

Indicators for Education Sector HIV Response Programmes:
A review of existing resources
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A review conducted on behalf of the
UNAIDS IATT on Education Indicators Working Group



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LIST OF ABBREVIATIONS AND ACRONYMS

AIS	AIDS Indicator Survey
AIDS	Acquired Immune Deficiency Syndrome
CRIS	Country Response Information System
DHS	Demographic and Health Survey
EFA	Education for All
EMIS	Education Management Information System
FRESH	Focusing Resources on Effective School Health
GCE	Global Campaign for Education
GFATM	Global Fund for AIDS, TB and Malaria
GSHS	Global School Health Survey
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
IATT	Inter-Agency Task Team (on Education)
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MTT	Mobile Task Team
NAC	National AIDS Committee
NAFCI	National Adolescent Friendly Clinic Initiative
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
PCD	Partnership for Child Development
SHN	School-based Health and Nutrition
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	The United Nations Joint Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation

GLOSSARY¹

Evaluation	Evaluation focuses on whether the programme has had the intended effect on specified outcomes.
Impact	Positive and negative long term effects produced by an intervention, directly or indirectly, intended or unintended.
Indicators	Quantitative and qualitative measures/variables that are used to assess current status, or progress towards programme goals, objectives, outputs and activities
Inputs:	Financial, human, material, technological and information resources that are used to implement an intervention.
M&E framework	Documentation which outlines the key (process) outputs and outcomes of a programme, with indicators for their measurement, along with baseline value and performance targets (if any), source, tools and frequency of data collection and reporting.
Monitoring	The routine tracking of priority information about a programme (at national or project level) and its intended outputs. It includes the monitoring of outputs (and to some extent inputs) through record-keeping and regular reporting systems as well as observation and client surveys. It can be called programme monitoring, process monitoring or output monitoring.
Outcome	The intended or achieved short and medium-term effects of an intervention's outputs. Outcomes represent changes in conditions which occur between the completion of outputs and the achievement of impact.
Output	The products and services which result from the completion of activities within an intervention.
Process Evaluation:	A type of evaluation that examines the extent to which a programme is operating as intended by assessing ongoing programme operations.

¹ A much more extensive glossary of terms in this area can be accessed at <http://www.unfpa.org/monitoring/toolkit/glossary.pdf>.

EXECUTIVE SUMMARY

Over the past decade, the education sector has played an increasingly important role in the multi-sectoral response to HIV&AIDS. The priority placed on the education sector's response is based on evidence that the "social vaccine" of education contributes to knowledge and personal skills essential for the prevention of HIV, and protects individuals, communities and nations from the impact of AIDS.

Thus, governments and education sectors globally are increasingly using their available resources to prevent HIV as well as mitigate its impact within the education system. Since 2002, the UNAIDS Inter-Agency Task Team (IATT) on Education, convened by UNESCO and comprising of UNAIDS co-sponsors and other multi-lateral organizations, civil society and bilateral agencies, has been supporting countries to accelerate and harmonise their education sector responses to HIV&AIDS.

In line with the Paris Declaration on Aid Effectiveness, which calls for results focused and better monitored interventions so that they are effective in accelerating the achievement of the Millennium Development Goals (MDGs), the IATT set up the Indicators Working Group in 2007 to provide guidance on measuring the process and outcomes of education sector HIV responses. One of the first tasks the Working Group identified in order to develop a monitoring and evaluation (M&E) framework (guidelines) for education sector HIV interventions was the review of existing indicators relevant to the sector. Given its prior experience in reviewing the M&E of school-based health, nutrition and HIV (SHN) programmes, the Partnership for Children Development (PCD) offered to undertake this review on behalf of members of the working group. This report summarises the methodology and findings of the review and serves as a resource for the development of an M&E framework for education sector HIV responses.

The methodology involved a desk review of literature containing indicators relevant to education sector HIV response programmes (see section 4.2 and annex 2 for details). It also included information gathered from key informants identified by PCD and the Working Group (see annex 3 for details). During the analyses of indicators, a set of criteria was used to prioritise the usefulness of indicators to the education sector and accordingly they were organised from highest to lowest priority. The criteria included indicator's relevance to the education sector; presence of international agreement on the indicator; its use for national or international M&E; presence of existing data and ease of data collection; and likelihood of measurement errors/ biases (see section 4.3 for details). Key findings of the review are as follows:

1. A commonly agreed M&E framework is required in order to outline and measure the main programme outputs and outcomes of education sector HIV responses (see section 4.1 for details). An analysis of existing conceptual frameworks on education sector HIV responses identified the following key processes. Output indicators identified were categorised by these key processes:

- Education sector policies, plans, and management

- Curricular and non-curricular modes of HIV prevention education to school-age children and youth
- HIV prevention education and training for educators
- Testing, care and support services to school-age children and youth, especially those at high-risk and most vulnerable, including orphans
- Testing, care and support services to educators

The key outcome indicators identified relate to knowledge and behaviour and were categorized by protective factors (e.g. abstinence, being faithful and condom use) and risk factors (multiple partners, unsafe injection use) for HIV. Indicators relating to HIV prevalence and education outcomes that affect HIV prevalence (such as demand, supply and participation) have been excluded for a number of reasons. Firstly because collecting such data is usually beyond the scope of most programmes. Secondly, because these outcomes are affected by whole range of inputs and outcomes, not only those of the education sector response to HIV. Also, because these data are routinely collected as part of national health and education statistics.

