to hear the message?
- Who has heard the message?
- How did they interpret the message?
- How was it different from other messages?
- What did they do in response?
- Have they heard of the project/SC UK?
- How do they differentiate the advocate from others who might be communicating similar messages?

Who are the key advocacy targets?

The targets for advocacy are the stakeholders of a project, ie, any person, group of people, or institution, with an interest in the project, including both beneficiaries and benefactors.

The community/beneficiaries

It is important to feed back results to the beneficiary group. This will demonstrate that efforts put in by various community members have been worthwhile, and this will foster future support for the project.

Government

It is becoming increasingly important that NGOs demonstrate their own effectiveness to governments in-country. Greater co-operation between government and NGOs is envisaged

in the near future in many countries, as donors tend to put money into government coffers in sector-wide strategies.

Donors, academics and UN agencies

As well as financial accountability, donors are particularly interested in examples of good practice or intervention models which they themselves can fund or advocate.

Save the Children

Lesson-learning is also important for other SC offices who are striving to achieve similar objectives. Documentation and experience-sharing is the first stage of good practice development and adaptation to other contexts

Information needs first to be presented in a form easy to disseminate and understand. The AIDS Awareness Programme (AAP) in Pakistan, using a pre-/post- questionnaire, showed an increase in knowledge on the part of school children attending the classes. This is important, as having the correct knowledge is an essential component of behavioural development in young people. The results of the pre- and post-tests are shown in Table 11.1.

Table 11.1 Increases in Knowledge in the AIDS Awareness Programme, Pakistan

Group of adolescents	Ave pre-test result (%)	Ave post-test result (%)	Ave increase	% change
PIB Colony (boys)	66.2	94.9	28.6	43.1
Zubaida Public School (boys)	57.8	86.7	28.9	50.0
Zubaida Public School (girls)	65.0	82.1	17.1	26.3
Neelum Colony 1 (girls)	73.4	92.8	19.4	26.4
Ayub Goth (boys)	60.8	90.2	29.0	47.8
Ayub Goth (girls)	42.2	88.3	46.1	109.3
Neelum Colony 2 (girls)	40.0	91.7	51.7	129.2

The scores represent composite scores regarding 'correct' responses to the true/false statements. In the future, target-setting could specify that groups should have an average composite score of over 90 per cent.

Measuring the impact of advocacy programmes

An important issue here is the time-frame adopted – awareness raising must be the initial step, with institutional change further down the line. The impacts themselves may be at different levels: national and district in particular.

1) National

- Children specifically targeted for activities in the National Action Plan.
- Children specifically targeted for activities in the National IEC Strategy.
- Increased financial allocation towards children in national and provincial plans.

These would indicate whether or not advocacy has been successful at the highest policy levels. Change here may be the result of the combined influences of numerous organisations.

2) District

- Percentage of service providers/employers considering children at risk of infection.
- Percentage of service providers believing that children should be educated on HIV/AIDS.
- Percentage of service providers believing that sexual and reproductive health services for children should be improved.
- Percentage of service providers who are able to articulate future policy change in their own institution.
- Increase in the number of communities and public/private institutions organising IEC events for children in the project sites.

The first four indicators are short-term/intermediate, and evaluation questions can be asked before and after education/training sessions. The last indicator is longer-term and this can only be assessed using local authority records (such as the district AIDS committee), if such information exists; this would need to be verified. 'Service providers' can also mean district level managers and policy makers, as well as direct service providers to the public.

The impact of the production of research/advocacy documentation is very difficult to assess. One can insert a questionnaire into the document asking the receiving institution (reader) to evaluate the document's usefulness, then return the questionnaire. But it would have to be a structured questionnaire and response rates tend to be very low with this method. More feasible is simply to record anecdotal feedback and the number of requests for further information (and the document itself) received by the SC office. Specific influence can be ascertained by looking at the citations in major policy documents.

Key-informant interviews can provide a qualitative, but still valuable, source of information. Policy makers or gatekeepers can be asked key questions about the use of information and research in directing policy or spending. Specific programme outputs can be referred to in the discussion, and their influence considered. In group situations, Venn mapping can be used to look at the various influences on key decision-making processes and how these are weighted by the participants (Roche 1999).

The main message about advocacy outputs is that the information produced will have subjective value according to the interpretations of reader, viewer or listener. But, no information should be rejected on account of this variance. At the start of an advocacy campaign, the links between advocacy outputs (documents, media, videos, etc.) and objectives (changes in spending, inclusion of children in policy statements, changes in service provision, attitudinal change of gatekeepers, etc.) must be made very clear; also, how these changes will be measured. The final chapter looks at these planning processes, and discusses the difficult issue of clarity within the project design.

