PREVENTING HIV/AIDS AMONG ADOLESCENTS
THROUGH INTEGRATED COMMUNICATION PROGRAMMING

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This manual is the result of many people's hard work.

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EXECUTIVE SUMMARY

Purpose of this Document

This manual is designed to assist national UNFPA officers in planning, designing, implementing and evaluating communication interventions for HIV prevention among adolescents that *integrate advocacy, behaviour change communication and education* with other policy and service components.

The manual provides a series of checklists to guide the programme or project officer in addressing key questions related to evidenced-based communication programming for HIV prevention among adolescents. The checklists follow a stepwise decision-making process and serve as menus of options to conduct thorough needs assessments, analyse programmatic responses, and handle strategic programming decisions.

The *first chapter* sets the tone in relation to UNFPA's support at the county level. It describes the three main communication approaches, HIV prevention, adolescent reproductive health, and explains how they relate to the UNFPA programming cycle.

The *second and third chapters* review the situation of HIV among adolescents from the viewpoint of their priority needs and government policies and intended response. Beneficiary needs and state policies become the set of priority issues that communication will need to address.

The *fourth chapter* assesses the ability of organizations involved in HIV prevention among youths to identify needs for capacity development and to help UNFPA determine its role vis-à-vis implementing partners.

The *fifth chapter* compiles a set of desirable programme results in advocacy,

behaviour change communication and education that focus on HIV prevention among young people. It also provides tips for selecting among them.

The *sixth chapter* provides information and suggestions for selecting the communication strategy that will be most effective, based on assessed adolescent communication and health needs.

The *seventh chapter* reviews issues to strengthen partnerships, management and coordination in programme implementation.

Chapter eight provides tips and tools for monitoring and evaluating processes and outcomes.

When to Use this Tool

The checklists can be best used:

- In developing the country programme outline and its component projects;
- In drawing up Common Country Assessments, Poverty Reduction Strategy Papers or reviewing progress in achieving the Millennium Development Goals. Inter-agency working groups on specific themes can use the checklists as a guide for identifying what studies remain to be undertaken in order to make sound decisions in advocacy, mobilization, information and education;
- During mid-term reviews and when assessing existing communication projects with partners, government counterparts, non-governmental organizations (NGOs) and other stakeholders to identify strategic shortcomings and future directions;
- During programme implementation, monitoring and evaluation, to inform research, develop communication strategies, assess progress, and adapt outcomes, outputs and indicators.

CHAPTER ONE:

UNFPA'S FRAMEWORK FOR INTEGRATED COMMUNICATION PROGRAMMING

What are the Communication Approaches that UNFPA Currently Supports?

UNFPA supports three intervention modalities that work together to create conditions conducive to helping adolescents adopt beliefs, attitudes and behaviours that reduce their risk of becoming infected with HIV. These three modalities include advocacy, behaviour change communication and education.

ADVOCACY

What is advocacy? Advocacy's primary function is to promote or reinforce changes in social norms, policies, and programme and legal frameworks. It can be defined as a systematic and collective effort to influence the political environment, policy and programme decisions, legislation, public perceptions of social norms, funding decisions, and community support for and involvement in a particular issue, through a set of planned actions that are undertaken by a group of committed individuals or collaborating organizations.[1]

Advocacy in UNFPA country offices operates at three levels:

- **Universal issues advocacy** is used to accelerate the implementation of actions and agreements from global conferences and summits and to promote, strengthen and coordinate partnership with various stakeholders.

- **Organizational advocacy** is used to raise UNFPA's profile in the international development arena: as the UN organization with a specific mandate for population and development and reproductive health issues and to mobilize voluntary contributions for its programmes.

[1] UNFPA Advocacy policy guidelines, Draft, 2 July 2002.

- **Programme-related advocacy** is used to remove environmental constraints and create a supportive politico-administrative, organizational and sociocultural environment for effective programme implementation.[2] This form of advocacy is the focus of this tool.

Adolescent health programming must take place in a supportive environment. Many societies regard adolescent sexuality as something that should never be spoken about. Traditional parental rights and responsibilities often conflict with the pressures of a fast-changing society and the obligations of government. Religious and other social barriers can increase a widespread reluctance to accept the fact that adolescents have sexual and reproductive rights and needs. For example, legal restrictions may prevent the dissemination of accurate information or the implementation of effective measures for adolescent reproductive health. These legal, religious and sociocultural barriers have to be addressed through dialogue, debate and networking for effective HIV/AIDS prevention to take place.

Programme-related advocacy plays a large role in promoting positive change.

Advocacy is based on a **rights-based approach to programming and gender analysis**. However, it also recognizes that one cannot simply impose views and standards on a national government or local community without respect to their cultural and religious values and traditions. It is therefore important to find a rationale for behaviour change from within existing norms and legislation. For instance, working together with religious leaders to reinterpret religious conventions in ways that do not deny reproductive rights is a way to recognize and build upon people's existing beliefs.[3]

BEHAVIOUR CHANGE COMMUNICATION

What is behaviour change communication? Behaviour change communication seeks to give individuals greater insight into their personal situations. It also seeks to instil the motivation and skills needed to voluntarily experiment with, adopt and maintain behaviours and practices that are likely to improve their condition in society and quality of life. It is a support strategy that can assist youth and other target audiences, such as service providers, to proactively adopt gender-sensitive attitudes and practices, make informed and educated choices, and change their personal behaviour and professional practices accordingly. It involves learning to understand people's situations and the influences that shape their lives through sociocultural and behavioural research, developing strategies that respond to their concerns within those situations, and using communication processes and media to increase their knowledge and skills and persuade them to adopt risk-reducing behaviours and practices.[4]

Behaviour change communication (formerly known as information, education and communication, or IEC) is a term that emphasizes the "results" dimension of communication rather than its specific methods. Behaviour change communication places the focus on the actual purpose of the communication intervention (behaviour change),

2 UNFPA Advocacy policy guidelines, Draft, 2 July 2002.
3 UNFPA Behaviour change communication policy guidelines, Draft, 2 July 2002.
4 Ibid.

whereas IEC tends to focus on methods (information, education, communication) and materials.

Behaviour change communication and advocacy may share some communication techniques, but they differ in their goals and in the audiences they target. Advocacy is largely political and aims to win support from influential people who contribute to the creation of an enabling environment. Behaviour change communication is more concerned with individual knowledge and with behaviour and attitude change. The target audiences for behaviour change communication are individual community members, reproductive health clients, reproductive health service providers, parents and teachers. In contrast, the target audiences of advocacy are usually decision makers, opinion leaders, legislators, and religious and traditional leaders.[5]

EDUCATION

In the context of UNFPA's programmes, education refers to the teaching and learning process involved in developing attitudes, values and skills that shape individual and social life in the areas of population and development, reproductive health, adolescent reproductive health, HIV/AIDS and gender. UNFPA supports the integration of population/family life/sexual health education in school-based and out-of-school education programmes and activities. This is to ensure that all adolescents receive the information they need to develop attitudes, values and skills that will enable them to make responsible choices regarding their sexual and reproductive health and to exercise their right to gender equality and equity. UNFPA also promotes youth participation in education activities. It views education as a key factor in linking adolescents to sexual and reproductive health services, including counselling. Additionally, UNFPA promotes youth empowerment through skill-building and rights-based education. These two themes are key to enabling youths to adopt new behaviours and to convince them that they can take control of their own lives, rather than letting other people, stereotypes or social norms dictate what is right for them.[6]

UNFPA-supported education usually takes one of the following forms:

- **Life-skills education:** emphasizes interactive learning and integrates the acquisition of knowledge (information), attitudes (behaviour and beliefs) and the building of skills (communication and negotiation).[7] It can take place in primary and secondary formal education and in non-formal education settings, via peer approaches, vocational/livelihood training, professional training, functional literacy classes and extension/outreach activities.

- **Population education:** designed to meet the needs of school-aged youths and to integrate population content into a wide range of educational material. The ultimate goal is to increase understanding of population dynamics at country and global levels and improve an individual's ability to make informed choices.[8]

5 UNFPA Behaviour change communication policy guidelines, Draft, 2 July 2002.
6 UNFPA Policy guidance note on education, Draft, 29 October 2002.
7 Cohen, S., and M. Burger. 2000. Partnering: a New Approach to Sexual and Reproductive Health. New York: UNFPA.
8 Ibid.

- **Family-life education:** similar to population education, but focuses more on health and environmental determinants and the effects of fertility and population.

- **Sexuality education:** learning and understanding the various elements of relationships, emotions and issues around sex and reproduction.

The integration of education into communication contributes to the effective prevention of HIV/AIDS among youths. The Plan of Action that emerged from the International Conference on Population and Development (ICPD) underscores the role of basic education in alleviating some of the contextual causes of the epidemic. These include lack of life skills, poverty and the disempowerment of girls and women. It also highlights the central role of education in promoting gender equality and equity and enhancing the well-being of adolescents, which includes protecting them from early and unwanted pregnancy, sexually transmitted diseases, including HIV/AIDS, and sexual violence.[9]

HIV/AIDS Prevention Among Adolescents: A Global Issue

The global HIV/AIDS situation for adolescents is deadly serious, and the need for a stronger, focused response is urgent. Young people are particularly vulnerable to HIV infection because of risky sexual behaviour and substance use, because they lack access to accurate and personalized HIV information and prevention services, and for a host of other social and economic reasons.[10]

An estimated 11.8 million young people aged 15-24 are living with HIV/AIDS. Moreover, about half of the 6,000 new infections each day occur among young people.[11] It is estimated that about half of all people who have had HIV were infected when they were between the ages of 15 and 24,[12] and nearly one third of those currently living with HIV/AIDS are between 15 and 24. If current trends continue, it is expected that the number of young people infected with HIV/AIDS could increase to 21.5 million by 2010.[13]

UNFPA has made youth and HIV its priorities in the context of international goals and commitments related to adolescent sexual and reproductive health. UNFPA is particularly well positioned to respond to the HIV epidemic among youths because of its decades of experience in: integrating population and family-life education in schools and in non-formal education settings; facilitating the shift towards gender-sensitive reproductive health education; building broad-based partnerships on reproductive health; negotiating controversial issues with government and key stakeholders from a respectful and culturally sensitive standpoint; advocating for public commitment, policies and legislation that support reproductive rights and gender equality; and supporting countries to improve the quality and accessibility of youth-friendly reproductive health services.

9 Key Follow Up Actions to Implement the ICPD, paragraph 35b.
10 UNAIDS. 2002. *Report on the Global HIV/AIDS Epidemic: July 2002*. Geneva: UNAIDS.
11 Ibid.
12 Kiragu, K. 2001. *Youth and HIV/AIDS: Can We Avoid Catastrophe?* Population Reports. Series L, No. 12. Baltimore, MD: Johns Hopkins University Bloomberg School of Public Health, Population Information Program.
13 Summers, T., J. Kates, and G. Murphy. 2002. *The Tip of the Iceberg: The Global Impact of HIV/AIDS on Youth*. Menlo Park, CA: The Henry J. Kaiser Family Foundation.

What are UNFPA's Priority Areas in HIV/AIDS?

In accordance with the ICPD Programme of Action, HIV/AIDS is an integral component of reproductive and sexual health and rights. Prevention is the challenge most appropriately and directly linked to the Fund's primary mandate since UNFPA is committed to ensuring universal access to high quality sexual and reproductive health services to all couples and individuals by 2015,[14] in addition to the adoption and maintenance of safe behaviours.

UNFPA has developed comprehensive and strategic guidance regarding HIV prevention.[15] Its framework for strategic programming has three core areas:

- Programming to promote the use of both male and female condoms with the aim of preventing HIV and other sexually transmitted infections;
- Preventing HIV infections in pregnant women;
- Preventing HIV infections in young people.

Until there is a vaccine or an efficient and affordable treatment, the priority should remain the prevention of new HIV infections through behaviour risk reduction, with a focus on those who are most vulnerable. Young people are particularly vulnerable to HIV infection. Yet it is also young people who are the window of hope for changing the course of the epidemic, if they are given the tools and support to do so.

Initiatives that focus on marginalized youths (including street children, refugees and migrants) are becoming increasingly important: these young people are at particular risk if they are excluded from health services, exposed to unprotected sex (sometimes in exchange for food, protection and money, or as a result of violence) or use illicit drugs. The estimated one million children who are forced into the sex trade each year are especially susceptible to contracting, and then spreading, HIV/AIDS.[16]

Additionally, two elements of UNFPA's strategic programming for HIV prevention are:

- Advocacy and partnerships for HIV prevention;
- Capacity-building, including education and behaviour change communication.

What are UNFPA Priorities in the Area of Adolescents and Youth?

Adolescents and youth constitute an institutional priority for UNFPA. They are central to its mandate to promote gender equality, reproductive rights and universal access to sexual and reproductive health throughout the life cycle. UNFPA supports young people's sexual and reproductive health through three interrelated programming areas: advocacy, reproductive health, and population and development strategies.

The organization places particular emphasis on:

- Promoting girls' empowerment and gender equality;

14 UNFPA. 2002. "Preventing HIV Infection, Promoting Reproductive Health: UNFPA Strategic Guidance on HIV prevention." UNFPA Response. New York: UNFPA.
15 Ibid.
16 UNAIDS. 2002. p. 71.

- Improving and expanding education and communication, including outreach strategies;

- Expanding access to youth-friendly sexual and reproductive health services;

- Promoting youth participation and leadership in these programmes.

Combining Three Priorities: UNFPA Support to Communication for Preventing HIV/AIDS Among Adolescents

Advocacy, behaviour change communication and education have complementary roles; their expected results are interdependent.

UNFPA support to communication for HIV/AIDS prevention is best when integrated within several communication approaches and when it is combined with appropriate policies and services (see Figure 1 on the next page).

- Advocacy supports behaviour change communication by promoting the removal of environmental constraints that discourage the adoption of safe behaviour and by creating a legal, social and cultural environment that supports personal behaviour change.

- Advocacy helps put behaviour and personal vulnerabilities in context. It helps people understand why people behave the way they do by showing the connections between sexuality, risky behaviour and social circumstances, such as gender inequality, poverty, marginalization and gender-based violence.

- Advocacy for basic education, with a focus on education for girls, contributes to effective HIV/AIDS prevention among adolescents.

- A narrow focus on skills-based education alone is unlikely to impact behaviour in the long term, unless appropriate services and policies are in place. Sustained individual outcomes are achieved when education is coordinated with advocacy to promote: changes in educational curricula and hiring policies, provision of youth-friendly reproductive health services and products, and mass media campaigns that model and reinforce positive changes.

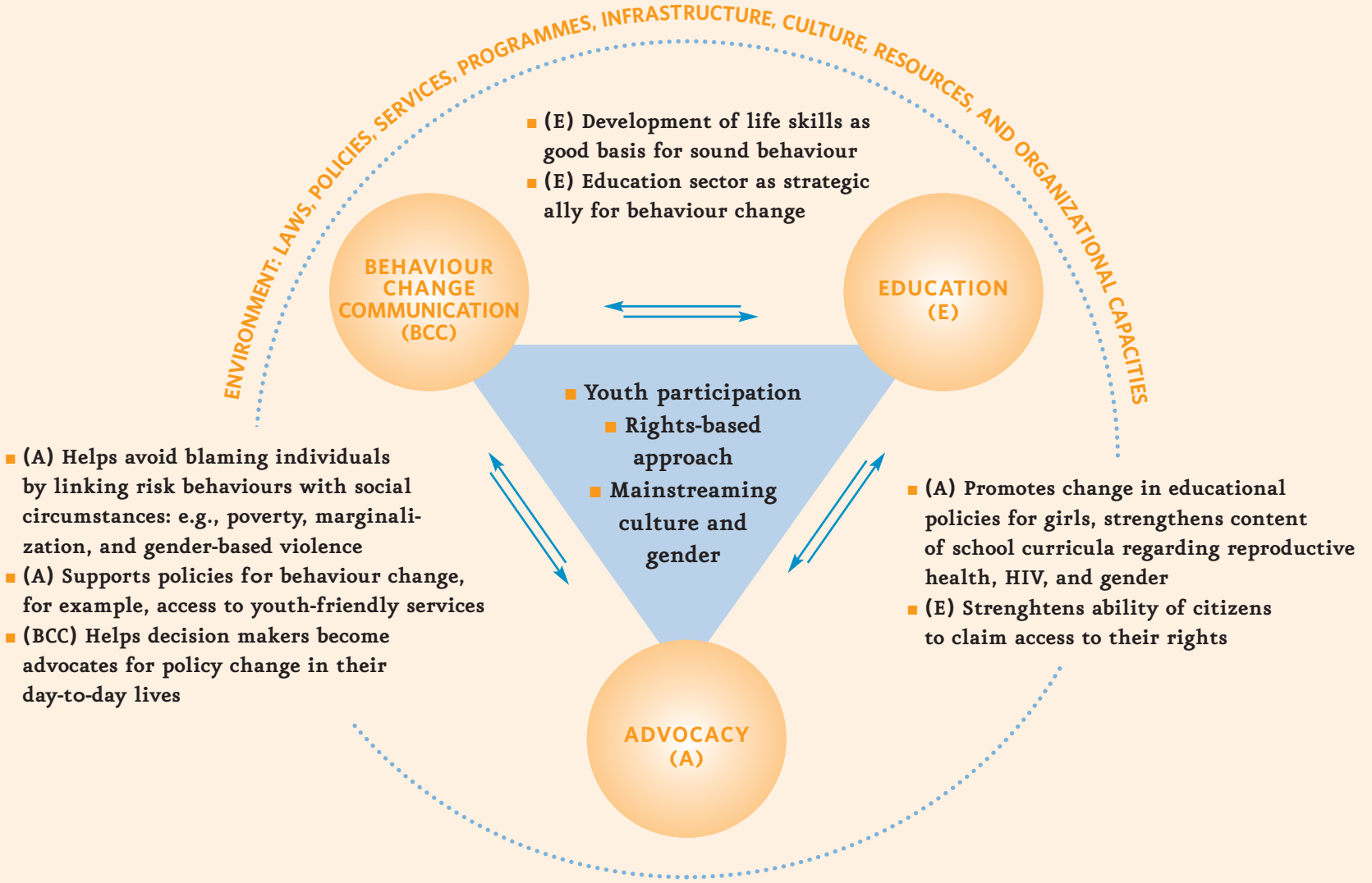
- Behaviour change communication reinforces advocacy by providing influential individuals with the information, attitudes and skills to enable them to effectively lobby for HIV prevention in their day-to-day lives.

- Individuals who have succeeded in adopting safe behaviours are often the best advocates to promote behaviour change among peers.