12: Bringing It All Together: Monitoring and evaluation plan design

There are two areas to consider here: (1) the information gathering that takes place throughout the project cycle, ie, the monitoring, and (2) the periodic gathering of information, such as baseline, mid-term review and end of project evaluation. Questions need to be asked, such as who will collect the information, what information is to be collected, and when will it be collected. A useful planning framework here is the logical framework (log-frame) approach.

The logical framework

The log-frame summarises, in tabular form (BOND n.d.):

- What your project is trying to achieve.
- How it aims to do this.
- What is needed to ensure success.
- Ways of measuring progress.
- Potential problems along the way.

The table consists of a basic four by four matrix (Table 12.1)

Table 12.1 The Logical Framework

Narrative summary (hierarchy of objectives)	Objectively Verifiable Indicators (OVIs)	Means of Verification (MOVs)	Assumptions
Goal			
Purpose			
Outputs			
Activities (clusters per output)	Inputs (budget summary)		

The log-frame should be produced by those most closely involved in the project, basing it on a thorough needs assessment, and through indicators possibly identified using a problem tree. If external technical assistance is used, the log-frame must be produced with full participation of the project staff, as part of a capacity building exercise.

The first column is sometimes called the hierarchy of objectives. The goal represents the overall reason for the programme's existence, eg, the *improvement of the sexual health of young people*. The purpose relates to the actual contribution the project will make to this goal, eg, *reduced risk behaviours* in young people, or *increased utilisation of sexual health services*. There should only be one goal and purpose in each log-frame. Outputs state what the programme will achieve and are its 'deliverables': people trained, clinics upgraded, school children educated, IEC materials produced and disseminated, curriculum designed and implemented, etc. These are often written in the past tense. Activities are what happen to produce these outputs.

The second column lists the Objectively Verifiable Indicators. These are measured to ensure that the objective has been reached, and are often expressed in terms of quantity and time, eg, number of people assisted (in terms of numbers or percentages) by a particular date. The Means of Verification describe how the indicators will be measured – the research methods, reporting forms, monitoring visits, documents, records, etc. The assumptions

column highlights conditions, processes or events outside the project's control which may affect the success or implementation of the project.

It is worth looking at a project example from Pakistan to see how a log-frame can be used to represent a project profile. It is used to illustrate both the value and limitations of the log-frame approach.

Health through mosques: AIDS Awareness Programme (AAP), Karachi, Pakistan

This project aims to assess the possibility of twelve religious leaders, from six mosques, helping to raise awareness of HIV/AIDS and sexual health among mosque attenders. The project also aims to document and disseminate the learning gained. An important point is that the project is only addressing awareness amongst *young* people through the intervention; therefore, it should not expect to see behavioural changes as a direct result of the programme. The main objective relates to an actual process or model, ie, religious leaders as effective communicators. The outputs are actually trained leaders having delivered a number of sessions – the actual target is unspecified. The objectively verifiable indicators (OVIs) for the expected impact, then, are changes in knowledge, attitudes, and communication behaviour of those attending the sessions. These can be assessed in pre- and post-KAP surveys, conducted with people before and after the education sessions.

A behavioural change, theoretical framework is essential to evaluate this programme, as the project cannot *in itself* expect to cause a widespread change in behaviour. A gain in information and changes in attitudes are essential, but not necessarily sufficient for behavioural changes to occur.