- Life skills enable youth to negotiate sexual relationships, including delayed sexual initiation, addressing pressure and violence, and correctly using condoms.

- Education can convince youths that they can take control of their lives and do not have to let other people, stereotypes or social norms dictate what is right for them.

FIGURE 1: CREATING SYNERGY AMONG THREE COMMUNICATION APPROACHES IN POPULATION, REPRODUCTIVE HEALTH AND HIV/AIDS PREVENTION PROGRAMMES



INTEGRATING COMMUNICATION IN THE COUNTRY PROGRAMMING CYCLE

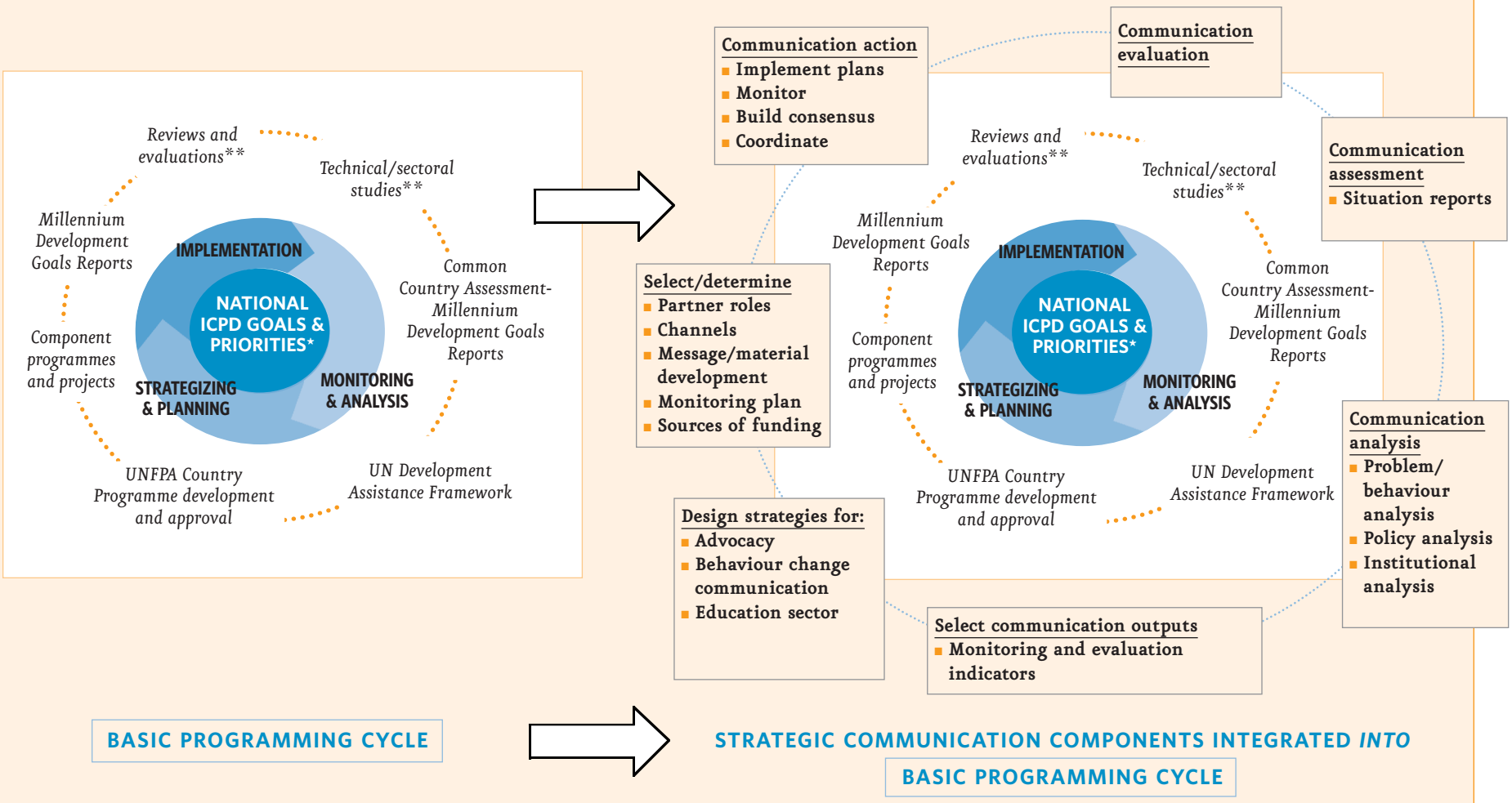
Figure 2 on the following page illustrates the UNFPA country programme cycle (left) and the addition of a synchronous communication programming cycle (right).[17]

For UNFPA, the overriding purpose of the programme approach is to integrate critical interventions or sets of interventions that directly contribute to achieving national population and reproductive health goals into national population programmes and/or strategies, along with other national development frameworks, such as sector-wide approaches (SWAps) and poverty reduction strategies. The ultimate aim is to further the goals and principles of the Programme of Action of the International Conference on Population and Development.

Communication programmes follow a cyclical planning process that is similar to the UNFPA planning process. As depicted on the right hand side of Figure 2, the steps in the communication cycle are synchronized with the steps in the UNFPA country programming cycle. The conclusion to be drawn from Figure 2 is that it is logical and relevant to conduct communication planning at the same time as country-level programme planning.

17 The Common Country Assessment is the first step in the UNFPA country programming cycle. It is a nationally driven exercise, managed by the UN country team, under the overall leadership and guidance of governments. Planning for the Common Country Assessment normally begins in the fourth year of a five-year programme cycle. The United Nations Development Assistance Framework is the strategic planning tool and document for operational activities of the United Nations system at the country level. The framework is based on the findings of the Common County Assessment, the national Millennium Development Goals Reports and any other relevant and complementary situation analyses. The UN Development Assistance Framework represents the collective response of the United Nations system to national priorities as set out in national development plans and strategies, including strategies for poverty reduction strategies.

FIGURE 2: INTEGRATING COMMUNICATION IN THE COUNTRY PROGRAMMING CYCLE



* *National ICPD goals and priorities include: Millennium Declaration, Millennium Development Goals, and poverty reduction strategies.*

** *Can be undertaken throughout the programme cycle.*

CHAPTER TWO:

ANALYSING THE SITUATION OF YOUNG PEOPLE

A thorough understanding of the status, knowledge, skills, perceptions, attitudes, behaviours and community context of adolescents in light of the HIV situation is vital for prioritizing national-level communication programming.

This chapter provides checklists for the programme manager to:

- Understand the HIV-related attitudes, knowledge and sexual behaviours of adolescents;
- Have a thorough and up-to-date understanding of how many and which adolescents are at risk of HIV infection or are HIV-positive;
- Know community and "gatekeeper" attitudes about the HIV situation among adolescents. Gatekeepers can be defined as influential persons or groups that function to filter out or censor information or policies that can directly affect beneficiaries.

The following should be taken into account when undertaking situation analyses:

- Data related to HIV among adolescents that is disaggregated on the basis of socio-demographic characteristics (gender, education, employment, etc.) can assist in defining and locating populations at increased risk of HIV and of spreading the infection;
- Gender differences in HIV status, risk, knowledge, attitudes and behaviours perpetuate the epidemic;
- Community norms influence the context of adolescent sexuality, which can affect prevention efforts and adolescent HIV vulnerability.

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
DEMOGRAPHICS ■ What is the present size of the youth population?	? Youth aspects of national and local population trends
■ What was the youth population during the past 10 years and what is the youth population projection for the next 10 years?	? Unique demographic characteristics of adolescents
■ What are the regions/districts characterized by a sex ratio imbalance? By population movements? Of which nature? To what extent are youth concentrated in these regions/districts?	? Main differences among adolescent groups, especially gender differences, and the relationship of these differences to risk
■ What are the socio-demographic characteristics of youths in the following categories (give % per sex): currently in school, employment status, geographic distribution (regional/district disparities), rural/urban residence, migrants/refugees/displaced persons, marital status, education levels, income levels, family size, orphan status, number of children, ethnicity, and religion?	? Socio-demographic categories with little or no adolescent data available ? Identify special adolescent populations at increased risk of HIV infection
HIV/AIDS EPIDEMIOLOGY ■ What is the current HIV seroprevalence?	? Provide national, regional and local breakdowns for age, sex, ethnicity and location

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
HIV/AIDS EPIDEMIOLOGY *continued* ■ What is the expected trend of HIV prevalence and transmission routes for the next 10 years? What was the trend in the last 10 years?	? Trends and differences in HIV seroprevalence and incidence patterns among youth, between men and women and for other demographic categories
■ What are the seroprevalence and incidence for males and females in the 15-19 year and 20-24 year age brackets?	
■ Is there seroprevalence data for youth aged 10-14?	
■ What are the socio-demographic characteristics of HIV-positive youths? (Provide information regarding gender, whether currently in school, employment status, geographic distribution (regional/district disparities), rural/urban residence, whether migrants/refugees/displaced persons, marital status, education levels, income levels, family size, orphan status, number of children, ethnicity, and religion. Other?)	? Common socio-professional and demographic characteristics of HIV-positive adolescents and of adolescents at increased risk of HIV infection
■ Proportion of adolescent pregnant women who are HIV-positive?	
■ What percentage of HIV-positive youths knows they are positive and what per cent are unaware that they are positive?	
■ What are the major routes of transmission by which youths become infected?	
■ What are the rates of other sexually transmitted infections among youths? What are the socio-demographic characteristics of adolescent clients with sexually transmitted infections?	

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
MARRIAGE AND FERTILITY PATTERNS	
■ What percentage of adolescents are married? Cohabitating? In unmarried, monogamous relationships?	? Vulnerability of married adolescents to HIV
■ What is the average age that men and women get married? What is the average age difference between husband and wife?	? Age difference between married men and women
■ What proportion of married adolescents are in polygamous unions?	? Expectations on women for early marriage and early childbearing
■ What is the average age a woman gives birth to her first child?	
■ What is the average number of births a woman will have before she is 20 years old? Twenty-four years old? How many children will a man father before these ages?	? Influence of socio-professional and demographic factors, such as religion or education, on the variation in marriage patterns and fertility rates
■ How do average age at marriage and childbearing patterns differ depending on socio-demographic characteristics (ethnicity, religion, employment status, geographic location, education, etc.)?	
■ What is the projected lifetime fertility of present-day adolescent women?	
■ Do couples ever receive voluntary counselling and testing together before getting married?	

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
KNOWLEDGE AND SKILLS	
■ What is the level of awareness about the existence of HIV/AIDS among youth? About the reality of the national/ local HIV/AIDS situation? About other sexually transmitted infections?	? Key demographic factors that predict which adolescents have knowledge about HIV/AIDS (Education? Employment? Geographic location? Urban/rural residence? Religion? Others?)
■ What proportion of adolescents know that a HIV-positive person who is asymptomatic may transmit the infection?	? Gender differences in HIV/AIDS knowledge
■ What is the level of knowledge about HIV/AIDS symptoms and disease progression?	? Association between levels of HIV knowledge and protection from HIV
■ What is the level of understanding that HIV/AIDS is a fatal disease?	? Most common prevention methods known by adolescents
■ What is the level of knowledge about accurate modes of transmission and effective means of prevention?	? Main adolescent misconceptions about modes of transmission and means of prevention
■ To what extent do youths attribute unprotected sex to substance abuse and violence?	? Level of adequate technical skills for condom use reported by youth
■ What is the level of knowledge about mother-to-child transmission of HIV/AIDS? What is the level of knowledge about the existence of mother-to-child preventive measures?	? Sexual negotiation and communication skills for HIV/AIDS prevention reported by youth
■ What is the level of knowledge about where to access male and female condoms? Other contraception methods?	

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
KNOWLEDGE AND SKILLS *continued*	
■ What percentage of youth can demonstrate proper condom use?	
■ What percentage of youth have discussed risk reduction and preventive methods with their sexual partner?	
ATTITUDES AND PERCEPTIONS OF YOUTH	
■ How many adolescents minimize the severity of HIV/AIDS in their country? In their community? Why?	? Denial about the reality of HIV as reflected in youth attitudes
■ How many adolescents perceive HIV/AIDS as an important health concern among youths?	? Minimization of personal risk to HIV infection as reflected in youth attitudes
■ What are adolescents' perceptions about their personal risk of acquiring HIV/AIDS? What percentage of adolescents feel personally vulnerable to HIV infection?	? Youth acceptance of the benefits of and confidence in the efficacy of preventive measures
■ What percentage of adolescents think that using condoms will protect them from HIV/AIDS?	? Cost-benefit comparison of prevention measures ? Level of stigma associated with being HIV-positive
■ What are adolescents' attitudes about abstinence? About faithfulness? About using condoms? Do they think it is feasible to adopt and maintain these behaviours?	? Influence of peers, parents and other community members on youth
■ What are adolescents' positive and negative expectations of adopting preventive measures? What are the benefits and costs youth associate with abstinence, faithfulness, condom use?	? Relationship between adopting preventive measures and social norms, community norms and peer norms

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
ATTITUDES AND PERCEPTIONS OF YOUTH *continued* What do adolescents think about the national HIV/AIDS response? Do adolescents feel that the national response to HIV/AIDS is adequate and addresses issues specific to adolescents?	? Difference between social norms and social realities
What do adolescents view as their information needs in terms of HIV prevention? For other reproductive health topics?	? Availability of youth-focused health services and products
How many adolescents think it is acceptable to have sex before marriage? To frequently change sexual partners? To have multiple sexual partners?	? Relationship between socio-demographic factors and positive and negative attitudes (for example, education, income, employment, marital status, religion, geographic location, HIV status)
To what extent do youths feel able to discuss sex with their sexual partners? To negotiate condom use? To refuse unprotected sex?	? Relationship between attitudes of youths and their preparedness and willingness to take measures to prevent HIV infection
How do youth feel about people living with HIV? To what extent do they fear household or job-related contact with someone who is HIV-positive?	? Attitudes and perceptions characterizing those most at risk for HIV
Do adolescents view existing reproductive health services as meeting their needs? Do they perceive the services to be youth-friendly? Do they perceive condoms to be easily accessible and affordable?	
What do youths believe that their peers think about preventive measures? Do youths believe that their peers should adopt them? That they have already adopted them?	

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
ATTITUDES AND PERCEPTIONS OF YOUTH *continued* ■ How do youth think their sexual partner and peers will react if they adopt preventive measures?	
■ Do adolescent girls automatically feel safe when they are married?	
■ Do adolescents take the attitudes and beliefs of gatekeepers and community norms into account when developing attitudes and making decisions? Do adolescents feel that the attitudes of their parents and community members about sexuality are out-of-touch?	
■ Do adolescent women want to have a large number of children following marriage? What do young wives think about becoming pregnant immediately after marriage?	
■ What do young, HIV-positive women or couples think about having children? How many still want to have children?	
■ What do other adolescents think about HIV-positive women having children?	
SEXUAL BEHAVIOURS ■ What is the average age of sexual initiation? How does the average age differ based on demographic factors such as gender, religion, education, HIV knowledge, attitudes and HIV status? Others?	? Relationship between demographic factors (education, religion, etc.) to safe and unsafe sexual behaviour

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
SEXUAL BEHAVIOURS *continued*	
■ What percentage of married adolescents have had sex before marriage? What percentage of unmarried adolescents are currently sexually active?	? Association between HIV knowledge and sexual behaviour
■ What percentage of those who have sex outside marriage use condoms? Do they consistently use condoms in potentially risky encounters?	? Degree to which the sexual behaviour of adolescents conforms to community and gatekeeper expectations
■ How many young people report using condoms during their last sexual encounter?	? Community norms about acceptable and inappropriate sexual behaviours
■ What percentage of married and unmarried youths use family-planning methods other than condoms? How often are these methods used?	? Socio-professional and demographic factors that characterize youth who engage in commercial sex (professional and occasional)
■ How many new sexual partners do adolescents report having had during the last six months?	
■ Are sexual behaviours different depending on level of HIV knowledge? Based upon perception of risk?	
■ Do women practice post-partum abstinence? Do their partners seek sex with other women during this period? Do their male partners use condoms?	
■ Do married adolescents have extramarital sexual relations? How often?	
■ Do adolescents give or receive sex for money? For gifts? Do they engage in professional commercial sex? Engage in occasional sex work?	

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
HEALTH-SEEKING BEHAVIOURS	
■ How many adolescents have undergone voluntary counselling and testing?	? Relationship between attitudes and beliefs of adolescents and the community and the desire and/or ability of adolescents to seek and obtain reproductive health services
■ How many adolescents seek information or services related to reproductive health? What kind of services?	
■ How many have successfully obtained reproductive health information or services? What kind of services?	? The change in sexual behaviour after voluntary counselling and testing
■ How many adolescents seek medical care for sexually transmitted infections?	? What are the reasons given for selecting alternative therapies for sexually transmitted infections?
■ What are the alternative therapeutic options for sexually transmitted infections? To what extent are they used by youths?	? Do demographic factors seem to be related to unhealthy health-seeking behaviours? Which ones?
REPRODUCTIVE HEALTH AND OTHER BEHAVIOUR	
■ How many adolescents have experienced a sexually transmitted infection?	? Association between sexually transmitted infections, abortion, and other reproductive health factors and adolescent vulnerability to HIV
■ What percentage of adolescent women have had an abortion?	
■ What percentage of youths have used or are using intravenous drugs?	? Relationship between demographic factors such as poverty or unemployment and unhealthy behaviours
■ Is there data that demonstrates the extent of abuse and assault by males against females? To what extent are adolescents the perpetrators and/or victims?	

continued on next page

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
REPRODUCTIVE HEALTH AND OTHER BEHAVIOUR *continued* ■ To what extent is there data about trafficking of women, and to what extent are young men and women involved in—or victims of—this practice? ■ Is there data that demonstrates the extent of alcohol abuse by men and the effect it may have on abuse or assault of adolescent females?	
COMMUNITY AND GATEKEEPER ATTITUDES AND PRACTICES What are the attitudes of influential gatekeepers (religious, traditional, politico-administrative leaders, media practitioners, service providers, health educators) and other community members (elders, parents, teachers, peers) about the following, as they relate to HIV prevention among youths: ■ Adolescent vulnerability? ■ Adolescent sexuality? ■ Sex before marriage? ■ Reproductive health and life-skills education? ■ Importance of promoting condom use among youth? ■ Adolescent reproductive health services? ■ How do the attitudes of influential gatekeepers compare to community attitudes? Are they the same? Does one carry more weight in influencing adolescent attitudes than the other? ■ Do gatekeeper and community attitudes and norms differ for adolescent boys and girls?	? The community social context/social norms that influence adolescent sexuality (such as social constructions that legitimize negative cultural practices; male/female identity and expected roles, rights and obligations with regard to sexuality, including power imbalances in sexual relations; physiology, including healthy sexual and reproductive behaviour) ? Contribution of gatekeeper and community attitudes to the prevention or vulnerability of youth to HIV ? The difference between gatekeeper and community attitudes about adolescent sexuality and adolescent attitudes

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
COMMUNITY AND GATEKEEPER ATTITUDES AND PRACTICES *continued* ■ Do gatekeeper and community attitudes about adolescent HIV risk reflect accusation and blame, or concern and empathy?	? The contribution of influential gatekeeper and community attitudes to stigmatization against HIV-positive adolescents, especially girls
■ Do rumours and myths such as "virgins cure AIDS" exist? Are they believed and practiced?	? The demographic characteristics that define the differences in attitudes and opinions of influential gatekeepers and community members (such as age, occupation, number of children, HIV status, others?)
■ Do gatekeeper and community attitudes tend to consider early marriage for girls as protection against HIV?	? Community willingness to partner in preventing HIV among youths
■ What are community and gatekeeper attitudes about age difference between men and women at marriage as an HIV risk factor?	? Key actors in the socialization process of boys and girls and the transfer of cultural norms that have an impact on sexual behaviour
■ What are the sociocultural beliefs that make influential gatekeepers and community members reluctant to provide youths with HIV/AIDS information, services and products?	? The negative practices of influential gatekeepers and community members towards adolescent reproductive health education and services that hinder youth's access to and utilization of such information, services and products
■ What are the common sexual practices to which youth are likely to conform but that are placing them at increased risk of HIV/AIDS (for example, early sex/marriage, sexual mobility, widow cleansing, dry sex, female genital cutting, traditional sexual initiation with an older man, forced sex, "sugar daddies," or men who have sex with women in exchange for favours, commercial sex, etc.)	