Table 12. 2 Draft Logical Framework, Karachi AIDS Awareness Programme

Narrative summary	Example Objective Verifiable Indicators (OVIs)	Means of Verification (MOV)	Assumptions
<p>Goal: To contribute to the improvement of reproductive health in Karachi through awareness raising</p> <p>Purpose: Religious leaders become effective agents of SRH information</p>	<p>As awareness is the only issue being addressed, sexual and reproductive health (SRH) impact indicators are not relevant</p>		
<p>Outputs:</p> <p><number> Religious leaders trained in SRH</p> <p>2. <number> Religious leaders have become active agents of SRH information</p>	<p>An increase by 50% of the proportion of the audience who can name three primary modes of HIV transmission and/or other STDs</p> <p>An increase by 50% of the proportion of the audience who can name three methods of HIV/STD prevention</p> <p>An increase by 50% of the proportion of the audience who can name two sources of information and support regarding sexual health</p> <p>An increase by 50% of the proportion of the audience who know that the latency period of HIV is greater than five years</p> <p>An increase by 50% of the proportion of the audience who state that a strong and healthy person can have HIV</p> <p>An increase by 30% of people who discuss SRH issues in the home</p> <p>An increase by 30% of people who discuss SRH with peer group</p>	<p>Pre-/post-KAP study</p> <p>Exit polls, post-session interview-questionnaires</p>	
<p>Activities</p>	<p>Increase in knowledge of religious leaders <composite indicator in relation to curriculum></p> <p>At least one religious leader in each institution has given appropriate SRH information at least six times to audience <time period></p> <p>% of audience exposed to messages (recall)</p> <p>% of audience stating that the SRH information received was useful</p> <p>Number of audience who approach leaders for further information</p> <p>Number of education sessions held</p> <p>Estimated number of people reached (broken down by age and gender)</p> <p>Costs per person reached</p> <p>Inputs</p>	<p>KAP study with religious leaders pre- and post-training</p> <p>Routine reporting <form needs developing: approximate size and composition of audience for each session></p> <p>Record-keeping of leaders – numbers counselled and types of questions asked</p> <p>Exit polls</p> <p>Monthly progress reports</p> <p>Routine reporting</p>	

A log-frame is not a work-plan but it is the basis of one. The activities and outputs identified need to be broken down further, into sub-activities and sub-outputs. Each of these needs to be costed, and the roles and responsibilities assigned to project staff members. Most importantly, a time-frame needs to be developed to ensure that activities contribute to the timely production of the outputs.

The logic model

An alternative to the log-frame is the Logic Model and, if properly used, it can guide evaluators on which process and outcome indicators to measure. The model, recently adapted by Kirby and others (Kirby 2000), in its simplest form specifies:

- The behaviours to be changed.
- The determinants of each of those behaviours.
- The particular programme/project activities designed to change each selected determinant.

There are four steps in generating the model:

1) *Identify the specific behaviour(s) to be changed.* These would be discrete behaviours such as 'increasing condom use', 'reducing the number of sexual partners', and 'delaying sexual debut'.

2) *Identify the specific risk and protective factors for each identified behaviour.* A risk factor can be anything that encourages a risk behaviour, increases vulnerability to a risk behaviour, or represents a greater opportunity to engage in a risk behaviour (Jessor 2000). A protective factor promotes positive behaviours, provides controls against risk behaviours, indicates commitment to society, and moderates the impact of risk behaviours. Risk and protective factors can be related to the environment, or the individual directly.

3) *Select specific determinants to be addressed by the project.* Projects should assess how easily a determinant can be influenced (eg, knowledge levels may be relatively simple to change, whereas poverty may be more difficult) as well the influence of that determinant over the behaviour. Projects should focus on determinants more likely to change as a result of a project, and which *themselves* have a big influence over a behaviour.

4) *Identify particular activities to address the selected determinants.* Some factors may need more than one activity to address them sufficiently.

An example is given in Table 12.3 regarding increasing condom use (adapted from Kirby 2000). Only selected determinants/factors are given. Note that the factors in the table are represented as objectives.

Composition of, and terms of reference for, an evaluation team

The composition of the periodic evaluation team will, to a certain extent, dictate the success of the evaluation. An appropriate mix of team members can overcome biases inherent in different individuals (Table 12.4). For instance, a recommended supervisory team would consist of the SC Project Officer, the counterpart project co-ordinator/manager, and a local consultant. The final decision would be dependent on the available resources, the level of commitment from the country office and the counterpart, and the level of locally/internationally available expertise.

Table 12.3 Logic Model as Applied to Condom Use

<ul style="list-style-type: none"> ▪ Environmental factors 	<ul style="list-style-type: none"> ▪ Individual factors 	<ul style="list-style-type: none"> ▪ Behaviours 	<ul style="list-style-type: none"> ▪ Goal
<ul style="list-style-type: none"> - make sure that adolescents are not denied condoms or birth control on account of their age (policy change) - expand media and folk messages promoting condom use - enhance social norms against unprotected sex - establish or expand community-based condom distribution - provide information on safe sex through health services - improve access to affordable condoms at clinics - develop adolescent-friendly health services - develop appropriate life-skills curricula for schools - increase teachers' ability and willingness to teach effective sex/STD/HIV education programmes - implement effective alcohol prevention - increase family support and values for delaying sex ▪ - increase parent-child communication about sexuality and condoms 	<ul style="list-style-type: none"> - reduce belief that using condoms reduces sexual pleasure - increase belief that most sexually active adolescents are using condoms - reduce stigma attached to condoms - increase self-efficacy to say 'no' to unprotected sex - increase self-efficacy to use a condom properly - increase beliefs that having unprotected sex is against personal standards - increase feelings of safety when using condoms - increase ability to seek help from a trusted person ▪ - increase ability to refuse alcohol or drugs 	<ul style="list-style-type: none"> ▪ Increase protection by increasing the use of condoms 	<ul style="list-style-type: none"> ▪ Reduction in HIV and STDs