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
COMMUNITY AND GATEKEEPER ATTITUDES AND PRACTICES *continued* ■ Who in the society imposes harmful cultural practices on youth and what is the rationale given for maintaining them in the context of HIV/AIDS?	

Conclusion

Based upon the information gathered as a result of this chapter, the programme manager should consider the following:

■ Is there enough data available? In what areas are the data weak or non-existent?	■ What are initial thoughts about priority needs that might be appropriate for communication interventions? ■ What are the main areas in which UNFPA has worked in the country? Are they relevant to initiatives that would help prevent the spread of HIV among youths?

■ In what ways does UNFPA's comparative advantages become relevant after gathering and analysing the information in this chapter?

CHAPTER THREE:

ANALYSING GOVERNMENT POLICY & RESPONSE

The legal and policy responses of a national government and its ministries are major steps in addressing the adolescent HIV epidemic. An analysis of these laws and policies, and how they are formed and implemented, is important to consider when prioritizing communication efforts for HIV prevention.

This chapter provides checklists for the programme manager to:

- Assess the government's HIV surveillance system and source of data on HIV and adolescents;
- Assess the government's use of such data in poverty reduction frameworks;
- Assess the legal and policy situation of the national government and ministries involved in HIV prevention among adolescents.

This chapter should promote consideration of the following:

- Government's inclusion of the HIV situation among adolescents into poverty reduction frameworks;
- Congruence between stated policies and government and ministerial response to HIV among adolescents;
- Areas where laws and policies are missing or inadequate.

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
HIV/AIDS SURVEILLANCE SYSTEM ■ Does the national government oversee a surveillance system to monitor the status and spread of HIV?	? Government involvement in collecting up-to-date data on youth conditions, by sex
■ If no, what are the sources of data on HIV used by the government for planning purposes?	? Government ability to associate the data on HIV and adolescents to national poverty indicators
■ What is the government's surveillance system and what are the possible limitations of the data? Does this system include a behavioural surveillance component?	
■ Has the government monitored and/or analysed the HIV/AIDS data to demonstrate the impact of HIV among adolescents on current and future poverty in their country?	
INCLUDING HIV/AIDS IN POVERTY ALLEVIATION FRAMEWORKS ■ Has an analysis been conducted to demonstrate the impact of HIV among adolescents on vital sectors, such as national health and education systems, labour markets or agriculture production?	? Official government acknowledgment of the relationship between poverty and HIV among adolescents through the use of relevant data as justification for development frameworks
■ To what extent do current national poverty reduction efforts include plans to reduce HIV infection among adolescents?	

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
INCLUDING HIV/AIDS IN POVERTY ALLEVIATION FRAMEWORKS *continued* ■ To what extent do current national poverty reduction efforts include plans to reduce HIV infection among adolescents? ■ Has the government used evidence of the relationship between poverty and HIV among adolescents in its poverty alleviation frameworks (such as Poverty Reduction Strategy Papers, Sector-Wide Approaches, Millennium Development Goals and Common Country Assessments)? ■ What is the country's participation in regional cooperation frameworks? To what extent has HIV prevention among adolescents been included in poverty reduction and development efforts at the regional level?	? UNFPA's plan to contribute to the integration of policy issues related to HIV among adolescents into Poverty Reduction Strategy Papers, Sector-Wide Approaches, Millennium Development Goals and Common Country Assessments
POLICY AND RESPONSE AT THE MINISTERIAL LEVEL **National Response** ■ Which ministries or national institutions are involved in the national response to HIV/AIDS, and in the response to HIV/AIDS among adolescents? ■ Does the national HIV/AIDS programme or committee specifically address HIV/AIDS among adolescents?	? The government agencies involved in responding to the situation of HIV/AIDS among adolescents ? The role of existing policies and laws towards promoting or thwarting HIV prevention among adolescents

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KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
POLICY AND RESPONSE AT THE MINISTERIAL LEVEL **National Response** *continued*	
■ What is the composition of the national HIV/reproductive health programme? Does it include true youth representation and power-sharing?	? The government policy gaps that could be addressed through advocacy and the measures that would need to be taken to advocate in this area
■ Does the national reproductive health programme specifically address HIV prevention among youths?	? The existing government policies that are beneficial for communication programmes for preventing HIV among adolescents
■ Have current policies identified any priority groups and/or zones/areas or implied as much?	
Ministry of Health	? The openness of government to include youths in decision-making related to HIV prevention
■ What are policies related to young people's sexual and reproductive health?	
■ Are there any policies specific to adolescent HIV/AIDS?	
■ Is there a legal age for first intercourse and marriage?	
■ Are there laws regarding homosexuality, prostitution and abortion?	
■ Is there staff training for work related to young people and sexual and reproductive health issues?	

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KEY INFORMATION TO OBTAIN KEY POINTS TO CONSIDER

POLICY AND RESPONSE AT THE MINISTERIAL LEVEL

Ministry of Health *continued*

- Are there laws or policies concerning the sale/provision or promotion of condoms or contraception to married and unmarried youths?
- Are there laws or policies about the provision of reproductive health services to adolescents?

Ministry of Education

- What are the policies about reproductive health and life-skills education in the schools? Are there laws or policies banning HIV-specific interventions such as HIV peer educators?
- What are the policies about reproductive health and life-skills education in the formal school curricula (primary and secondary)?
- What is the context in which reproductive health and life-skills education takes place in schools?
- Is there training of teachers and other education administrators for reproductive health and life-skills education?
- What are the policies regarding provision or promotion of reproductive health services within schools?
- What are the school policies regarding sexual harassment of students by other students or teachers?

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KEY INFORMATION TO OBTAIN KEY POINTS TO CONSIDER

POLICY AND RESPONSE AT THE MINISTERIAL LEVEL

Ministry of Health *continued*

- What are the laws or policies about the distribution/sale or promotion of condoms/contraceptives in schools?
- Are there laws or policies excluding HIV-positive youths from schools?

Ministry of Information and Culture

- What is the extent of freedom of expression? Freedom of press? Freedom of speech? Freedom of association?
- What is the policy for use of local languages in television and in the media?
- What are the policies and laws regarding dissemination of information about HIV and other reproductive health topics?
- What is the approved national terminology for discussing HIV/AIDS and reproductive health among adolescents?
- Are there acceptable words to describe sensitive topics such as male and female genitalia? Risk behaviours? Body fluids? Other?
- Is there a legislative framework promoting coverage and debate of reproductive health issues in the media?

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KEY INFORMATION TO OBTAIN KEY POINTS TO CONSIDER

POLICY AND RESPONSE AT THE MINISTERIAL LEVEL

Ministry of Information and Culture *continued*

- If any, are the private/commercial and local media under the same regulations as public media?

Policy Environment

- Which leaders have positive or negative attitudes on HIV prevention among adolescents?
- Who has power to bring about political change?
- Who do policy makers turn to for policy advice on adolescent reproductive health issues? What sources of information do they trust most?
- How are the ideas generated for new or revised policies on adolescent reproductive health issues?
- What is the process for discussing, debating and presenting proposals on adolescent reproductive health issues?
- How is a proposed issue introduced into the formal decision-making process?
- How is a proposal approved or rejected?

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KEY INFORMATION TO OBTAIN KEY POINTS TO CONSIDER

POLICY AND RESPONSE AT THE MINISTERIAL LEVEL

Policy Environment *continued*

- If approved, what are the steps to move the proposal to the next level of decision-making?

Conclusion

After gathering and analysing the information in this chapter, the programme manager should consider the following:

- The extent of government investment in the problem of HIV among adolescents through surveillance and inclusion of the problem in poverty reduction frameworks;
- The extent of national and ministerial responses based on the existence of sound laws and policies;
- In what areas are there strong policy responses to preventing HIV/AIDS among youths and in what areas do there appear to be policy gaps?
- What is UNFPA's history in the country of contributing to policy formation or advocacy?
- What are the relevant areas that UNFPA might contribute to in terms of advocating for laws or policies or strengthening those that already exist?

CHAPTER FOUR:

ANALYSING CURRENT COMMUNICATION EFFORTS & ORGANIZATIONAL CAPACITY

Communication efforts have been conducted in the past to address HIV prevention among adolescents and related health issues. In order to chart the course for future activities, it is important to gauge the extent of existing efforts and overall capacity in the area of communication.

This chapter provides checklists for the programme manager to:

- Identify and assess the organizations involved in communication efforts related to HIV prevention among adolescents;
- Determine the policies and practices of organizations and programmes working in the area of HIV prevention among youths;
- Characterize the organizational and national capacity to plan and implement effective communication programmes.

This chapter should promote consideration s of the following:

- The discrepancies between national and programme-level policies regarding HIV prevention among adolescents;
- What national laws and policies are not implemented at the organizational level?
- What are the gaps in the national communication capacity that could be addressed by UNFPA?

KEY INFORMATION TO OBTAIN	KEY POINTS TO CONSIDER
IDENTIFY ORGANIZATIONS **National Response** Identify the main organizations with an interest in HIV prevention among adolescents. ■ Consider multilateral, bilateral, governmental, non-governmental, private sector, media, religious, and community groups	? The major players in communication activities in general, and in communication for HIV prevention among youths in particular
WHAT ARE THE POLICIES AND PROGRAMMES OF RELEVANT ORGANIZATIONS? **Characteristics of Current HIV Prevention and Reproductive Health Programmes for Youths** ■ Who are the target populations (age, marital status, rural/urban)?	? The similarities and difference between national laws and policies on HIV prevention and the policies and practices of organizations working in the field
■ What are the key elements of the programme? Does it provide communication-related training? It is involved with service provision?	
■ How is the programme implemented? Through schools, health services, peer groups, etc.?	
■ What is the source of funding? Does the funding source have influence on policy or programme content and delivery?	? The organizational policy and programme gaps that communication efforts could address to improve HIV prevention among adolescents
■ Does the programme run in collaboration with government health services? What is the nature of the collaboration? Are costs shared?	
■ Are the programme plans based on in-depth research?	
■ Are there participatory methods used in the planning, implementation and evaluation of the programmes? How active have adolescents been in this process?	

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KEY INFORMATION TO OBTAIN KEY POINTS TO CONSIDER

WHAT ARE THE POLICIES AND PROGRAMMES OF RELEVANT ORGANIZATIONS?

Characteristics of Current HIV Prevention and Reproductive Health Programmes for Youths *continued*

- Has the programme been evaluated? What was the quality of the evaluation? What were the results?

Sexual Behaviour

- What are the organization's policies or views about sexual behaviour issues (for example, adolescent sex, sex between unmarried people, same sex sexual relationships, sexual activity for money)?

Marriage

- What are the organization's policies or views about marriage (for example, age at first marriage, early marriage, age difference between partners, forced marriage, polygamous marriages)?

Contraceptive Use and Voluntary Counselling and Testing

- What are the organization's policies or views about contraception use (for example, providing or selling condoms and other contraceptives to people under a certain age, or for unmarried persons)?
- What is the quality of the services?
- Is it confidential?
- Is it welcoming to young people?

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KEY INFORMATION TO OBTAIN KEY POINTS TO CONSIDER

WHAT ARE THE POLICIES AND PROGRAMMES OF RELEVANT ORGANIZATIONS?

continued

Abortion

- What are the organization's policies or views about abortion (for example, abortion after rape, abortion when a mother's health is at risk, for HIV-positive mothers)?
- Is abortion included in their reproductive health services?

Employment

- What are the organization's policies or views about child labour and, in particular, hours of work, pay and exploitation?
- Does their programme address young people's working conditions, pay, right to join unions/syndicates, conditions of urban/rural migration?

Education

- What are the organization's policies or views about school attendance, female education, reproductive health and life-skills education in schools?
- Does their programme include activities concerning female schooling, education for marginal groups, the content of national or NGO-sponsored reproductive health and life-skills curricula? Is the content gender-sensitive?

Out of School

- What provision is there for out-of-school activities, particularly to reach children not attending school?
- How are hard-to-reach groups included?

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KEY INFORMATION TO OBTAIN KEY POINTS TO CONSIDER

WHAT ARE THE POLICIES AND PROGRAMMES OF RELEVANT ORGANIZATIONS?

continued

Organizational Level

- Which organizations have strong political power or clout to support their stance on HIV prevention among youths?
- Does the organization have an institutional base and resources for sustainability in the long term?
- Is there a clearly designated "focal point" in charge of social mobilization and communication for HIV/AIDS initiatives focused on youths?
- To what extent do an organization's advocacy, education and behaviour change communication programmes support and complement each other?
- What is the ability of each programme to reach its intended audiences in terms of frequency and cost?
- To what extent do organizations involved in adolescent communication activities ensure consistency of their messages?

? The current strengths and weaknesses of organizations to implement communication programmes at the local and national level

National Level

- Are there integrated plans for communication activities among organizations?
- Are there active committees for planning and managing communication at national or local levels?
- Are there sufficient resources and materials for all communication activities?
- Do organizations have essential technical capabilities?
- Are there sufficiently trained personnel at all levels?
- Is there an active programme to upgrade skills of current communication personnel at all levels?
- Does the national level provide support, guidelines, training, and funding to encourage subnational communication planning and implementation?

Conclusion

After gathering and analysing the information in this chapter, the programme manager should consider the following:

- The gaps in capacity at the organizational level and how UNFPA could address those gaps;
- The weaknesses in national and organizational communication capacity and UNFPA's strengths in this area;
- The gaps between national laws and policies and their implementation in the field.

CHAPTER FIVE:

SELECTING DESIRED COMMUNICATION RESULTS

Communication-based interventions for HIV prevention require that programme planners develop a set of results that they would like to see become reality as a consequence of the programme. Identifying desired results is a delicate selection process and a vital component to the overall effectiveness of any programme that hopes to foster and sustain behaviour change.

This chapter provides checklists for the programme manager to:

- Understand how selecting desired communication results fits into the UNFPA programming process;
- Appreciate how communication in general, and advocacy, behaviour change communication and education each contribute to youth-based HIV prevention;
- Recognize where the communication dimension appears in country programme log frames;
- Begin the process of identifying and segmenting primary and secondary audiences;
- Consider the menu of options that UNFPA/ICPD see as desirable changes;
- Understand how to prioritize among desired communication results and decide which are most important, based on a country's particular situation.

Selecting Communication Results in the UNFPA Programming Process

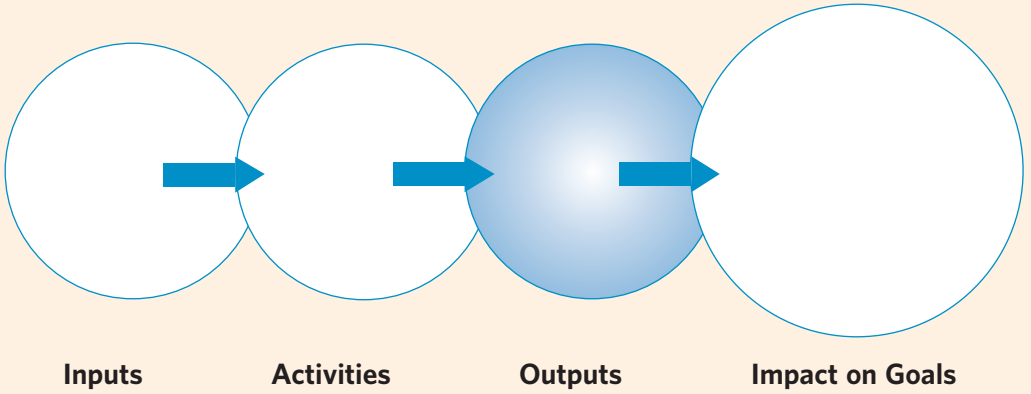
What results do we want to see once the programmes are implemented? What is the situation we want to create as a result of our investment in communication interventions?

Chapters 1-3 of this manual analysed country-specific problems as they relate to HIV and adolescents. They should have prompted answers to the questions of *why* we need to act and *what* is the baseline situation we will be responding to. Later in the programming process, communication strategies will be designed and implemented with partner organizations, answering questions about *how* and *who* will be implementing the interventions.

Prior to a decision on implementation strategies, a strategic vision guided by the results-based approach should establish *who* we are prepared to reach and *what* the programme will achieve. Once an idea about the desired end-state is set, it will act as a catalyst for the remainder of the planning process.

The process is represented in the Chain of Influence diagram below.[18] When using a results-based approach for planning, stakeholders first need to agree on expected impact (or goals and purposes in log frame parlance), based on their analysis of the situation. Then they can decide which outputs will best contribute to achieving such impact. At this crucial stage in the programming process, it is important to have a clear understanding about what communication can or cannot contribute, and then to apply this understanding to our thematic focus on HIV prevention among adolescents, and to what is feasible to achieve during the programme cycle given the country context (see Chapter 1).

FIGURE 3: RESULTS ALONG THE CHAIN OF INFLUENCE



[18] Smutylo, T. May 2001. *Crouching Impact, Hidden Attribution: Overcoming Threats to Learning in Development Programs*. Draft Learning Methodology Paper. Ottawa: International Development Research Centre.

To provide a rationale for selecting communication results, three questions are addressed in this chapter:

- What are the expected pathways that the three modalities of communication (advocacy, behaviour change communication and education) follow towards achieving the programme's goals?
- What are the desired results that the UNFPA/ICPD Plan of Action and other international commitments want to achieve through communication in order to prevent the spread of HIV among adolescents?
- How do you prioritize among these in your country?

A Results-Based Framework

UNFPA uses three interrelated communication modalities to prevent the spread of HIV among youths: advocacy, behaviour change communication and education. When selecting desired communication results, it is helpful to have some perspective about the sequence in which progress is likely to occur.

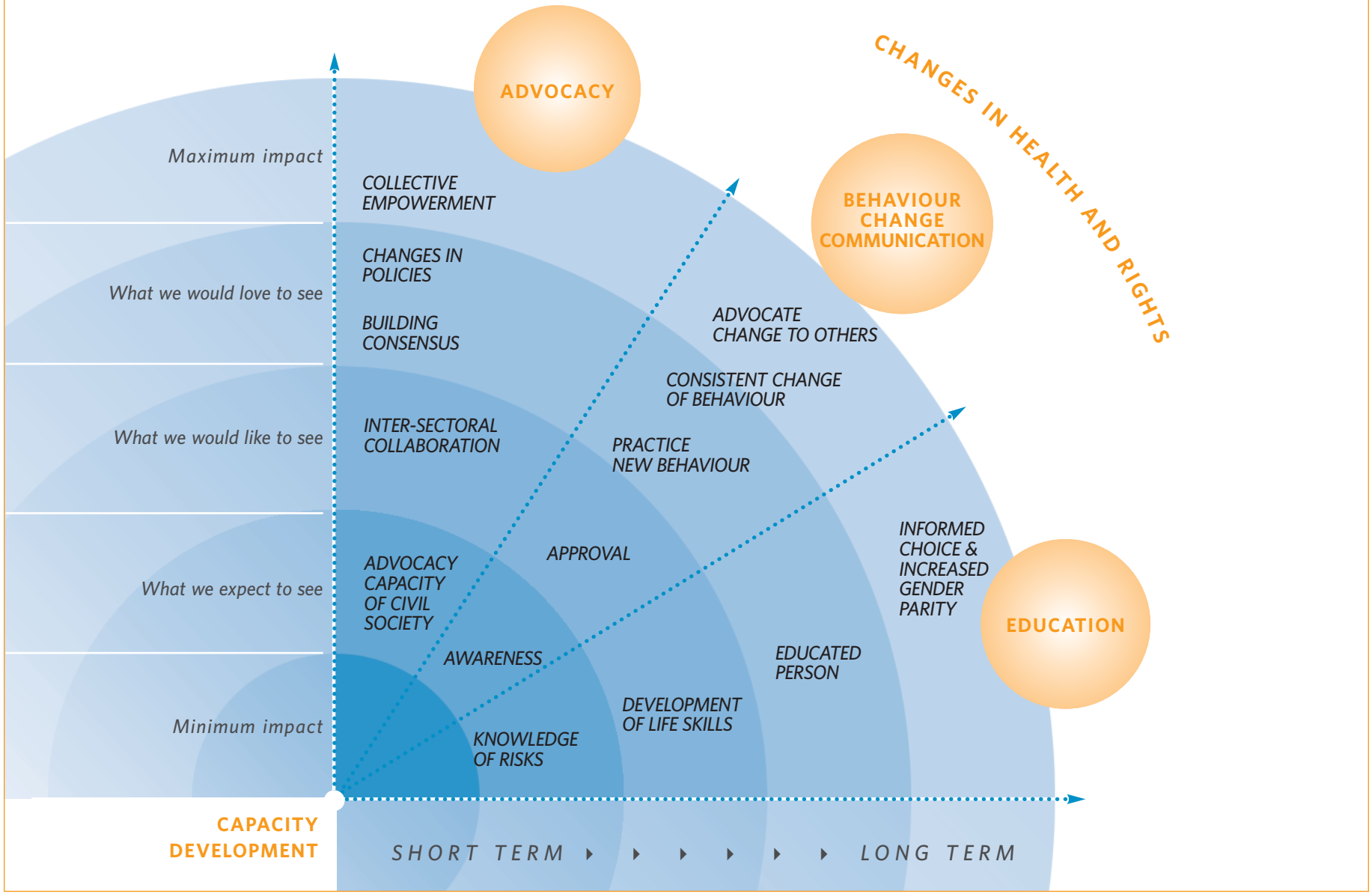
Consider the diagram on the facing page as a conceptual framework for communication programming. The framework illustrates how the three communication modalities simultaneously contribute to programme outputs. It is based on three important dimensions of programme results:

- *Intensity of impact:* from low impact (what we *expect* to see), to medium impact (what we would *like* to see), to high impact (what we would *love* to see) in terms of improvements in health status and rights.
- *Speed of impact:* From short-term to long-term effects.
- *Indirect/direct effect:* From indirect effects on institutional and organizational capacities to direct effects on the capacities of individuals and communities.

The figure also highlights the following points:

- According to behaviour change theories, it is necessary to follow the pathways sequentially, one step at a time, to get closer to the maximum positive changes in health and rights.
- Certain steps require a longer time to achieve.
- The three communication pathways work synergistically to create overall change.
- Advocacy and capacity development need to occur first in order for the other two pathways to achieve their maximum effectiveness.

FIGURE 4: RESULTS-BASED COMMUNICATION FRAMEWORK

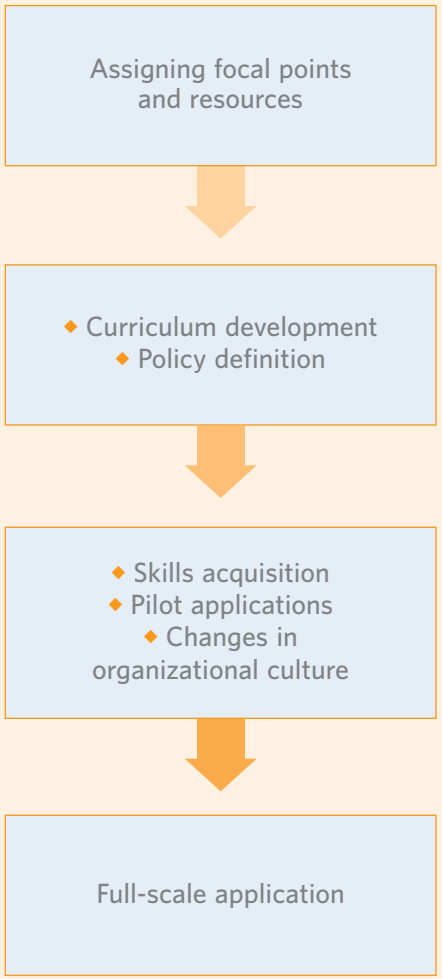


Capacity Development in Communication

One of UNFPA's main roles at the country level is to build capacity at the national, regional, sectoral and district levels. While this is an indirect rather than a direct link to beneficiaries, it is a necessary first step to achieving lasting change.

Capacity development is therefore a valid programme result in and of itself for UNFPA. It is a process that advances the capabilities of an individual or institution to address certain problems using certain methodologies. The following diagram is a model of capacity development that could be applied to the education, health or media/information sectors:

FIGURE 5: MODEL OF CAPACITY DEVELOPMENT PROCESS



Communication in UNFPA's Logical Framework: Making it Visible

Although it is necessary to know how communication works to achieve desired results, communication outputs are often not explicitly stated in country programme results frameworks. Communication is needed, however, whenever there is an expectation of change in behaviours or attitudes (behaviour change communication), policies and social norms (policy or community-based advocacy), or skills (education). The following table is a section of a country programme's logical framework (2001-2005). Next to it are highlighted those communication modalities that seem relevant to achievement of the desired output. Note: It is useful to scrutinize the selected indicators, because they usually reveal the nature of the expected change, whether it is in terms of behaviour, policies, skills or infrastructure.

EXAMPLE OF COUNTRY PROGRAMME RESULTS FRAMEWORK

GOAL OF COUNTRY PROGRAMME: To contribute to the national development objectives of poverty reduction and sustainable improvement in living standards		
COUNTRY PROGRAMME'S HIV-RELATED OUTCOME: To contribute to the reduction of HIV/AIDS and incidence of sexually transmitted infections among 15-24 year olds from x to y, by 2005.		Main underlying dimension of change here is: *behavioural*, to reduce prevalence
OUTPUTS	**OUTPUT INDICATORS**	**COMMUNICATION MODALITY**
OUTPUT 1: Increase in percentage of sexually active adolescents who have access to condoms	a) Increase proportion of youth aware of sources of condoms (from x to y per cent) b) Increase number of outlets providing condoms to youths (from x to y per cent)	a) Behaviour change communication (youth) b) Behaviour change communication (service providers)
OUTPUT 2: Creation of a supportive policy and legal environment for adolescent reproductive health information and provision of services at the national level	c) Increase frequency of positive media coverage of adolescent reproductive health issues (including HIV, sexually transmitted infections, teenage pregnancies, substance abuse, gender-based violence and sexual abuse, from x to y per cent) d) Adoption and implementation of youth-friendly policies regarding reproductive health	c) Advocacy (media) d) Advocacy (policy dialogue)

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EXAMPLE OF COUNTRY PROGRAMME RESULTS FRAMEWORK

OUTPUTS	OUTPUT INDICATORS	COMMUNICATION MODALITY
OUTPUT 3: Creation of political support at the community level for the provision of reproductive health information and services to youths	Increase percentage of leaders speaking out favourably on adolescent reproductive health (from x to y per cent): e) to parents and communities f) to members of government	 e) Advocacy (consensus building) f) Advocacy (policy dialogue)
OUTPUT 4: In selected regions, a majority of health facilities with skilled service providers offer youth-friendly counselling services	g) Increase percentage of health facilities providing youth-friendly services (from x to y per cent) h) Increase percentage of health providers offering youth-friendly counselling and services i) Increase percentage of youth satisfied with services (from x to y per cent)	g) Advocacy (policy dialogue) h) Behaviour change communication (providers) i) Behaviour change communication (youth)
OUTPUT 5: Prioritization of HIV prevention among adolescents at the regional level and the development of regional HIV plans and other development frameworks at the regional level	j) Number of multisectoral coordination mechanisms set up at the regional level k) Increase in resources mobilized from multisectoral coordination at the regional level	j) Advocacy (intersectoral collaboration and networking) k) Advocacy (fund-raising)

Who Needs to Change?

Effective communication programmes develop strategies based on current, research-based characteristics of a target audience. The decision about *primary and secondary* audiences needs to be based on evidence that changing their behaviour will make a difference in achieving our objectives. Bringing focus to a set of priority audiences will also facilitate strategy design. The following table outlines some steps to be taken in selecting audience segments and provides questions that can assist in the section process.

AUDIENCE DEFINITION AND SEGMENTATION

DECIDE ON THE PRIMARY AUDIENCE. *It is safe to assume that the primary audience will be high-risk adolescents, but the focus or sub-populations might change depending on the country or the primary communication channel that is selected.*

- Who is the programme trying to reach?
- Whose behaviour is the programme trying to change?
- Which group exhibits behaviour that places them and others at risk?
- Which groups of people are most important to reach in order for the behaviour to change?

Primary audience examples:

- 15-24 year old boys and girls
- 15-19 year old in-school youth
- 10-14 year old poor urban children
- 15-19 year old poor rural women

DECIDE ON THE SECONDARY AUDIENCE(S)

- Who are the people or groups that have influence on the behaviour of adolescents or can exert positive influence?
- Who are the allies and opponents in promoting adolescent behaviour change?
- What individuals or groups can help bring about necessary policy changes?
- What are the secondary audience's own knowledge, attitude and value "gaps" about the problem?

Secondary audience examples:

- Parents of 10-14 year old youth
- Community leaders and decision makers
- Teachers, health providers and programme managers
- High-level government officials
- Leaders of faith-based organizations

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AUDIENCE DEFINITION AND SEGMENTATION *continued*

SEGMENT THE AUDIENCES

- What are important demographic characteristics that characterize the primary and secondary audiences and that may be related to the targeted behaviour change?
- What characteristics beyond demographics are important in determining what kind of information the audience will need in order to change?
- What are behaviours that can realistically be expected to change and to what extent are they exhibited by these groups?
- Where along the continuum of behaviour change are the audience groups located?

Audience segmentation examples:

- 15-19 year old unmarried, sexually active urban females
- Reproductive health service providers at the primary health care level in region x who lack gender sensitive counselling skills for pre- and post- voluntary counselling and testing

CONSIDER NINE CRITERIA FOR SELECTING AUDIENCE SEGMENTS [19]

- **Segment size.** Are there enough people in a segment to comprise a useful market?
- **Problem incidence.** Are there higher rates of the problem or risky behaviours in some audience segments?
- **Problem severity.** Are the consequences of the problem more severe in some audience segments?
- **Defencelessness.** Are members of the audience segment able to take care of the problem themselves, or do they need outside help?
- **Accessibility.** Are some audience segments harder to reach because they are difficult to find or require costlier methods?
- **General responsiveness.** Are some audience segments more ready, willing and able to respond to the social marketing programme than others?
- **Incremental costs.** How much more will it cost in money and effort to reach additional audience segments? Is it worth it?
- **Responsiveness to marketing mix.** Will some audience segments respond differently to particular marketing mixes and require different strategies?
- **Organizational capability.** Does your organization have the expertise to create and deliver differentiated strategies?

[19] As described in: Weinreich, N.K. 1999. *Hands-on Social Marketing, A Step-by-Step Guide.* Thousand Oaks, CA: Sage Publications.

Desired Outputs

There are many desirable outputs that will contribute to the overall goal of behaviour change for a reduction in HIV among adolescents. The following tables present a comprehensive list of desirable results based upon the ICPD goals and other international agreements (United Nations General Assembly Special Session, etc.). From this menu, the country stakeholders should select which ones are appropriate for a given situation to reach the desired HIV prevention outcome.

EXPECTED ADVOCACY RESULTS

STRONGER POLITICAL COMMITMENT

Political and community leaders acknowledge HIV situation among adolescents

- Officially acknowledge the HIV situation among adolescents as well as the unique situation of adolescent sexuality among both married and unmarried youths
- Recognize and address root causes and high-risk situations of HIV transmission among youths: poverty and conflicts, early marriage, high fertility, commercial sex involving youths, gender-based violence, migration, military posting, multiple concurrent partners, and same-sex behaviours
- Continuously collect gender-based data (both qualitative and quantitative) on national characteristics of HIV infection among adolescents and share data and analysis
- Stimulate debate on HIV issues among adolescents

INSTITUTIONAL REFORMS AND CAPACITY DEVELOPMENT

Government establishes coordinated and comprehensive national mechanisms

- Consult with communities, young people and special groups to carry out needs assessments and policy decisions
- Prioritize prevention among youths through a rights-based approach
- Promote role of civil society organizations in programming for prevention

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EXPECTED ADVOCACY RESULTS

INSTITUTIONAL REFORMS AND CAPACITY DEVELOPMENT *continued*

Development institutions and donors

- Promote a participatory programming process that includes inputs from youths
- Make the programming process easier for young stakeholders to participate in and to express their opinions
- Recognize and address gender roles in the programming process: use disaggregated data, recognize power balances, ensure participation of women

NATIONAL POLICIES FOR HIV PREVENTION THAT REDUCE VULNERABILITY OF ADOLESCENTS

- Ensure adolescent access to accurate information on personal reproductive health and freedom to share information
- Ensure access to reproductive health services, such as treatment of sexually transmitted infections: persuade government to remove or mitigate barriers to accessing counselling, treatment and condoms in health and youth institutions and in the workplace
- Remove laws requiring a husband's (or parent's) consent for a young unmarried or married woman to obtain condoms or reproductive health services
- Raise legal age of marriage for females and minimum age of consent for sexual relations
- Provide HIV/AIDS counselling sessions and voluntary testing before marriage [20]
- Ensure freedom from sexual exploitation for girls and boys
- Institute laws against gender-based violence, including rape

NATIONAL POLICIES PROTECTING THE RIGHTS OF ADOLESCENTS LIVING WITH HIV

- The right to voluntary counselling and testing and to know one's HIV status
- Right to confidentiality and privacy concerning their health and HIV status

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[20] In the Russian Federation, the youth centre's counselling room, (managed by the deputy mayor and located next to the city's marriage registration office) became a mandatory stopping point for all couples about to be married.

EXPECTED ADVOCACY RESULTS

NATIONAL POLICIES PROTECTING THE RIGHTS OF ADOLESCENTS LIVING WITH HIV *continued*

- Anonymous notification of HIV status, even for surveillance purposes
- Remove requirement of partner/spouse notification if there is a security risk
- Criminalize the practice of knowingly infecting a partner with HIV/AIDS [21]
- Right of young, HIV-positive pregnant women [22] to pre- and post- HIV test counselling and medical care
- Right to terminate pregnancy on grounds of HIV infection and women's health risks
- Outlaw segregation, isolation or quarantine of people living with AIDS in prisons, schools, hospitals and elsewhere
- Promote rights of people living with AIDS to assure their autonomy, the security of their person (including right to land and property) and their freedom of association to the same level as that of the general population
- Eliminate discrimination against people living with AIDS in all sectors, specifically in the informal sector, which is mostly comprised of women

NATIONAL POLICIES THAT PROMOTE A HEALTH SYSTEM THAT MEETS ADOLESCENT NEEDS

- Focus on and acknowledge youth-friendly counselling and voluntary counselling and testing; provide timely feedback of test results
- Promote condom distribution to unmarried and married adolescents for dual protection
- Train health staff on adolescent-specific reproductive health needs, including mother-to-child transmission
- Promote change in health-facility accessibility, such as clinic hours, making it easier for young couples to come together or for young men to come alone
- Support services for young people living with HIV/AIDS, particularly involving medical care
- Promote involvement of young pregnant women's partners in reproductive health and prenatal care and advice on care for babies born to HIV-positive mothers, including infant feeding practices
- Provide the necessary facilities and services to assist vulnerable youth groups, including sex workers and out-of-school youth, in seeking regular and frequent voluntary counselling and testing for HIV/AIDS and sexually transmitted infections
- Guarantee that disability laws include HIV/AIDS

21 The critical imperative is that accurate and effective counselling and information needs to be in place before any laws or judgments on partner notification are outlined and enforced.