Table 12.4 Factors Relevant to the Composition of the Evaluation Team

Composition of evaluation team	Strengths	Weaknesses
SC staff	No additional financial resources required Evaluation experience for staff	Some training may be required Time-consuming Lack of objectivity
Government or CBO/NGO Counterpart	Ownership Capacity building Familiarity with project	Some training required Lack of objectivity Time-consuming
Local consultant(s)/ institution	Local knowledge Research experience Objectivity	Some orientation to project essential
International consultant(s)	Research experience Objectivity	Increased costs Thorough orientation to project essential

Greater involvement of Save the Children staff in the design and execution of HIV/AIDS programme evaluations is an implicit aim of this handbook. It is impossible to give exact terms of reference but some central themes are notable (after Barton 1997b):

- background and purpose of the study/evaluation
- questions to address
- study approach; data collection/analysis methods, including suggested indicators
- time-frame
- staff/project participation clarification
- reporting requirements; final work-plan (before evaluation begins), preliminary and final reports, participatory review meetings, dissemination meetings
- deliverables.

A final word

At the end of a handbook such as this, it appears that there is so much – maybe too much – to do. But there are no prescriptions here, simply ideas and suggestions. It is important to remember that all of us involved in HIV prevention and AIDS care with young people are experimenting. We are learning all the time and through the sharing of these lessons we collectively move forward. So, please see projects as opportunities to be creative with monitoring and evaluation – the learning we do with children and young people is powerful and we are in a privileged position.

Good luck in your work.

REFERENCES

AIDSCAP (no date), How to conduct Effective Pre-tests, Family Health International/USAID

Barton, T(1997), Care Uganda – Guidelines to Monitoring and Evaluation: How are we doing?, Care Uganda, Kampala

BOND (n.d), Beginners Guide to the Logical Framework Analysis, British Overseas NGOs Development, Guidance Notes No.1

Catatania, JA, Moskowitz, JT, Ruiz, M, and others (1996), A Review of National AIDS-Related Behavioural Surveys, AIDS 10 (suppl A): s183-s190

Clark, LR, Brasseur, C, Richmond, D, and others (1997), Are Adolescents Accurate in Self-Report of Frequencies of Sexually Transmitted Disease and Pregnancies? Journal of Adolescent Health, 21, 2, pp91-96

Colling and others (1998), Children Living in a World with AIDS: Guidelines for children's Participation in HIV/AIDS Programmes, CAINN/UNAIDS

Dallabetta, G, Hassig, S (1995), Indicators for Reproductive Health Programme Evaluation: Final Report of the subcommittee on STD/HIV, Futures Group, Washington DC

Davies, R (1997), Placing a Value on Advocacy Work, unpublished report, University of Swansea

Elliott, L, Gruer, K, Farrow, A, and others (1996), Theatre in AIDS education – A controlled study, AIDS care, 8, 3, pp. 321-340

Elsy, H (1998), ActionAID Uganda: Strategies for Action Phase III Evaluation May-June 1998, unpublished, ActionAID

Fee, N, Youssef, M (1993), Young People, AIDS and STD Prevention: Experiences of peer approaches in developing countries, WHO/GPA, Geneva

Feldman, D, O'Hara, P, Baboo, KS, and others (1997), HIV Prevention amongst Zambian Adolescents: Developing a value utilisation/norm change model, Social Science and Medicine, 44, 4, pp 455-468

Feurstein, MT (1986), Partners in Evaluation: Evaluating development and community programmes with participants, TALC, MacMillan

Fishbein, M (1995), Developing Effective Behavioural Change Interventions: Some lessons learned from behavioural research, in Reviewing the behavioural science knowledge base on technology transfer, 1995, NIDA research Monograph 155, Washington DC

Gachuhi, D (1999), The impact of HIV/AIDS on Education Systems in the Eastern and Southern Africa region and the Response of Education Systems to HIV/AIDS, UNICEF ESARO, Nairobi

Grunseit, A (1997), Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update, UNAIDS, Geneva

Holloway, R (1996), OOPPP and Beyond: An objectives-orientated participatory project planning course, PACT, Lusaka

Ickovics, JR, Yoshikawa, H (1998), Preventive Interventions to Reduce Heterosexual HIV risk for women: Current perspectives, future directions, *AIDS* 1998, 12 (suppl A): S197-208