22 When a women has advanced HIV, pregnancy carries the risk of hastening her own progression to full AIDS. For more information on mother-to-child transmission, see UNFPA Technical Staff Manual on HIV Prevention: "Module 3: Preventing HIV Infection Among Pregnant Women," Thailand, July 2002.

EXPECTED ADVOCACY RESULTS

POSITIVE CHANGES IN NORMS OF GATEKEEPERS (RELIGIOUS LEADERS, THE MEDIA, ELDERS AND PARENTS)

Adapting social and collective norms

- Promote portrayals of gender equitable couples and gender equality, condemnation of violence against women and unsafe male role models in the media, in schoolbooks, literacy curricula, as well as in popular culture such as songs, theatre, etc.
- Promote change in community attitudes: from acceptance to condemnation of violence against women
- Promote sustained communication between gatekeepers and youth on reproductive sexual health issues
- Change social expectations linked to early marriage and high fertility, wife's submission to husband, and immediate and frequent childbearing following marriage
- Advocate against sexual coercion of married and unmarried female adolescents

EXPECTED RESULTS THROUGH BEHAVIOUR CHANGE COMMUNICATION

AMONG ADOLESCENTS

- Seek and find relevant information about adolescent reproductive health on topics such as sexual anatomy, puberty, pregnancy, sexually transmitted infections, HIV/AIDS, local prevalence rate, etc.
- Use adolescent reproductive health information to recognize signs of sexually transmitted infections and rapidly seek care to treat such infections
- Use adolescent reproductive health information to access quality services, including voluntary counselling and testing
- Acknowledge social and cultural norms and traditional gender roles and recognize their contribution to risky sexual behaviour and gender inequality
- Use negotiation, refusal and assertion skills to refuse or delay sexual intercourse and/or negotiate use of male and female condoms, including within marriage
- Demonstrate the ability to understand other's needs, show care and respect for people living with or affected by HIV/AIDS, and/or understand and respect a sexual partner’s choice
- Use cooperation and teamwork to increase capacity to maintain involvement in HIV prevention activities among peers

EXPECTED RESULTS THROUGH BEHAVIOUR CHANGE COMMUNICATION

AMONG YOUNG MEN OR OLDER PARTNERS

- Demonstrate the ability to understand other's needs, show care and respect for people living with or affected by HIV/AIDS, and/or understand and respect a sexual partner's choice
- Use cooperation and teamwork to increase capacity to maintain involvement in HIV prevention activities among peers
- Reflect on masculine stereotypes involving risk-taking and power relations, and male vulnerabilities to disease
- Discuss reproductive health issues and gender roles with peers, elders and partner
- Use adolescent reproductive health information to better understand women's reproductive health needs
- Adopt positive role in sexual relationships and fatherhood

AMONG HEALTH AND EDUCATION PROVIDERS

- Desired behaviours among health agents, teachers or social workers include a sustained client-based perspective on adolescent reproductive health needs
- Adopt supportive and non-judgmental attitude towards adolescents' reproductive health needs and practices
- Recognize and address gender roles: motivate men to share reproductive health decision-making, provide equitable counselling to both men and women
- Provide non-judgmental and anonymous services to treat sexually transmitted infections among young women

AMONG PROGRAMME MANAGERS

- Desired behaviours among programme managers include a sustained, client-based practice of programming
- Adopt supportive and non-judgmental attitude towards adolescent reproductive health needs and practices
- Promote participatory analysis, feedback and input into the programming process among youth, stakeholders and health agents
- Recognize and address gender roles in the programming process: use disaggregated data, recognize power balances, motivate women to participate

EXPECTED RESULTS IN EDUCATION

POLICIES THAT ENCOURAGE HIV PREVENTION AMONG ADOLESCENTS

- Incorporate or update training of health, school, professional and non-formal education agents on adolescents' specific reproductive health issues
- Ensure safe and healthy school environment: address issues of sexual harassment, abuse of students and violence in school settings
- Incorporate life-skills education, focusing on development of knowledge, attitudes, values and life skills within official school curricula or in other non-formal, extracurricular settings
- Increase access for in- and out-of-school adolescents to socially and culturally relevant life-skills education in formal and non-formal education settings
- Implement life skills as part of a comprehensive school health programme, one that is complementary to other HIV prevention strategies such as policy development, peer education and health services
- Link school education and administration to youth-friendly reproductive health services
- Promote peer education and other interventions in school settings
- Ensure a lively debate on adolescent sexuality issues
- Guarantee access to education for pregnant girls and young mothers

ENHANCED INSTITUTIONAL CAPACITY

- Address institutional capacity of education sector to provide quality education for all, especially girls
- Ensure that the HIV situation among the teaching force is addressed and provides high quality prevention and care services
- Promote effective partnerships between teachers and health providers and also in the health and education sectors
- Train teaching force to a minimum level on reproductive health topics to improve their ability to impart necessary prevention information to students
- Create a pool of leaders, managers and service delivery personnel with expertise and experience
- Increase collaborative ability of partnering organizations
- Create a long-term financial and management strategy
- Create a healthy and safe environment for students and teachers by addressing peer pressures and social norms that contribute to HIV transmission and gender discrimination

EXPECTED RESULTS IN EDUCATION

ENHANCED LEARNING AMONG ADOLESCENTS

- Increase knowledge, attitudes and skills among adolescents in school and other locations to help them avoid the disease
- Ensure that content of education and prevention programmes is relevant to behavioural outcomes
- Address the local factors that affect an individual's ability to change their behaviour
- Ensure that programmes are appropriate for age and developmental level and are sequenced in a logical and appropriate manner
- Increase the total number of adolescents who are aware of HIV prevention might appear to be overblown, but that every year there are new youths that enter the school system who may not have been exposed to facts about HIV
- Ensure that teachers and students are equipped with the skills needed to successfully avoid high-risk situations for contracting HIV
- Increase the level of community awareness of the rights and situations of adolescents with respect to reproductive health and HIV

Selecting Realistic Results

There are many competing factors that need to be taken into account when selecting which communication results will be prioritized as programme outcomes. As demonstrated in the previous tables, there are many possible beneficial results that will contribute towards achieving our goal and it will not be possible to expect to reach them all.

The six categories presented below provide a simple and effective criteria framework to assist in an appropriate selection of outputs and results.[23]

FACTORS TO CONSIDER WHEN SELECTING RESULTS

EVIDENCE OF EFFECTIVENESS Do qualitative or quantitative data exist to show that achieving the communication results will improve the identified problem or contribute to the overall goal?	? What data is available about best practices and the link between specific desired results, process and impact? ? What data or monitoring and evaluation results does the country or UNFPA have to demonstrate the previous effectiveness of in achieving similar desired outcomes? ? Will the desired result have an impact on a large proportion of the target population? ? If data is unavailable, consider desired results that collect relevant data
Feasibility Is the desired result feasible, achievable and likely to succeed?	? Assess the opposition (see next item) ? Has the UNFPA had experience in achieving similar results? ? Is the country environment ripe for these particular results?

23 Table adapted from Sprechmann and Pelton, 2001, and World Bank.

FACTORS TO CONSIDER WHEN SELECTING RESULTS

Clarity Does the output have a clear and realistic time frame and is it easy to understand?	? Behaviour change is a long-term process. Are the desired results manageable in a reasonable time frame? ? Will you be able to show results from the outputs you selected in a reasonable amount of time? ? Clear and concise desired results are understandable by everyone and will allow for good advocacy, strong partnerships and sound evaluation
Risks What is the risk of selecting the output?	? What are the prospects for opposition in achieving the desired result? ? Does the desired result address controversial topics? ? Ensure that the desired result will not overwhelm an organization and partners ? Ensure that the desired result is feasible to achieve with given capacities; if capacities limit output selection, consider output that will improve capacity
Partnerships Are the necessary alliances in place with key people/organizations to ensure that the output will be achieved, or will the output allow the creation of new alliances?	? UNFPA does not operate in isolation; it is important to take advantage of established partnerships and to create opportunities for new ones ? Are there a significant number of interested and committed partners that can be mobilized to address the issue?

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FACTORS TO CONSIDER WHEN SELECTING RESULTS

Partnerships *continued*	? Have the prospects for NGO, private sector and community participation and collaboration been fully explored?
Comparative Advantage What is the potential for UNFPA to advocate and operate effectively?	? Is the issue within UNFPA's mandate and ICPD principles? ? What does UNFPA usually do in these areas and what are UNFPA's strengths and weaknesses? ? What are UNFPA's other commitments? Would you be more effective if there were a limited number of policy options? ? Are the issues being addressed through other UNFPA projects or activities? ? Is UNFPA the best advocate on this issue at this time?

Conclusion

It is the job of the programme manager to be creative and strategic in developing a vision of what integrated communication interventions should achieve. This vision is instrumental in the planning process since it guides the selection of appropriate strategies. This chapter has provided many ideas about desirable advocacy, behaviour change communication and education results to create a situation favourable to preventing HIV among adolescents.

CHAPTER SIX:

SELECTING COMMUNICATION STRATEGIES

The communication strategy necessitates the selection of primary and secondary audiences so that messages and approaches can be tailored to their specific characteristics. There are several effective methods to choose from in doing this. The task at the national level is to select which options are appropriate for the objectives and audiences selected and with the capacity currently available.

This chapter will provide checklists for programme managers to:

- Review the communication options available to address the HIV situation among adolescents;
- Assess the benefits and lessons learned about the most commonly employed HIV prevention tactics;
- Review additional considerations influencing strategy design, such as audience media habits and media channel selection.

This chapter will not provide in-depth information explaining how to apply all the existing methodologies. However, such information is available in other publications and web sites.

What are the Options for Reaching Young People?

There is a wide range of intervention options that can be effective in adolescent HIV prevention; designing a communication strategy means selecting the best option for a specific country or specific group. When deciding which communication strategies and methods will

reach target audiences, it may be helpful to consider the best practices of each of the methods and what factors contribute to effective programmes.

The following table[24] lists commonly used options for adolescent HIV prevention, indicates their benefits and the lessons learned about key elements of effective programmes.

COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

	POSITIVE ASPECTS / POTENTIAL OUTCOMES	KEY PROGRAMME ELEMENTS: LESSONS LEARNED
PEER PROGRAMMES	■ Peers share a social and cultural identity and therefore act as credible information sources to each other ■ Involvement and participation of young people ■ Able to reach marginal groups who don't have access to formal institutions ■ Flexible approach—use in many different settings ■ Peers often identified as major source of reproductive health information ■ High chance of cultural relevance and acceptance ■ Peers shown to have positive behaviour change	● Comprehensive theory-based training and motivation necessary ● Involve adults and community as well as young people ● Utilize/strengthen existing youth networks ● Promote social norms supportive of positive behaviour change ● Use in combination with other strategies ● Requires access to up-to-date information and referrals, and sometimes contraceptives ● Shown to be effective when programme has narrow focus on reducing sexual risk-taking behaviours or combined behaviour and knowledge outcomes ● Emphasis on skills building: avoiding risk situations, negotiating limits or safe sex, resisting peer pressure, empathy and support for people living with or affected by HIV/AIDS

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[24] The following sources were instrumental in developing this table: FOCUS on Young Adults. 2001. *Advancing Young Adult Reproductive Health*. End of Program Report. Watertown, Massachusetts: Pathfinder International; Kiragu, K. 2001. *Youth and HIV/AIDS: Can We Avoid Catastrophe?* Population Reports, Series L, No. 12. Baltimore, MD: Johns Hopkins University Bloomberg School of Public Health, Population Information Program; Save the Children. 2000. *Monitoring and Evaluating HIV/AIDS Programmes for Young People*. United Kingdom: Save the Children; Norman, Jane, Advocates for Youth, Personal communication, September 2002.

COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES

KEY PROGRAMME ELEMENTS: LESSONS LEARNED

PEER PROGRAMMES *continued*

- Commonly accepted method but data on effect on younger youth (aged 10-14) are lacking
- High peer turnover: plan on new and refresher trainings
- Can be costly in terms of training, logistics and supervision

YOUTH CENTRES

- Provides a supportive, safe and desirable environment with access to reproductive health services, counselling and information
- Able to address individual risk factors and issues
- Can be useful in promoting other positive health behaviours (avoidance of alcohol and tobacco)
- Offering reproductive health services and information in non-clinical settings may attract youth who otherwise would avoid a health facility
- An apt setting for peer educators

- Provide reproductive health services in addition to other attractive youth activities
- Maintaining emphasis on reproductive health activities cited as a successful element
- Evaluations have largely demonstrated that youth centres are not a cost-effective option; this has resulted in tendency to promote community efforts that reach out to youths instead of programmes that attract them to a youth centre
- Programmes found to be more effective for young men than for young women

LIFE-SKILLS EDUCATION

- Facilitates not only transmission of knowledge but aims at shaping attitudes and developing interpersonal skills
- Teaching methods are youth-centred, gender-sensitive, interactive and participatory

- Essential to address peer norms that encourage risky behaviour
- Youth need to acquire ability to refuse sex and negotiate with partners

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COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES	KEY PROGRAMME ELEMENTS: LESSONS LEARNED
LIFE-SKILLS EDUCATION *continued* ■ Been show to be effective in delaying onset of sexual intercourse, increasing use of condoms and decreasing number of sexual partners ■ Generally beneficial to the life of the youth, not just for positive reproductive health	● Focus on specific behaviours ● Use theoretical underpinnings ● Use clear messages about risks and methods to avoid the risks ● Use a variety of teaching methods that are participatory and creative ● Make sure it is age appropriate ● Gain commitment from community and gatekeepers
SCHOOL-BASED EDUCATION PROGRAMMES ■ Can reach an already established population in an educational environment ■ Improvement can be made in the level of knowledge and attitude about HIV/AIDS ■ Short-term impact on behaviours ■ Can also affect parents, teacher, and community members' knowledge and attitudes about HIV	● Should start before young people become sexually active and be sustained throughout adolescence ● Can't assume teachers are good sexual health educators ● Coordinate school-community partnerships: participation of teachers and community leaders vital due to sensitive nature of topic ● Consider a variety of methods aside from formal classroom style ● Implement skills-based health education
MASS MEDIA/ENTERTAINMENT-EDUCATION ■ Shown to have wide acceptance among many audiences ■ Reaches large audiences. Media is more and more an everyday part of life for youths	● Target audience baseline information and needs assessment ● Careful formative research

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COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES	KEY PROGRAMME ELEMENTS: LESSONS LEARNED
MASS MEDIA/ENTERTAINMENT-EDUCATION ■ Very cost-effective ■ Entertainment-education thought to be especially effective ■ Can use a variety of media, such as traditional theatre and dance, radio and TV	*continued* ● Quality production ● Rigorous dissemination plan ● Audience segmentation: use of theory ● Needs to take into account audience characteristics, organizational factors, media environment, infrastructural factors ● Institutional partnerships: link with school programmes and services ● Effective communication programmes use both mass media and interpersonal methods (such as counselling and peer education)
YOUTH PARTICIPATION AS REPRESENTATIVES, LEADERS OR GOODWILL AMBASSADORS ■ Youth gain skills and access to opportunities ■ Youth feel and are seen as valued ■ Develops more effective and relevant programming ■ Programming becomes more attuned and responsive to youth ■ Youths become advocates for reproductive health and HIV issues in their peer groups and communities	● Be selective about youth and adults who participate ● Be prepared to offer support to young people in the form of financial assistance, transportation, training, etc. Provide capacity-building and training for both youths and adults ● Share decision-making power ● Get acceptance from high levels of organization ● Youth more likely to thrive when programme leaders are committed ● Involvement can be difficult: high turnover, legal barriers, time-consuming ● Be open and non-judgemental about young people's insights and suggestions. It may take time and effort to get young people to participate fully. Work to make teens feel comfortable

COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES	KEY PROGRAMME ELEMENTS: LESSONS LEARNED
CONDOM PROMOTION THROUGH SOCIAL MARKETING ■ Better condom access can increase use ■ Access can increase through using formal distribution networks and subsidized prices ■ Social marketing of condoms increases both demand and supply, makes condoms better known, affordable and widely available in preferred outlets ■ Social marketing is a valuable component in the overall behaviour change process that will allow youths to choose safer sexual behaviours ■ Can promote dual protection, against sexually transmitted infections and pregnancy ■ Can reduce personal barriers to condom use, such as shyness about purchasing condoms or reluctance to discuss condom use with partners	● Important to impart knowledge and skills of correct condom use ● Address barriers and promote benefits to adolescent condom access ● Take advantage of existing distribution and promotion systems ● Audiences are segmented and messages developed based on market research
VOLUNTARY COUNSELLING AND TESTING FOR YOUTH ■ There are few places where current programmes provide counselling and testing tailored to the special needs of young people ■ Can lead to timely care, improve the medical management of HIV-related diseases, and provide opportunity to reduce mother-to-child transmission ■ Early treatment reduces viral load and thus reduces likelihood of transmission ■ Evidence suggests that people change their behaviour once notified of their HIV-positive status; however, supportive and repeated counselling is needed	● Confidentiality is essential ● Youth-oriented promotion of services ● Youth-friendly counselling and strong referral networks to other health and psychosocial support services ● Non-judgemental health-care providers ● Access to particularly vulnerable populations, such as out-of-school youths and street children

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COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES

KEY PROGRAMME ELEMENTS: LESSONS LEARNED

VOLUNTARY COUNSELLING AND TESTING FOR YOUTH

- Testing can provide motivation for HIV-negative people to avoid infection

continued

- Barriers include lack of information, low perception of risk, laws or social environment preventing adolescent testing

MEDIA ADVOCACY

- Media is often considered credible information source by leaders and decision makers
- Can improve credibility of issues or organizations
- Delivers information to a large number of people
- Powerful tool to create broad support for advocacy issues

- Need to build and maintain strong relationships with the media
- Learn media habits of audiences
- Involve people from intended audience in designing media content
- Reach gatekeepers of youth

SOCIAL MOBILIZATION OF YOUTH BY YOUTH

- Increase capacity of youth and youth organizations to advocate for themselves and organize self-directed initiatives
- Youth ownership of programmes and intervention efforts
- Specific to community needs and situation, therefore relevant and effective
- Engage already organized youth groups and reach large numbers of people
- Transfer of management and implementation skills increases sustainability, capacity and is protective for those who are involved
- Effective way to increase peer awareness and generate public support for programme or issue

- Prevention efforts will be most effective if they involve diverse players, including adolescents, parents and other family members, service providers, religious organizations, the media, businesses and policy makers

COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES

KEY PROGRAMME ELEMENTS: LESSONS LEARNED

HOTLINES AND NEW INFORMATION & COMMUNICATION TECHNOLOGIES

- Offer easy access, anonymity and confidentiality in a non-threatening and non-judgmental environment
- Can focus on a variety of health topics
- Can reach a large number of clients at low cost
- Potential for 24-hour service, enhancing accessibility

- Selection and training of hotline counsellors is a crucial factor in programme operation; strong, professional and unbiased communication skills are a must
- Develop and utilize standardized protocols and information kits to ensure accurate and effective information dissemination
- Confidentiality for callers is key
- Hotline marketing is vital for success
- Collaborating with other organizations will improve effectiveness and reduce costs
- Need up-to-date referral information

SAFE SPACES FOR GIRLS

- Safe and supportive home, school and community environments greatly increase ability of young girls to protect themselves against HIV/AIDS
- Can develop new and valued life and livelihood skills [25]
- Form friendships and peer support networks
- Enjoy freedom and expression of movement

- Parents, schools and community leaders need to be equipped with knowledge and skills to create an environment where girls are safe from harm and cared for equally
- Communities and advocates need to condemn sexual violence, abuse, exploitation

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[25] Brady, M. 2002. "A Place of Her Own: Safe Spaces for Girls." Ch. 7 in: *Charting Directions for a Second Generation of Programming*. Background Document Prepared by the Population Council for the UNFPA Workshop on Adolescent and Youth Sexual and Reproductive Health, New York, 1-3 May 2002.

COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES	KEY PROGRAMME ELEMENTS: LESSONS LEARNED
SAFE SPACES FOR GIRLS *continued* ■ Receive mentoring support from trusted adults who can also serve as advocates ■ Capitalize on new learning opportunities	● Governments need to enact laws that protect young women from all forms of sexual violence, both in and out of marriage, and impose criminal penalties on abusers ● Need to ensure equal access to public space in a non-threatening way for women ● Ensure participation of girls ● Protect girls' safety, reputations and marriageability ● Offer trusted role models and teachers ● Involve boys and encourage them to become more respectful
EMPLOYMENT-BASED PROGRAMMES ■ Many young people can be found in employment settings, so it is a good way to reach young people where they are ■ Good strategy for out-of-school and hard-to-reach youths ■ A comfortable and familiar environment; form a ready audience and may be more receptive to new information ■ Convenient, cost-effective way to reach those who seldom visit clinics ■ Effective results have been found showing improvements in respondents' understanding of risk-reduction and importance of communicating with partners about HIV/AIDS and safer sex	● Many workplaces have some health services so can integrate adolescent reproductive health and HIV-prevention activities ● Integrate life skills into job training ● Consider the full range of formal and non-formal work settings, including the military ● Informal settings particularly important way to reach out-of-school and hard-to-reach populations, including controversial high-risk workplaces, such as sex-work establishments

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COMMONLY USED OPTIONS FOR ADOLESCENT HIV PREVENTION

POSITIVE ASPECTS / POTENTIAL OUTCOMES	KEY PROGRAMME ELEMENTS: LESSONS LEARNED
EMPLOYMENT-BASED PROGRAMMES *continued* ■ Prime opportunity to reach adults with information about adolescent health needs and issues	● Positive and negative aspects of adolescent work experiences need to be explored ● Need to develop relationships between health sector and private sector to gain access to the workplace, including advocating for the importance of youth programmes
INVOLVING PARENTS AND OTHER ADULT GATEKEEPERS ■ Young people seek and thrive from information from trusted adult role models ■ Adults can and do contribute to a supportive and healthy environment for young people ■ Adult support of adolescent reproductive health efforts will greatly enhance the prospects for successful programming	● Positive relationships between youth and adults provide safety not only from HIV and other sexually transmitted infections, but in other areas of life ● Youth learn from and respect adults, especially parents, so adults should set positive examples by practicing safe behaviours ● Adult attitudes about intervention programmes will influence the involvement of youth. It is important to gain participation and perspective from adults in order to be effective for youth ● In addition to situations where adults are integral, programmes need to recognize and address situations where adults fail to provide for the needs of young people or violate their rights

How to Decide on a Communication Strategy

The strategy operates by matching specific audiences with relevant approaches, messages and appropriate communication channels. After selecting key audiences and communication options, the next step is to select the mix of communication channels based upon audience profiles. The following table lists some of the considerations about channel selection and other factors influencing the strategy design process.

COMMUNICATION FACTORS TO CONSIDER

AUDIENCE MEDIA HABITS AND INFORMATION SOURCES ■ What are the main media channels that adolescents and other audiences are exposed to? ■ What do adolescents consider the most credible sources of information on health and sexuality issues and how does this differ for different adolescent groups? ■ What types of media and interpersonal channels do the audiences use to seek reproductive health-related information? ■ What media do audiences enjoy the most and find the most credible? ■ How is reproductive health information traditionally learned by youth?	Media and information source examples: ● Radio ● TV ● Print: newspaper, pamphlets ● Friends ● Parents, older relatives ● Religious leaders ● Siblings ● Traditional song, dance or theatre ● Health services ● Schools ● Workplace
REACHING SPECIAL POPULATIONS Acknowledge and address the unique risk situations of adolescents outside mainstream systems (orphans, street youth, sex workers, etc.)	● Consider what they perceive as important health concerns ● Reach with information and services while also addressing root causes of vulnerability ● Provide or link to a comprehensive array of services on urgent social needs

COMMUNICATION FACTORS TO CONSIDER

MULTI-CHANNEL APPROACH & SELECTION Analyse available channels	■ What media channels are available and appropriate to use? ■ What channels will lead to meeting objectives and desired behaviour change? ■ What is the cost-effectiveness of each channel—the degree to which they will reach the target audiences per unit cost? ■ Can the channel provide the frequency and reach that is necessary?
Channel selection criteria	■ Consider the channels that target audiences already use and have access to ■ Use channels that the audiences like ■ Use channels that are credible sources ■ Use channels that mesh with the message content ■ Use channels that provide the frequency that messages need ■ Consider broadcasting costs
Assess current capacity of various communication channels	■ Is there a stable infrastructure that can be relied upon to implement communication efforts? ■ Is there adequate funding to be able to meet goals? ■ Is there an adequate budget within the ministry of health and/or education to be able to meet the goals of the national HIV-prevention effort directed to adolescents? ■ Are there enough trained staff to meet objectives and goals?

COMMUNICATION FACTORS TO CONSIDER

COORDINATION WITH SERVICES Communication efforts need to be coordinated with relevant services. Assess the status of current health services related to HIV and adolescents	■ What health facilities are available that can offer the services necessary for behaviour change? ■ What health facilities do people use? ■ Are providers trained in interpersonal communication skills specific to adolescents that will increase their use of these services? ■ How will supplies in reproductive health commodities such as condoms, testing kits and antibiotics for sexually transmitted diseases be increased to meet the increase in demand?

FINAL POINTS OF CONSIDERATION

- Try to meet the wide-ranging needs and concerns of adolescents and communities, while focusing on the particular agenda of HIV-prevention among adolescents.
- Pinpoint specific vulnerable groups with respect to age, marital status, gender, sexual activity and access to social and economic power, and design appropriate strategies with their participation.
- Bring together multiple stakeholders from multiple sectors and involve them in defining, assessing and creating support for HIV-prevention activities among youths. Participatory methods provide many benefits but are challenging and difficult in practice.
- Address multiple health problems: HIV prevention initiatives need to be integrated into a comprehensive package of interventions associated with various reproductive health concerns, including unsafe sexual activity but covering issues of early unwanted pregnancies, post-abortion care, access to a choice of contraceptive methods and also non-reproductive-health-related issues.
- Engage multiple audiences with one programme while ensuring that messages are targeting specific audiences: multi-faceted projects are able to reach many subgroups of young people as well as adults with unmet needs.

Conclusion

The communication strategy necessitates the selection of primary and secondary audiences so that messages and approaches can be tailored to their specific characteristics. There are several effective methods to choose from in doing this. The task at the national level is to select which options are appropriate for the objectives and audiences selected and with the capacity currently available.

CHAPTER SEVEN:

IMPLEMENTING COMMUNICATION INTERVENTIONS

Project management and implementation are vital components of HIV-prevention that must not be overlooked during communication planning. Effective coordination of all the elements that go into a communication-based intervention are necessary in order to translate ideas about HIV-prevention into reality.

This chapter will provide checklists for the programme manager to:

- Assess the capacity for, build upon existing, and create new strategic partnerships;
- Consider the issues that are relevant for communication programme implementation;
- Appreciate the complexity of the coordinated management and communication necessary to implement communication programmes;
- Consider costs, cost-effectiveness and cost-recovery for budgeting and planning.

Selecting Strategic Partners

To make communication for HIV prevention among adolescents as effective as possible, UNFPA country offices need to assess their current and potential partners and the roles these partners play in communication programming. Key to successful initiatives is the development and maintenance of strong partnerships with other organizations and institutions. The work that goes into deciding who to partner with and how to develop those partnerships is important in the success-

ful planning and implementation of communication programmes. The following lists provide tips on how and with whom to develop strategic partnerships.

FORM RELATIONSHIPS WITH ALLIES

- Create and sustain alliances with other organizations working in the same setting or delivering similar services to the same clients to maximize organizational integration.
- Many forms of assistance can be obtained from partner organizations, such as skills, experience and financial assistance.
- It is particularly helpful to collaborate with organizations that have expertise in areas that are lacking in the current organizational structure.
- Allies are critical for policy initiatives. Joint efforts are more likely to draw attention to key policy issues and result in policy change.
- Partner organizations must be involved in planning as early as possible to ensure maximum contribution and ownership.

NETWORK FOR PARTNERSHIP OPPORTUNITIES

- NGO networks and coalitions provide excellent opportunities to discuss advocacy initiatives already under way and to find partners for policy advocacy. Such networks and coalitions represent a pooling of ideas and resources and demonstrate coordinated support for particular issues.
- Alliances with professional associations maximize opportunities for links with existing networks, including the private sector (for example, for working with private midwives to develop and sustain youth-friendly services).
- Linking with clinic-based quality teams can encourage collaboration between service delivery sites, referral sites and the community they serve. For example, eight public and private sector sites in Dakar, Senegal formed a network to test innovations and application of best practices and learn from each other.[26]
- Networking builds an organization's skills in mobilizing around an issue.

CREATE INTERSECTORAL ALLIANCES

- Intersectoral alliances can promote collaboration among youth organizations, youth centres, health facilities and local schools.
- Student club members can participate in health staff trainings on adolescent reproductive health and give insight and examples about adolescent sexuality.
- Teachers and parents can be invited to participate in youth centre activities and to promote them in the wider community.
- Health staff and peer educators can be invited to give talks in schools and

[26] Newton, N. January 2000. *Applying Best Practices to Youth Reproductive Health - Lessons Learned from SEATS' Experience*. Family Planning Service Expansion and Technical Support (SEATS I & II). Washington, D.C.: SEATS.

provide regular updates on reproductive health information.

- Medical staff can provide services in schools or schools can organize referrals to quality adolescent services.

- Organizations that could be partnered with include: research institutions, programmes with community research experience, NGOs with community-based staff, women and youth associations, associations of health professionals, organizations that provide health services, local chiefs and community leaders, and other groups that have experience in carrying out communication campaigns.[27]

- Partnership and support to youth organizations need to be prioritized based on their potential to contribute to programme results.

Finding an Effective Division of Labour

For an organized and effective response, it is necessary to: identify a lead agency, assess the organizational capacity of partnering organizations, clearly allocate responsibilities, and set up a committee for planning, monitoring and coordination of resource inputs and funding.

SELECT A LEAD AGENCY[28]

- The government agency responsible for selecting or approving the lead agency should be identified.

- The lead agency should be selected with the agreement and support of government and non-governmental stakeholders.

- The lead agency should be responsible for the organization and accounting of joint initiatives.

ASSESS ORGANIZATIONAL CAPACITY[29]

Assessing organizational capacity will provide a basis for deciding how government institutions, NGOs, community associations, academia and the private sector can work together. In addition to the capacity assessment conducted in Chapter 3, the following questions should be considered:

- What projects are being implemented?

- Which organizations are involved?

- How long have they been involved?

- What is their commitment in terms of funding and personnel?

- What are their management and coordination mechanisms?

- What are their needs for capacity development?

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27 Starrs, A.M., and R.R. Rizzuto. 1995. *Getting the Message Out: Designing an Information Campaign on Women's Health*, New York: Family Care International, p. 75.

28 Piotrow, P. T., D. L. Kincaid, J.G. Rimon II, and W. Rinehart. 1997. *Health Communication: Lessons from Family Planning and Reproductive Health.* Westport, Connecticut: Praeger.

29 Cabanero-Verzosa, C. 1996. *Communication for Behaviour Change: An Overview.* Washington, D.C.: The International Bank for Reconstruction and Development/The World Bank.

OUTLINE A CLEAR DIVISION OF RESPONSIBILITIES

All organizations involved need to have a clear understanding of their responsibilities, which are best spelled out in a work-plan. When identifying implementing partners, it is critical to specify at the outset which communication tasks are to be undertaken by government communication units, and which are to be contracted to outside agencies. If more than one government unit is involved, specify which unit will have management responsibility.

Potential sources of in-country technical support and expertise can be identified based on the following categories:

- Core skills that are required within the government communication unit: strategy development planning and management of activities, including monitoring
- Skills that can be tapped from the private sector, academia, NGOs and youth associations: qualitative and quantitative research message and material development and pre-testing message and material dissemination

DEFINE THE ROLES OF INSTITUTIONS INVOLVED [30]

- Political leadership helps coordinate a programme or project. For national programmes, many find it desirable to have a central government agency or a multisectoral committee assume political leadership.
- Organizations can provide technical expertise in research, training, creative aspects of message or material development and strategic planning.
- Institutions can be involved in dissemination, promotion and mobilization.
- Executing institutions—with managerial responsibility for implementing and coordinating projects and programmes—may be from central or local governments or from the private sector, including NGOs.

SET UP A COMMUNICATION COMMITTEE

UNFPA should support the creation of or tap into existing communication committees to:

- Ensure good communication and planning among partners;
- Collect and disseminate information on who is doing what, where, how and with which objectives to avoid delays, duplication of efforts, disruption in the disbursement of promised financial support, and to promote coherent collaboration.

The communication committee should be multidisciplinary, with broad membership that includes representatives of public sector organizations, media, partner organizations, civil society, NGOs and academia at the central, provincial and district levels. It should not have

30 Cohen, S. 1993. Developing IEC Strategies for Population and Development Programmes. Technical Paper No. 1. New York: UNFPA, pp. 32-34.

the power to decide or authorize who is entitled to do what, where, how and with which objectives.

The terms of reference of the communication committee may include: [31]

Coordination

- Collect and disseminate communication materials and national documents;
- Identify communication needs and provide recommendations to address these, including need for research and dissemination of research findings;
- Identify resource persons or focal points (including the ministry of health) to coordinate and liase with the communication committee, ministries and partners to ensure linkage with services: for example, referrals by peer educators or social workers should be made in coordinated collaboration with health structures offering treatment, screening or counselling.

Advocacy

- Advocate for and mobilize resources to bridge the gap between existing and needed communication activities;
- Develop communication strategies and plans at the national, regional and local levels;
- Work with partners to prepare national directives on communication for social change.

Technical assistance

- Document and evaluate communication, advocacy, social mobilization strategies and activities;
- Provide training, technical assistance, monitoring of communication activities, especially at the provincial and district levels.

The terms of reference of the committee at the provincial or district levels may include:

- Mobilizing resources, building partnerships to support activities at district or provincial levels;
- Adapting national communication strategies to accommodate local challenges;
- Providing feedback and recommendations;
- Addressing the issue of hard-to-reach groups.

Other tips for effective coalitions[32]

- Share information among members of the network;
- Develop a network mission statement and goals;
- Develop objectives and strategies;
- Create and follow a realistic time line;
- Establish a structure and leadership roles;
- Be explicit about how decisions will be made;
- Share responsibilities through committees;
- Expand the base;
- Hold regular meetings;
- Involve youth.

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31 Adapted from: WHO, UNICEF and USAID. 2002. *Communication for Polio Eradication and Routine Immunization: Checklists and Easy Reference Guides*. WHO/POLIO/02.06. Geneva: WHO.

32 Shannon, A. 1998. *Advocating for Adolescent Reproductive Health in sub-Saharan Africa*. Washington, D.C.: Advocates for Youth, International Division, and UNFPA.

Coordinating Inputs

BENCHMARK ACTIVITIES

The table below describes typical communication activities and lists issues that must be taken into consideration when implementing each activity.

COMMUNICATION ACTIVITIES	ISSUES TO CONSIDER
FORMATIVE RESEARCH	■ Which audiences are you seeking information about? ■ Is there existing data that can be useful? ■ Where will you go to collect primary data? ■ What type of data will be collected? Qualitative versus quantitative? (Surveys, focus groups, other) ■ Who will do the data collection and how will they be trained? ■ How will the analysis be conducted and by whom?
REACHING SPECIAL POPULATIONS	■ Can UNFPA and the government subcontract material development to youth associations? If no competent organizations are available, can partnerships between youth association and the private sector, academia or national or international NGOs be organized? ■ Are materials being pre-tested in local conditions? ■ Are materials being produced in sufficient quantities? ■ Are blueprints and originals being properly archived for re-supply?
CLEARING HOUSE: CENTRAL POOLS OF INFORMATION, EDUCATION, COMMUNICATION MATERIALS	■ Are locally produced communication materials available? ■ Are training manuals available in local languages? ■ Are blueprints available for reprinting? Have mechanisms for re-supply been set up? ■ Are all materials classified and archived in a clearing house?

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COMMUNICATION ACTIVITIES	ISSUES TO CONSIDER
CLEARING HOUSE: CENTRAL POOLS OF INFORMATION, EDUCATION, COMMUNICATION MATERIALS *continued*	■ Are the clearing house and its available materials being promoted? Are communication partners informed about the availability of these resources? ■ How easy is it for individuals and organizations to obtain an overview and access the range of materials available? ■ Is there an active central authority responsible for pooling and disseminating resources?
MATERIAL DISTRIBUTION	■ Are materials reaching all target groups? ■ Are materials in place before launch of campaign? ■ Are materials being distributed through several types of media, for example, print, folk, mass, audiovisual, electronic, and at special events? ■ Has the project decided where and how many print materials to deliver? ■ Is storage available for large orders of materials? ■ Are service providers prepared to receive flip-charts and educational handouts? ■ Are centrally produced materials ready when local level activities begin?
TRAINING	■ Have mechanisms for continuous supervision and training been established? ■ Have teachers and facilitators been provided with materials in sufficient quantities? ■ Have work performance indicators been set up? ■ Is training on communication strategy development and management being provided? ■ Does a training scheme exist to provide skills that health workers need to carry out communication activities critical to the strategy? ■ Is the project team being kept updated on: policy, sociocultural and institutional research, situation and response analysis, and baseline data?

COMMUNICATION ACTIVITIES	ISSUES TO CONSIDER
CAPACITY-BUILDING	To what extent do project activities facilitate an organization's ability to: ■ Articulate what they will do (in terms of strategy, mandate) ■ Mobilize resources (human, financial and partnership) ■ Use one's experience to learn
FUNDING	■ Is the timing of funds for the elements of health communication projects and campaigns adequate? ■ Does the coordination unit channel communication resources in a timely manner?

THE CHALLENGE OF INPUT AND RESOURCE COORDINATION

The social marketing model is a good example of synchronized planning of communication inputs:

- Formative research - Social marketing techniques have been used to carry out sociocultural analyses of vulnerability situations and audience segmentation to identify and define strategies for particular adolescent audiences;

- The four "Ps" of social marketing (product, price, place and promotion) highlight the importance of synchronizing supply, logistics and demand creation;

- Concentrating communication activities in a short time period, such as during intensive campaigns, can attract the most attention and foster a high demand.

Budgeting

HOW DO YOU BUDGET AN HIV-PREVENTION COMMUNICATION STRATEGY?

- Cost per printed material and per person reached should be calculated;

- Enough funds should be allocated for multiplication or reprinting of existing information materials;

- Evaluation of communication initiatives is 10 per cent of the total communication cost;

- What per cent of the total country programme budget is the country office ready to allocate for communication among the various adolescent groups?

- UNFPA is working on a costing tool to determine and compare the cost-effectiveness of various interventions and strategies related to reproductive health.

WHAT ARE THE STRATEGIES FOR MAXIMIZING IMPACT?

- Clients might be willing to pay for a service if they are satisfied with it;

- Sharing costs of entertainment-education with the private sector means incorporating health information into health products or entertainment that consumers or sponsors are willing to pay for to reach and gain recognition from young audiences at low cost per person. For example, commercial sponsorship was offered by *Bic* to Mauritania's country office for marked pencils to be distributed to all students in secondary schools nationwide. The pencils contained a message that supported peer education sessions on HIV throughout the country;

- Negotiate with national authorities to obtain free mass media airtime and news coverage on social development issues, or tax reductions for sponsoring companies. For example, the set-up and recurring costs of a hotline in a UNFPA-funded reproductive health centre for adolescents in Côte d'Ivoire is entirely sponsored by the national telecommunications company;

- Co-produce with private television.

HOW CAN WE ENGAGE THE HARD TO REACH WHILE REMAINING COST-EFFECTIVE?

Using a rights-based approach means that all individuals have equal rights to development benefits. The Office of the UNFPA Executive Director (and the Millennium Development Goals) recommend a "focus on the priority needs of the most vulnerable, excluded and disadvantaged." [33]

However, considering limited resources and a results-based management approach, behaviour change communication procedures and guidelines encourage "focusing on cost-effective communication interventions, i.e., on those audiences that are more likely to change behaviour." [34] Country offices may reconcile these two approaches by:

- Selecting one remote area or youth group in especially difficult circumstances to develop a small pilot initiative, which can be scaled up at a later stage;

- Work with audiences that have high potential for change. While not concentrating on the hardest to reach, communication can focus on youth who have expressed their intention to use the service but are not yet using

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33 Integrated guidelines for Common Country Assessments-UN Development Assistance Framework (CCA-UNDAF). UNFPA Executive Director's Office. Ch. 2, step 4, May 2002.

34 UNFPA, Technical Support Division. October 2001. *New UNFPA policy and procedures guidelines in the area of behaviour change communication* (BCC).

it, or on youth who have adopted a positive behaviour and need to maintain it over time. [35] Attention should also focus on prior users and their reasons for eventual discontinuation;

- Both strategies entail better promotion of existing services and products, prices and retail points, and supporting satisfied clients to advocate for the services among their peers;

- In-school youth generally have more potential for change than out-of-school peers. Programmes should focus on keeping adolescents in school, especially girls.

HOW MUCH TO INVEST IN HIV/AIDS PREVENTION

UNFPA country offices are in a key position to identify innovative and successful field initiatives and to use monitoring and evaluation results for evidence-based advocacy.

- Money spent on HIV/AIDS is not spent on other reproductive health needs;

- How much does UNFPA contribute to preventing HIV/AIDS at the national level, as a per cent of total donor investment? Will it make a difference?

- If UNFPA's investment is less than five per cent of the total investment, UNFPA should carefully focus its intervention on either a pilot initiative or advocacy to scale up;

- Demonstrating cost-effectiveness is vital for advocacy and to convince donors to scale up programmes;

- Condoms are the most cost-effective way to protect against AIDS.[36] UNFPA should prioritize fund-raising for condom programming for adolescents;

- UNFPA can coordinate with major bilateral partners and regional banks to scale up initiatives;

- Empower municipal governments, which, in the context of decentralization, are gaining control over social services and health budgets. In a reproductive health project for youth led by SEAT in Senegal, the municipalities of Dakar and Louga funded at least 20 per cent of activities and obtained additional outside support.[37]

Conclusion

The management, coordination and implementation of communication-based interventions for HIV prevention among youths is a complicated and important component of overall prevention efforts. This chapter has considered the importance of establishing and maintaining partnerships, coordinating and managing the entire process, and issues concerning budgets. It is vital not to overlook implementation; without this step, great ideas, research and planning will go unrealized.

35 Refers to states 3 and 4 of state of behaviour change theory.

36 Population Action International. July 2002. *Condoms Count: Meeting the Need in the Era of HIV/AIDS.* Washington, D.C.: Population Action International.

37 Newton.

CHAPTER EIGHT:

EVALUATING AND MONITORING COMMUNICATION STRATEGIES

Evaluating the progress and effects of a communication intervention for HIV prevention among youths is an integral component of the planning and implementation process. Monitoring and evaluation show what progress is being made and provides an opportunity to make necessary changes. They also show whether interventions are having their desired effect. This can be crucial information for researchers and policy makers trying to determine the most effective use of limited resources.

This chapter provides tools and tips for the programme manager to:

- Assess the importance of participatory evaluation involving youths;
- Review the relevance of monitoring and evaluation;
- Define communication output indicators;
- Select indicators for monitoring and evaluation.

Why Involve Youth in Monitoring and Evaluation?

Involving youth in monitoring and evaluation is a commonly used strategy simply because it is so effective. The numerous benefits include:

- *Relevance:* a youth's perspective ensures that the concerns of beneficiary groups are recognized and used in programme formulation. It also ensures that evaluation is relevant to local conditions and that the programme is attuned to the reality of the adolescent situation;

- *Collective learning and capacity-building*: through participation, youth become more knowledgeable about their social environment and gain valuable perspective about community improvement. Additionally, the process of indicator generation is in itself educational and empowering to beneficiaries; [38]

- *Sustainability*: participatory evaluation gives youths a sense of ownership and builds self-reliance through the transfer of skills.

Four additional points should be taken into consideration for youth participation in monitoring and evaluation: [39]

- Young people should be involved in the evaluation from the onset and at every stage;

- The content of the evaluation should be agreed upon among all members of the evaluation team, including the youths;

- The evaluators should make youth participation their goal, and should see their role as training young people in the use of evaluation;

- The cost of youth participation (in money, time and other resources) should be accepted.

When and How to Monitor Progress

MONITORING IMPLEMENTATION OF COMMUNICATION ACTIVITIES

Monitoring means regular checking to see whether the plan of action is running as scheduled, and whether all planned activities are being undertaken; this is often referred to as *process monitoring*. Monitoring can look at both the quantity and quality of progress—for example, the number of materials produced or people trained, or the quality of print materials or radio broadcasts, training methods and materials, or performance of trainees once they return to work.

Through monitoring, the programme manager can: [40]

- Make sure that activities are relevant to the objectives of the project, and to the identified needs of the target group;

- Keep track of what the project is doing, and check whether activities are taking place as planned;

- See whether enough has been budgeted to carry out all the planned activities;

- Find out whether peer educators, youth workers and outreach staff are able to carry out project activities;

- Find out whether the planned number of young people in the target audience are actually being reached;

- Detect problems with the methods and materials being used;

38 Webb, D., and L. Elliott. 2000. *Learning to Live: Monitoring and Evaluating HIV/AIDS Programmes for Young People*. Save the Children, UK Department for International Development and UNAIDS.

39 Save the Children, p.32.

40 WHO, The Commonwealth Youth Programme and UNICEF, *Working with Young People, A Guide to Preventing HIV/AIDS and STDs*, 1995.

- Detect problems in the management of the project.

In communication monitoring, information about the communication activities is systematically collected and can be reported on at any time. In most cases, monitoring requires simple forms or questionnaires to be completed by project staff on a routine basis, during follow-up visits, by youth workers in the field, by members of the target audiences who should benefit from the activities or by the project coordinator. To measure quality, one may need to use interviews, focus groups or other qualitative methods to obtain target groups' opinions about the communication activities. [41]

Process monitoring is used to find out what is and is not being accomplished. But it can also serve as a resource to discover *why* activities are and are not working. Sometimes referred to as *process evaluation*, this type of monitoring system allows us to understand what is and is not working in a programme's implementation and the reasons why, which can be used to make improvements. This involves investigation, analysis and recommendations. It is concerned not only with problems but also achievements. For example, when a process indicator shows that a target is not being reached, analysis will look for the possible causes of the problem and propose solutions. [42]

The following tables give examples of key questions for monitoring progress and drawing out critical information to support such an analysis: [43]

[41] WHO, UNICEF, and Commonwealth Youth Programme. 1995. *Working with Young People: A Guide to Preventing HIV/AIDS & STDs.*

[42] Civil-Military Alliance (CMA) and UNAIDS. 1999. ***Winning the War Against HIV and AIDS: A Handbook on Planning, Monitoring and Evaluation of HIV Prevention and Care Programmes in the Uniformed Services***. Hanover, NH: Civil-Military Alliance.

[43] Adapted from Starrs and Rizutto, p.78.

QUALITY OF IMPLEMENTATION	KEY MONITORING QUESTIONS
SYNCHRONIZATION OF INPUTS	■ Is the project schedule or work plan being followed? If not, why? ■ What can be done to fix the problems? ■ Are training materials developed, pre-tested and distributed before training takes place? ■ Is training taking place before outreach activities? ■ Is material developed, pre-tested and distributed before the campaign is launched? ■ Are reproductive health services and commodities made available before the demand is created?

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QUALITY OF IMPLEMENTATION	KEY MONITORING QUESTIONS
SYNCHRONIZATION OF INPUTS *continued*	■ Do outreach educators provide referrals for services? ■ Does the environment support the behaviour change being promoted?
COST	■ Have any activities cost much more than the budgeted amount? ■ If so, can more money be raised, or can the cost of other activities be reduced? Can some activities be cancelled without jeopardizing expected communication outputs? ■ Is the combination of communication strategies giving the best value from the budget available? ■ Is it of continued relevance to invest more resources in one communication strategy rather than another?
COORDINATION AND COLLABORATION	■ Are the planned numbers and categories of youth organizations or ministries involved? ■ If not, what can be done to encourage participation and collaboration? ■ Which additional organizations, groups, or individuals could be contacted? For what purpose?
USE OF HUMAN RESOURCES	■ Are project staff carrying out their assigned duties and responsibilities? ■ If not, what can be done to motivate them and increase their effectiveness? ■ Are peer educators, youth workers and outreach staff all active, or only some of them? ■ Why are some of them not active? *continued on next page*

QUALITY OF IMPLEMENTATION	KEY MONITORING QUESTIONS
USE OF HUMAN RESOURCES *continued*	■ What can be done to encourage their participation? ■ Does the project need to hire specialists to carry out certain tasks? Which ones?
RIGHTS-BASED APPROACH	■ Are youth participating in research, materials development, advocacy and monitoring? ■ Are rights of young people to information, health, privacy and their own well-being respected, promoted, facilitated and protected?

PROCESS MONITORING

Communication interventions are typically comprised of research about audiences, strategy design, training of facilitators, message development and dissemination. The following table presents examples of key questions for monitoring the process of these activities:

ACTIVITIES	KEY MONITORING QUESTIONS
RESEARCH	■ Are representatives of the target groups involved in the design of the research questionnaire? ■ Do interviewers and target groups understand the research questions? ■ Have the interviewers been adequately trained in questionnaire administration? ■ Were enough copies made of the research questionnaire? ■ Are focus group discussions or interviews taking longer than expected? ■ Have the research results been analysed and reported? ■ How have the findings been used?

ACTIVITIES	KEY MONITORING QUESTIONS
STRATEGY DESIGN	■ Are youth participating in research, materials development, advocacy and monitoring? ■ Are rights of young people to information, health, privacy and their own well-being respected, promoted, facilitated and protected?
TRAINING OF FACILITATORS	■ Are peer educators, youth workers, teachers, service providers and outreach staff trained as planned? How many of them? ■ Are they able to plan and implement activities as decided in the training? ■ Has their performance improved after training? ■ How many planned refresher courses for peer educators, youth workers, service providers, teachers and outreach staff have actually taken place? ■ What proportion of peer educators, youth workers, service providers, teachers and outreach staff that have previously been trained received refresher courses?
MESSAGE/MATERIALS DEVELOPMENT	■ Do messages reflect audience research findings? ■ Are members of the target groups helping draft the messages? ■ Are messages being reviewed for technical accuracy? ■ What is the rating by the target groups of the materials?
PRE-TESTING OF MESSAGES AND MATERIALS	■ Are the messages and illustrations being tested among members of the target groups? What aspects are being tested? ■ Are the responses being recorded for each testing session? ■ Are the responses from some target groups very different from others? Why? ■ Have messages and materials been revised based on pre-testing results?

ACTIVITIES	KEY MONITORING QUESTIONS
DISSEMINATION OF MESSAGES AND MATERIALS	■ Are the channels reaching the target groups? (For example, are radio or TV spots being broadcast at the right time?) ■ Are the planned numbers of young people in the target audience actually being reached? ■ Are there any unexpected barriers to reaching some segments of the target groups? Which ones? ■ How can these barriers be overcome? ■ What is the proportion of schools, peer educators, youth workers, teachers, service providers and outreach staff that have received textbooks or teaching materials? ■ What is the proportion of schools, peer educators, youth workers, teachers, service providers and outreach staff that are using the textbooks or teaching materials? ■ Are there mechanisms in place for re-supplying training and motivational materials?

Indicators to Monitor Progress

One of the most important monitoring techniques is the use of indicators. A *process indicator* is a measurement of a designated aspect of implementation. Each indicator determines the extent to which planned activities have been carried out. The following table presents possible indicators for monitoring the process of several communication strategies.

COMMUNICATION STRATEGIES	KEY MONITORING QUESTIONS
GROUP MEETINGS	■ How many planned community meetings have taken place? Where? ■ About how many people attended the meetings? How would you categorize those who attended?

COMMUNICATION STRATEGIES	KEY MONITORING QUESTIONS
GROUP MEETINGS *continued*	■ About how many young people have been reached through outreach activities? How would you categorize these young people? ■ How many planned group discussions have been held with young people? How many young people? ■ Have support materials been distributed through community meetings (for example, posters, leaflets, promotional materials)? How many? What type? ■ How many action plans have been formulated? How many actions have been taken?
CAMPAIGNS/SPECIAL EVENTS	■ How many planned campaigns or special events have taken place? On what topics? In how many sites? ■ Who collaborated in the organization and implementation of these campaigns or special events? ■ How many of what type of printed materials were distributed during the campaigns or special events? ■ How many social marketing materials were disseminated to promote the new product or lifestyle? ■ How many and what category of youths were reached through the campaigns or special events? ■ What was the coverage by the mass media of the event or campaign?
PEER EDUCATION	■ Are goals being met in terms of the number of adolescents involved in peer education outreach? What is the sex ratio? ■ What is the dropout rate among peer educators? Why?

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COMMUNICATION STRATEGIES	KEY MONITORING QUESTIONS
PEER EDUCATION *continued*	■ Is it possible to limit dropout rates among peer educators? How? ■ How many planned peer education sessions have actually been held? ■ What are the topics discussed? Do these sessions involve life-skills education? ■ To what extent do peer education sessions include activities that let participants observe and rehearse communication and negotiation skills? ■ Where are peer education sessions taking place? ■ What are the estimated number and categories of youth being reached through peer education outreach? ■ To what extent do peer educators reach marginalized groups denied access to formal structures? In what location are these vulnerable populations reached? ■ Are education sessions separated by age group to allow for discussion of issues that may be appropriate to specific groups? ■ Are youth exposed to more than one session of HIV education? How many? ■ How many planned multi-sessions of education have been conducted? ■ How many peer educators have received textbooks or teaching materials? ■ How many peer educators use books or materials in the correct sequence? ■ Are peer education sessions interactive, participatory? ■ Are peer educators credible sources of information for youths? ■ Are peer educators spending enough time with the target group? ■ Have the planned number of communication materials been distributed? ■ To what extent is the community (of which the peer education process is part) in favour of HIV/AIDS education?
SCHOOL-BASED PROGRAMME	■ To what extent is the community (of which the school is part) in favour of sexual health education? Are teachers in favour of sexual health education?

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COMMUNICATION STRATEGIES	KEY MONITORING QUESTIONS
SCHOOL-BASED PROGRAMME *continued*	■ What proportion of teachers have been trained in life-skills education? What proportion have been trained to include HIV prevention among adolescents in the curriculum of primary and secondary schools? ■ What proportion of schools are integrating HIV/AIDS education into the wider curriculum? ■ What proportion of schools are implementing HIV/AIDS education? ■ How many youths have been reached through the school-based programme? What is the age and sex of the young people reached? ■ What proportion of schools have received textbooks or teaching materials? ■ What proportion of schools are using the textbooks or teaching materials? ■ How do teachers rate the materials being used? ■ How do students rate the materials being used? ■ Is the education programme being implemented in the time frame prescribed? ■ Has a peer health education programme been set up to supplement the official curriculum? ■ How many youths have been reached through anti-AIDS clubs? What is the age and sex of people reached? ■ Have locations been explored for expanding out-of-school activities to support the school-based programme? ■ What is the proportion of schools with active anti-AIDS clubs? ■ Has peer education outreach been organized in anti-AIDS clubs (snowball effect)?
SERVICES (COUNSELLING, ETC.)	■ How many planned pre- and post-service training sessions for service providers have actually taken place? ■ What proportion of service providers are using textbooks or teaching materials? ■ Do service providers demonstrate better counselling skills after training?