Jessor, R (2000), Adolescence as a Critical Life Stage, Presentation made to the WHO/UNICEF meeting on adolescent development and health, Washington DC, June 2000

Kathuria, R, Wilson, D (1995), Community Peer Education to prevent STD/HIV/AIDS among women in Zambia and Zimbabwe, Harare, unpublished

Kirby, D (2000), Logic Models: A Useful tool for designing, strengthening and evaluating programs to reduce adolescent STD/HIV and pregnancy, ETR Associates, draft paper

Konings, E, Bantebya, G, Carael, M and others (1995), Validating Population Surveys for the Measurement of HIV/STD Prevention Indicators, *AIDS*, 9: 375-382

Mashababe, S, Mclean, D, Gomo, R, and others (1998), Peer Education to Reduce STI/HIV Transmission in Mutare, Zimbabwe, Paper presented at XIIth World AIDS Conference, Geneva, 1998

Mitchell-DiCenso, A, Thomas, BH, Devlin, MC, and others (1997), Evaluation of an Educational Program to Prevent Adolescent Pregnancy, *Health Education and Behaviour*, 24 (3): 300-312

Newton, N (2000), Applying Best Practices to Youth Reproductive Health: Lessons learned from SEATS' Experience, USAID

O'Donoghue, J (1995), Zimbabwe's AIDS action Programme for Schools: Flashback and Hindsight, UNICEF, Harare

Peers, IS, Johnston, M (1994), Theory, Utility and Stakeholders: Methodological issues in evaluating a community project on HIV/AIDS, in Boulton, M (ed), *Challenge and Innovation: Methodological advances in social research on HIV/AIDS*, Taylor and Francis, London

Roche, C (1995), Impact Assessment for Development Agencies: Learning to value change, Oxfam/Novib

Schapink, D, Hema, J, Mujaya, B (1997), Youth and HIV/AIDS Programmes, in Ng'weshemi, J, Boerma, T, Bennett, J, Schapink, D (eds), (1997), *HIV Prevention and AIDS Care in Africa: A District level approach*, Royal Tropical Institute, Amsterdam

Senderowitz, J (1999), Making Reproductive Health Services Youth Friendly, Washington DC, Focus on Young Adults Program

Solim, L, O'Brien, C, Davis, M (1997), Young People, HIV/AIDS, STDs and Sexual Health Project, Survey of Knowledge, attitudes and practices, SC UK, Cambodia

Tarantola, D, Gruskin, S (1998), Children confronting HIV/AIDS: Charting the confluence of rights and health, *Health and Human Rights*, 3, 1, pp61-68

Tewari, R (1998), HIV/AIDS Prevention Strategies for School-Age Children in South Asia: Examples and possibilities, SC UK, OSCAR, Kathmandu

Theis, J (1996), Child-focused Development: An introduction, Briefing Paper 2, SEAPRO Documentation Series, SC UK

- UNAIDS** (1997), Learning and Teaching about AIDS in School, Geneva
- (1999b) Peer Education and HIV/AIDS: Concepts, use and challenges, Best Practice Collection, Geneva
 - UNAIDS/WHO (2000), Guidelines for Second Generation HIV Surveillance, Geneva

Vasconcelos, A, Garcia, V, Mendonca, MC, and others (1997), Sexuality and HIV Prevention among Adolescents in Recife, Brazil, Women and AIDS Research Program, Report in Brief, International Center for Research on Women, Washington DC

Webb, D (1997), The Evaluation of Behavioural Development and Change in Sexual Health Programmes, UNICE Eastern and Southern Regional Office, Nairobi

Webb, D, Fleming, A (1996), The Importance of Antenatal Clinics in AIDS Control, Current AIDS Literature, 9, 4