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COMMUNICATION STRATEGIES	KEY MONITORING QUESTIONS
SERVICES (COUNSELLING, ETC.) *continued*	■ How many adolescents are seen for treatment and counselling for sexually transmitted infections? ■ How many youths are referred for voluntary counselling and testing? ■ How many and what category of youths have received counselling? Has the amount of counselling increased? ■ Where is counselling most successful? At the service delivery point, in youth clubs, at school? ■ Who is the most successful counsellor? A peer? An adult? ■ Have counsellors been trained in interpersonal counselling skills specific to adolescents? ■ Have counsellors been provided with support materials? Which ones? ■ Is counselling linked with the provision of services or commodities? ■ Is the correct use of condoms been demonstrated and consistent use explained?
MASS MEDIA	■ How many advocacy kits have been distributed to media practitioners? ■ How many and what type of media productions have been produced that contain messages about HIV/AIDS prevention? ■ How many copies of posters and information leaflets have been distributed? ■ How many copies of brochures have been distributed to members of the target group? ■ How many planned articles have been published in local newspapers for sensitizing opinion leaders? ■ How many planned radio or TV spots have been aired for sensitizing parents or other target groups? ■ How much feedback has the media received from youths? ■ Has this feedback been taken into account in upcoming media productions?

How to Evaluate the Impact of Communication

PURPOSE OF IMPACT EVALUATION

The purpose of impact evaluation is to determine whether a project has had its intended effect, through its expected results. The baseline information collected at the beginning of the project must be revisited to see what has changed for young people. The evaluation must define if the needs of the target audiences have been met and, in particular, if the project has had an effect on their knowledge, skills, feelings, attitudes and behaviours.

Demonstrating that the project has affected the target audience can help to convince donors, policy makers and sceptical community groups of the value of the project and should elicit more support, funding and acceptance in the future.

Budget, time and logistical constraints may limit in-depth programme evaluation. For this reason, it is suggested impact evaluations be limited to pilot projects. For projects that have already demonstrated impact, process evaluation (monitoring) will be the only type of evaluation that is needed. Processes that have demonstrated effectiveness can be replicated. They can also help shape policies needed to bring the project to scale and to advocate for additional funding.

INTERMEDIATE RESULTS, OUTPUTS AND OUTCOMES

Changes in behaviour, social norms, policies and programmes take a long time to achieve. Therefore, during the four-year programme cycle, it is important to measure intermediate progress towards behaviour change and social transformation. *Intermediate results* in communication work include short-term changes that we can realistically expect at national and/or local levels, and in knowledge and attitudes of facilitators and gatekeepers. *Medium-term impacts* include the adoption of positive behaviours and increased service utilization by young people. Successful medium-term impact is a reliable indicator of *long-term impacts*, which include the maintenance of positive behaviours to prevent the onset of risky behaviours, and changed social and peer norms (see communication results framework in Chapter 6). [44]

As just one of the many donor organizations in the country or in the specific project area, UNFPA is only accountable for achieving intermediate results, which are also called *outputs*. Outputs, defined as time-bound measurable or describable changes produced by a programme and for which the Fund is willing to be held accountable, are carefully selected to effectively contribute to achieving medium-term and long-term impacts, also called *outcomes*. Outcomes are defined as describable or measurable changes that occur in behaviour, attitudes, commitment, or sociocultural values of groups, as well as legal, institutional and societal practices, as a consequence of achieving the expected outputs. [45]

[44] Web and Elliott.

[45] UNFPA. November 2002. *Policies and Procedures: Programme.*

HOW TO STATE COMMUNICATION OUTPUTS AND INDICATORS

UNFPA has adopted results-based management as its guiding principle for programming. Because of this, indicators have become important instruments to define and track programme results, particularly at the output level, since this is the level of results for which UNFPA is accountable.

For indicators to be specific, results must be clearly stated. Who and what are expected to change? What kind of change is expected to take place? [46]

Output indicators are used to measure programme outputs. They must be clear about what is being measured, closely measure the intended change, and specify what data is to be collected to ensure that progress towards the outputs is sufficiently captured. One would also expect reasonable data collection cost, adequate frequency and timeliness for decision-making purpose. [47] *Objectively Verifiable Indicators* is the name that UNFPA gives to such indicators. They are defined as a quantitative and/or qualitative measure of programme performance that are used to demonstrate change and detail the extent to which programme results are being or have been achieved (baselines and targets have to be established).[48] Indicators are especially valuable when paired with targets—a target states the level that an indicator is expected to achieve by a given date.

The results-based communication framework presented in Chapter 5 [page 43] indicates the typical intermediary results that can be expected for each of the three communication categories: advocacy, behaviour change communication and education. These intermediary results are the foundation for formulating sound communication outputs.

The following table presents examples of output statements and related indicators for each of the three categories of communication approaches and their expected intermediary results.

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46 UNFPA, Office of Oversight and Evaluation. August 2002. *Programme Indicators*. Monitoring and Evaluation Toolkit for Programme Managers. Tool No. 6. New York: UNFPA.

47 Ibid.

48 UNFPA. November 2002. *Policies and Procedures: Programme*.

ADVOCACY OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
CONSENSUS CREATION Improved awareness and attitudes of religious and traditional leaders in region *x*, on youth vulnerability to HIV/AIDS and the importance of addressing their reproductive health needs and rights in a sensitive and compassionate manner	■ In (date and place), number of religious and traditional leaders who report concern for adolescent vulnerability to HIV/AIDS ■ In (date and place), number of religious and traditional leaders who support HIV prevention activities among adolescents ■ Number and type of social networks identified and sensitized on the issue ■ Number and type of social networks involved in lobbying or campaigning on the issue ■ Number of meetings, conferences, presentations of benefits of HIV/AIDS prevention among youths facilitated between advocates, decision makers and communities ■ Number of political or religious leaders who have attended and participated in these meetings ■ Number of government officials who have attended education programmes addressing youth issues
POLICY CHANGES Formulated and adopted policies on HIV prevention among youths in sector *x* (for example, education, health, social work, employment)	■ Number of meetings to advise minister and staff on policy development ■ Number of policy-related debates facilitated in concerned ministries, parliament, national assembly ■ Number of advocacy kits produced and disseminated to specialized media and opinion leaders ■ Number of research or technical reports on needs and expected benefits of HIV/AIDS prevention among adolescents presented to decision makers ■ Number of media forums that feature discussions or information on policy proposals

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ADVOCACY OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
POLICY CHANGES *continued* Implemented policy on HIV prevention among youths in sector *x*	■ Number of stakeholders that have received and accepted the approved policy ■ Number of decision makers in concerned ministries who speak to peers to facilitate collaboration between ministries for policy implementation ■ Number of stakeholders that have been exposed to study tours, regional and international conferences and debates ■ Number of meetings, debates among members of different ministries, academia, the private sector and civil society to inform and develop joint plans of action ■ Number of planned meetings with technical advisers of concerned ministries to draft action plans ■ Number of approved plans of action disseminated to all stakeholders ■ Number and type of partners involved in the implementation of action plans ■ Parts of the primary and secondary school curricula that include life skills and content about HIV/AIDS prevention among adolescents ■ Number of primary or secondary schools that have adopted skills-based HIV/AIDS prevention curricula
Integrated adolescent needs and rights into national development and sectoral policies and plans of action	■ In (date and place), number of intersectoral mechanisms to review development and sectoral plans ■ In (date and place), number of national/sectoral policies and plans of action established to address HIV/AIDS prevention among adolescents

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ADVOCACY OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
POLICY CHANGES *continued* Increased allocation of resources to implement youth HIV/AIDS prevention component of national development and sectoral plans of action	■ In (date and place), per cent of national or sectoral budgets allocated to youth HIV/AIDS prevention component of national development and sectoral plans of action ■ In (date and place), number of regions or districts where youth HIV/AIDS prevention component of national development and sectoral plans of action are being implemented
Strengthened capacity of ministries to implement policies aimed at preventing HIV/AIDS among youths in a strategic and coordinated fashion	■ Existence of youth-specific advocacy and behaviour change communication strategies in those ministries ■ Existence of youth focal points in those ministries ■ In (date), number of project staff involved in preventing HIV/AIDS among youths who know about the new policies and have been trained in communication methods and techniques ■ Surveillance mechanisms in place to monitor the application of the new policy
Improved attitude and skills of service providers in region x in providing youth services for HIV/AIDS prevention	■ In (date), per cent of service providers in region *x* who say that they should contribute to meeting adolescents' sexual and reproductive health needs and rights through counselling and provision of appropriate service and commodities ■ In (date), per cent of service providers in region *x* who can state provider characteristics of youth-friendly health services ■ In (date), per cent of service providers in region *x* who practice privacy and confidentiality when providing services to adolescents

ADVOCACY OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
PARTNERSHIPS/ALLIANCE-BUILDING FOR ADVOCACY Increased partnership for addressing HIV prevention among adolescents	■ Does an intersectoral collaboration mechanism exist? Is it effective? ■ If not, why? If so, how can it be made more effective? ■ Has there been an increase in the number of stakeholders working together to prevent HIV among adolescents? ■ How many new stakeholders have become involved? ■ How many stakeholders are identified as contributing to efforts in national/regional/district work plans? ■ Number and type of intersectoral mechanisms to review development plans to integrate adolescent issues ■ Has there been a national or regional planning/steering committee established and is it functioning in the intended manner? ■ Existence of coordination mechanisms at central/regional/district levels ■ Are youth NGOs consulted or supported? Do they participate in decision-making?
ADVOCACY CAPACITY Increased advocacy capacity of civil society organizations	■ Do individuals, groups and networks have the ability to communicate their desires to government authorities? ■ Ability of civilian groups to organize for effective advocacy ■ Government's willingness to hear voices of young people ■ Increased level of funding for youth NGOs involved in advocacy for programmes to prevent HIV among adolescents

ADVOCACY OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
COLLECTIVE EMPOWERMENT Youth empowered as a group in their communities to address their vulnerabilities and control their future	■ Number of community or youth groups that have taken the initiative to become involved in HIV prevention ■ Number of groups that feel they have improved their capacity to advocate or act on issues that are important to them ■ Increased sense of ownership through active participation ■ Do individuals or groups feel less fatalistic and have a greater ability to confront problems?
Increased involvement of youth in advocacy for adolescent HIV prevention	■ In (date and place), per cent of youths of both sexes in and out of school in region x who report having advocated for their sexual rights to others ■ In (date and place), per cent of youths of both sexes in and out of school who have participated in peer education outreach ■ In (date), per cent of youths of both sexes in and out of school in region x who have participated in campaigns or special events ■ Number of role-plays, storytelling, youth peer education sessions in and out of schools ■ Number of letters and calls received by the media on HIV and gender grouped by sex and age of the audiences ■ Number of press releases and public debates, including media produced by youths themselves ■ Number of meetings organized by youths and their community on HIV/AIDS prevention among adolescents ■ Are positive role models incorporated as advocates into the behaviour change communication campaign?

YOUTH BEHAVIOUR CHANGE OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
ACCESS TO ACCURATE INFORMATION Improved geographic access to and availability of quality information on HIV/AIDS prevention by youths of both sexes in and out of school in region *x*	■ In (date), per cent of youths of both sexes in and out of school in region x that have been exposed to/remember/understand/like (research-based and pre-tested) HIV/AIDS messages produced by the programme
Improved knowledge of youth of both sexes in and out of school in region *x* about HIV/AIDS	■ By (date), per cent change in number of youths of both sexes in and out of school in region *x* that can state the outcome of unprotected sex and the means to avoid it (at least three options) ■ By (date), per cent of youths of both sexes in and out of school in region *x* that know what a condom is ■ By (date), per cent of youths of both sexes in and out of school in region *x* that understand the importance of a condom ■ By (date), per cent change in number of youths of both sexes in and out of school in region *x* that can provide counter-arguments to main misconceptions about HIV/AIDS preventive and curative measures ■ By (date), per cent of youth of both sexes in and out of school in region *x* that can state place and time to get treatment for sexually transmitted infections, sexual and reproductive health counselling, voluntary counselling and testing and condoms

YOUTH BEHAVIOUR CHANGE OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
PERCEPTIONS, BELIEFS AND ATTITUDES Increased sense among young people of the efficacy of risk-reducing behaviours in region *x*	■ By (date), per cent change in number of youths of both sexes in and out of school in region x that believe it is feasible and good to practice safe behaviours ■ By (date), per cent change in youths of both sexes in and out of school in region x that believe their peers are practicing safe behaviours ■ By (date), per cent change in number of youths of both sexes in and out of school in region x that express support for social norms that lead to risk-reducing behaviours, and that question social norms and practices that increase their vulnerability to HIV.
Improved skills of youths of both sexes in and out of school in region *x* for reducing their risk of HIV/AIDS through behaviour change	■ By (date), per cent of youths of both sexes in and out of school in region x that report ability and confidence to talk with sexual partner or peers about sexual and reproductive health issues ■ By (date), per cent of youths of both sexes in and out of school in region x that can report reasons for standing up for decisions regarding relationships and sexual intercourse ■ By (date), per cent of youths of both sexes in and out of school in region x that can identify personal reasons for resisting pressures for unwanted sex or drugs ■ By (date), per cent change in number of youths of both sexes in and out of school in region *x* that can recognize and avoid or leave a situation that might turn risky ■ By (date), per cent change in number of youths of both sexes in and out of school in region *x* that report ability and confidence to refuse (unprotected) sex in at least three risky situations ■ By (date), per cent of youths of both sexes in and out of school in region *x* that can provide counter-arguments to at least three reasons given by peers to disregard risk-reducing behaviours

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YOUTH BEHAVIOUR CHANGE OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
PERCEPTIONS, BELIEFS AND ATTITUDES *continued* Improved skills of youths of both sexes in and out of school in region *x* for reducing their risk of HIV/AIDS through behaviour change *continued*	■ By (date), per cent of youths of both sexes in and out of school in region *x* that report ability and confidence to seek voluntary counselling and testing and treatment for sexually transmitted infections ■ By (date), per cent of youths of both sexes in and out of school in region *x* that report ability and confidence to seek and acquire condoms ■ By (date), per cent of youths of both sexes in and out of school in region *x* that can demonstrate correct condom use ■ In (date), per cent of youths of both sexes in and out of school in region *x* that report ability and confidence to negotiate protected sex or other forms of safer sex with sexual partner
Improved attitudes of youth of both sexes in and out of school in region *x* towards HIV/AIDS risk-reducing behaviours	■ In (date), per cent of youths of both sexes in and out of school in region *x* that report willingness to talk with sexual partner or peers about sexual and reproductive health issues. ■ In (date), per cent of youth of both sexes in and out of school in region *x* that report easier access to and trust in confidentiality and ability of reproductive health services promoted by the programme ■ In (date), per cent of youths of both sexes in and out of school in region *x* that can state reasons for personal susceptibility to HIV infection ■ In (date), per cent of youths of both sexes in and out of school in region *x* that believe they must protect themselves against HIV/AIDS ■ In (date), per cent of youths of both sexes in and out of school in region *x* that report willingness to seek professional treatment for sexually transmitted infections ■ In (date), per cent of youths of both sexes in and out of school in region *x* that intend to use condoms in the future

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YOUTH BEHAVIOUR CHANGE OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
PERCEPTIONS, BELIEFS AND ATTITUDES *continued* Improved attitudes of youth of both sexes in and out-of-school in region *x* towards HIV/AIDS risk-reducing behaviours	■ In (date), per cent of youths in and out of school in region *x* that can state how to show compassion and support for people with HIV/AIDS ■ In (date), per cent of youths in and out of school in region *x* that report willingness to care for someone with AIDS in the family or the community ■ In (date), per cent of youths of both sexes in and out of school in region *x* that intend to get an HIV test ■ In (date), per cent of youth of both sexes in and out of school in region *x* that intend to perform safe behaviours in the future

EDUCATION OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
CHANGES IN CURRICULA Increased access to formal and informal education on adolescent HIV/AIDS prevention in the school system in region *x*	■ In (date), per cent of primary and secondary schools that have adopted HIV/AIDS prevention curricula ■ In (date), per cent of primary and secondary schools that have set up anti-AIDS clubs
IMPROVED ATTITUDES AND SKILLS ON THE PART OF EDUCATORS Improved attitudes and skills of health or school educators in region *x* in providing HIV/AIDS education to adolescents	■ What new information have peer educators, youth workers, teachers, service providers and outreach staff learned after a training session or a series of sessions? ■ In (date), per cent of health educators in region x that report concern for adolescent vulnerability to HIV/AIDS

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EDUCATION OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
IMPROVED ATTITUDES AND SKILLS ON THE PART OF EDUCATORS *continued* Improved attitudes and skills of health or school educators in region *x* in providing HIV/AIDS education to adolescents	■ In (date), per cent of health educators in region x that state that adolescents have sexual and reproductive needs and rights that they must help to meet ■ In (date), per cent of health educators in region x that can demonstrate skills for imparting adolescents with the life skills they need to combat HIV/AIDS
IMPROVED LIFE SKILLS AND GENDER EQUALITY COMPETENCIES Increased knowledge on the part of students about HIV prevention	■ See behaviour change indicators
Skills developed	■ What new skills have peer educators, youth workers, teachers, service providers and outreach staff developed after a training session or a series of sessions? ■ Can youth exposed to education sessions demonstrate technical skills for condom use? ■ Can trained youth demonstrate communication and negotiation skills about condom use? ■ Can youth address gender equity issues, including violence, related to HIV prevention?
Increased gender parity	■ By (date), increase from *x* per cent to y per cent the percentage of girls in primary and secondary school

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EDUCATION OUTPUTS	OBJECTIVELY VERIFIABLE INDICATORS
IMPROVED LIFE SKILLS AND GENDER EQUALITY COMPETENCIES *continued* Increased gender parity	■ Increase from *x* per cent to y per cent the percentage of families that send both boy and girl children to school ■ Increase the level of knowledge among community members about the importance of gender parity in education ■ Increase in the number of teachers who deliberately participate in ensuring gender parity in schools

Conclusion	■ Monitoring and evaluation need to be planned for from the beginning; ■ Consider the benefits of participatory evaluation methods; ■ Select indicators that will be sound measures of the progress and results of the programme;	■ The decision to conduct an impact evaluation depends upon the purpose of the programme and intended use of the results.

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