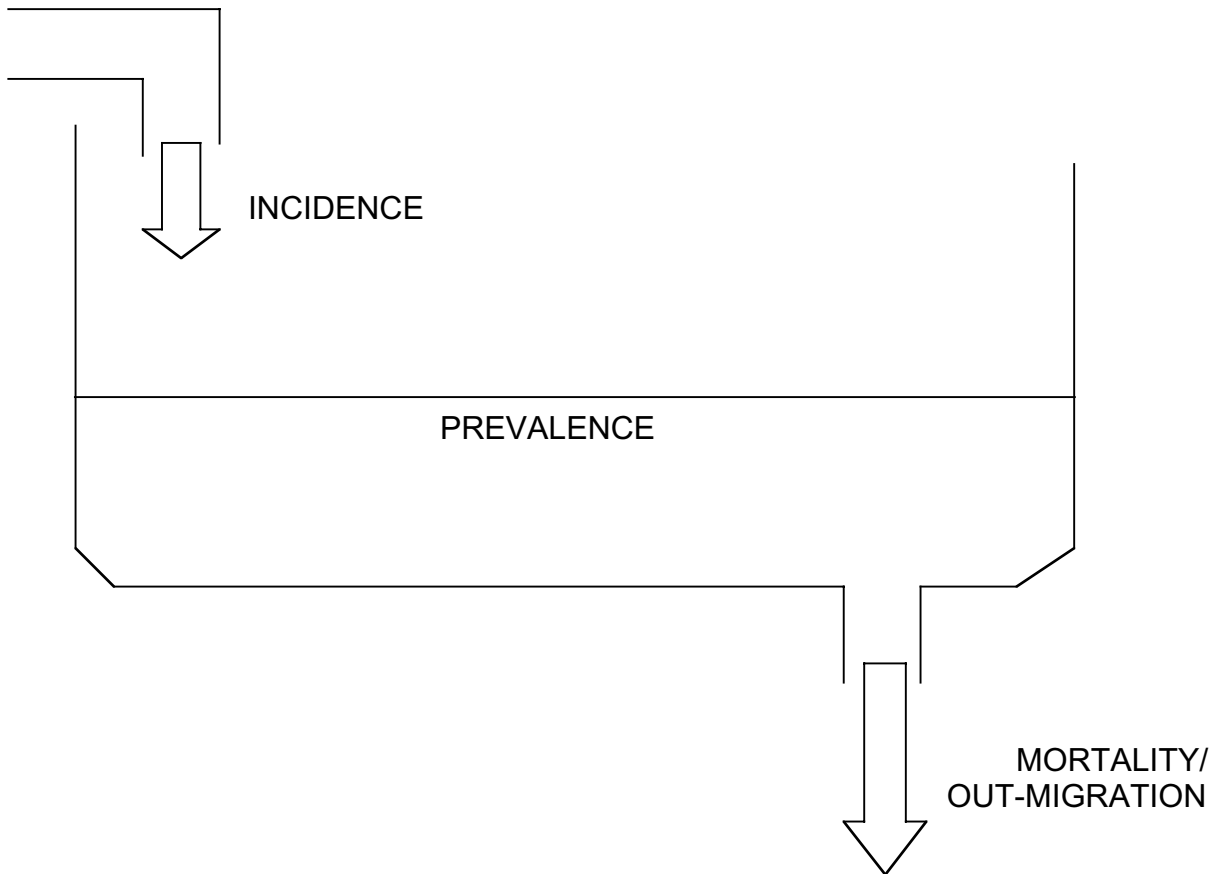
WHO (1996), Life-skills Education: Planning for Research, Division of Mental Health and Prevention of Substance Abuse, Geneva

Woelk, G, Mataure, P (1997), Training Teachers to lead Discussion Groups on HIV/AIDS Prevention with Adolescents in Zimbabwe, Women and AIDS Research Program, Report in Brief, International Center for Research on Women, Washinton DC

ANNEX 1

Understanding Incidence and Prevalence

DIAGRAM TO ILLUSTRATE DEFINITIONS OF INCIDENCE AND PREVALENCE



Prevalence (seroprevalence) is defined as the proportion of a defined population infected at any one given point in time. Prevalence is dependent on *incidence* and people leaving the infected pool (either through death or migration out of the sample area). Incidence is the proportion of a defined population becoming infected in a given period of time (usually per annum). Prevalence stabilises when incidence and mortality are equal, and will rise or fall if they are not. So a declining death rate, which can be due to improved treatments or widespread use of ARVs, combined with stable (or even dropping) incidence, will cause an *increase in prevalence*. Conversely, if death rates start to rise dramatically, as they do as the epidemic starts to mature, the declining prevalence rate may hide the fact that incidence rates are themselves high or even rising.

ANNEX 2

Key-Informant Guide for Institutions

Introductory remarks

We are here on behalf of Save the Children (*name your country*), who are conducting a situational analysis and institutional profile on agencies carrying out HIV/AIDS activities in the country.

During the past 10 years' HIV/AIDS programmes, at both national and agency levels, there have been significant changes in the socio-economic context, disease trends and the operating environment. The information we are collecting will inform SC's planning for an HIV/AIDS strategy and ensure it remains relevant and realistic.

1. What are the strengths of this agency in its HIV/AIDS activities and strategies? (*Probes - where, who, what are the main contributing factors to those strengths?*)
2. (a) What are the unmet needs in addressing/combatting the HIV/AIDS epidemic (in terms of activity, geography, and target groups)?
(*Probes – in the whole arena of HIV/AIDS [not just your agency's service or topic/focus areas].*)
(*Probes – for behaviour change and prevention? For management of the infected? For addressing impacts at individual/family/community/social levels? Other?*)
(b) Why do these gaps in national or regional AIDS programming exist?
(*Probes: low staff capacities, insecurity, not on agency's mandate, other.*)
3. What suggestions and/or cautions do you have now for an agency planning to expand into HIV/AIDS interventions/activities? (Based on experiences of this agency.)
(*Probes - sources of information, strategies of work, methods of assessment, locations of work, kinds of training necessary, use of volunteers, etc.*)
4. What do you think are some of the areas you would recommend for operational research (to help in planning or assessing programme activities), or district-specific HIV/AIDS research?
5. In your opinion, what are the under-served and/or vulnerable districts for HIV/AIDS activities? And why is that so?
(*Probes – groups at risk, risk factors, trends, etc.*)

Closing remarks

Thank you very much for your useful answers. As we mentioned at the beginning, the results of this exercise will be very useful to SC. If requested, we will keep all your answers confidential and share them only in aggregated analysis with other agencies. We will ensure that a summary of the results is made available to you. We will also have more to share in this exercise when we conduct a strategic planning workshop in (*give month/date*) of (*this/next year*). Finally, we would be glad to receive any documents from your agency that you think would possibly be of relevance to this exercise.

ANNEX 3

Focus Group Preparation and Discussion Guide (Youth-friendly Health Service Development: Source Webb 1997c).

1. Activity check-list for focus group discussions

Activity	Persons responsible	Done?
1. Identify group conveners		
2. Meet with group convener to explain group requirements		
3. Arrange venues		
4. Confirm venues are OK		
5. Arrange meeting times		
6. Buy refreshments		
7. Ensure all materials ready (flip-chart paper, markers, tape, pads, pens)		
8. Conduct focus group		
9. Write up meeting		
10. Put report in labelled box or envelope		

2. Discussion guide. The underlying question is: why are young people not using formal health care services in relation to sexual and reproductive health?

The focus groups should consist of no more than 15 people, all the same sex. Take down the name and age of each participant. Stress that they are free to say whatever they want and that their answers are confidential. The session should last no more than one-and-a-half hours. Focus on the age group concerned (eg, 10-14, 15-19, 20-24).

3. What are the sexual and reproductive health problems, in rank order, of young people in the community? The output should be a list of the five most serious problems. If time allows, the recorder should produce a table or matrix as on page 21. Answer these questions, with the group, while, or straight after, compiling the list.

- Why are these problems considered serious?
- How common are the problems?
- Do participants have personal experience, or know of someone who has experience, of these problems?
- Is there are any stigma attached to these problems?

4. What are the services available in the community for dealing with these problems? Produce a list, similar to the one you have just completed for the health problems. For each of the five most serious problems, identify the most common forms of treatment and services used.

- How popular are these treatments and services?
- Who uses them especially?

- Why do people use these treatments and services?

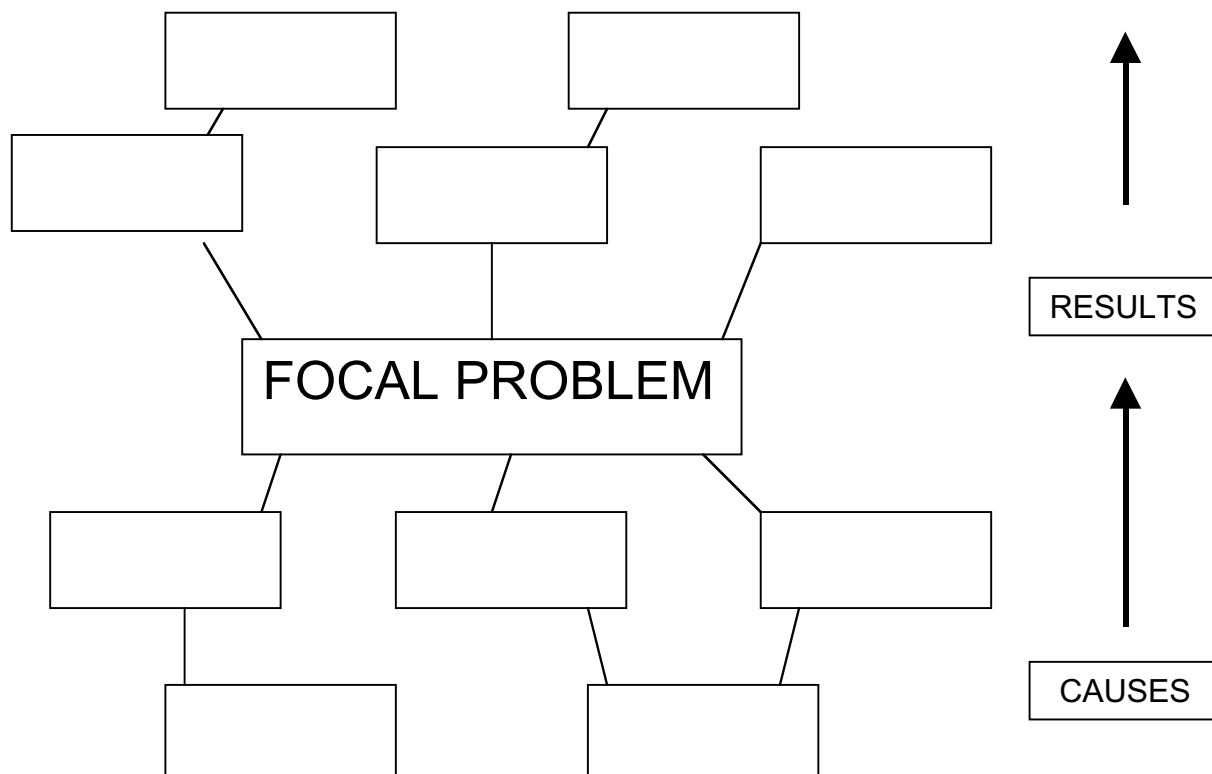
5. In the second session, it may have become apparent that young people do not use the formal health services. Ask if this is a problem – if it is, go on to look at the causes and effects of this low usage: produce a problem tree. If it is not considered a problem, explore with the group how the community hopes to overcome the health problems mentioned in session one and what role the formal health sector should play.

ANNEX 4

Producing a Problem Tree

Use a flip chart or blackboard. The focal problem in this example is the non-use of clinic services for sexual and reproductive health by young people (again focus the specific age group concerned).

1. Brainstorm to produce a list of causes, and consequences, of the focal problem.



2. Rank them in terms of importance.
3. Turn the problem tree into an objective tree by making the causes issues to address, and change, eg, if 'ignorance' is given as a cause, then the objective box would read 'reduce ignorance', or provide education. Do the same with the consequences. So, an effect says 'high rate of STDs', the objective tree would read 'reduce number of STDs'. This helps identify key problems, objectives and indicators, though not all the objectives may be relevant to the project. Further discussion can clarify the priorities.
4. Arrange into a problem tree, discussing the links between factors.
5. If time allows, develop the objective tree: state all the solutions/ objectives.

Make sure the recorder has a copy of the causes/effects and the problem tree. If you run out of time do not worry - do what you can in the time - if the participants want to discuss an issue in depth, let them, and guide them through the issues.

Source: adapted from Holloway 1996 and Team Technologies Inc.

ANNEX 5

Studying Patient/Clinic Interaction for Youth-friendly Service Development

Questionnaire for adolescent users: ask adolescents as they leave the clinic (ask patients only, not visitors).

1. Date:

2. Clinic name/town:

3. Sex:

4. Age:

5. Clinic attended: OPD MCH ANC

6. Waiting time:

7. Did the nurse/doctor ask you any questions about your condition?
 yes no

8. Did the nurse/doctor give you any information regarding your condition?

9. Were you able to ask all the questions that you wanted to?

10. Were you given or prescribed any medicines/treatments?

- [a] medicines/treatments not needed
- [b] medicines were given at the clinic
- [c] medicines were prescribed

10. If treatments were given, were they explained to you (what it does, when to take, any side-effects)

 give details:

11. How did you find the clinic staff who saw you? Were they friendly, not so friendly, or unpleasant to you?

12. Did the nurse call you by your name?

13. Did you feel that you had enough privacy while with the nurse?

- [a] yes
- [b] no

if no, explain:

14. How much money did you have to pay?

- [a] for consultation
- [b] for a prescription
- [c] travelling costs to and from the clinic

15. In general, do you feel satisfied with the service you have just received?

- [a] very satisfied
- [b] satisfied
- [c] neither satisfied nor unsatisfied
- [d] disappointed
- [e] angry

16. Would you come back here again if you had a similar need?

- [a] yes
- [b] no

17. What did you like best about the service?

18. What did you like least about the service?

19. Any other comments:

Source: adapted from Webb 1997c.