2. Many internationally-agreed indicators and data collection tools, which are already in use as part of education or HIV programmes, are relevant to sector specific responses. The use of these indicators and tools should be prioritised. Wherever possible data should be disaggregated by age, sex, educational status and geographic location in order to maximize the information they provide to the education sector.

3. Methodological strengths and limitations in the measurement and use of indicators exist and these should be considered during the development of an M&E framework for education sector HIV responses.

4. For some components of processes and outcomes, no indicators were found during the review. Gaps have been identified with respect to a number of areas; for example indicators that reflect the needs of children affected by conflict/violence, the implementation of community-school links, the impact of gender and power dynamics, the needs of children with disabilities and HIV positive youth.

5. Recommendations for applying the indicators identified during the review to an M&E framework for education sector HIV responses are discussed in detail in section 4.4. and 4.5. The reviewed indicators, their prioritisation, and recommendations for use in the M&E framework for education sector HIV responses require further examination and consideration in order to develop a standardized M&E framework for education sector HIV responses. Almost all the indicators identified would benefit from amendment or adaptation in order to enable them to be more fully effective. As it stands, many of the indicators lack sufficient specificity, the age range they address is greater than that which applies to school aged children and there is much lack of clarity with respect to definition of terms. Indicators from individual country responses, which were not assessed during the review, may also need to be considered to help refine the list of indicators for the M&E framework. Finally, it is also hoped this review and M&E framework thus developed will inform a thematic section on HIV of a wider M&E framework for SHN programmes, which is currently being developed by FRESH partners.

6. The top-most priority indicators identified for each of the key processes and outcomes listed above are given in the following table. It should be noted that this does not imply that other indicators, prioritised less highly, should be excluded from any finalised M&E framework for education sector HIV responses.

The review has demonstrated that considerable common ground exists that could enable the development of an internationally recognized M&E framework for education sector HIV responses, created under the auspices of the UNAIDS IATT on Education. A number of issues remain to be resolved:

- The appropriateness of the M&E framework proposed
- The sufficiency and prioritisation of the criteria suggested for the prioritisation of indicators to be included in the framework
- The prioritization of indicators that has occurred in this review
- Indicator gaps will need to be identified and filled

Further agreement will be required with respect to the indicators that have been identified:

- The indicators will need to be refined so that they give information that is clear, unambiguous and enlightening
- Common terms and definitions will need to be agreed e.g. in the area of “life skills”
- The comparability of indicators will need to be considered e.g. in showing differences in the extent and quality of teaching or services provided

It is proposed that the next step now required is a meeting of stakeholders with an interest in developing an internationally agreed M&E framework for HIV and AIDS. Such a gathering would spend time thinking through and reaching consensus answers to the issues posed above, resulting in the agreement of an M&E framework and a set of corresponding indicators. Endorsement of such work by groups such as the FRESH partners and the UNAIDS IATT on Education would enable the adoption of a common M&E framework for use by countries, governments, programmes and projects around the world, driving forward, the most necessary work in the education sector’s response to HIV and AIDS.

Table 1 Priority indicators among those reviewed identified for key processes and outcomes of education sector HIV response programmes

LEVEL	DESCRIPTION	INDICATORS
Process monitoring		
OUTPUTS	Education sector policies, plans, and management	Strategic plan and operational matrix for integrating HIV/AIDS education in MOE completed and disseminated to stakeholders
	Curricular and non-curricular HIV prevention education to school-age children and youth	% schools that provided life skills-based HIV education in the last academic year
	HIV prevention education and training for educators	1.1 No. (%) of major teacher training institutions providing HIV prevention and skills building to protect teacher trainees out of total number of teacher training institutions 1.2 No.(%) of major teacher training institutions preparing teacher trainees to teach Family Life Skills course out of total number of teacher training institutions.
	Testing, care and support services to school-age children and youth	1.1 Sexually active young women and men aged 15–24 years who received an HIV test in the last 12 months and know their results 1.2 % women and men aged 15–49 who received an HIV test in the last 12 months and who know their results
	Testing, care and support services to educators	None identified
Outcome evaluation		
INTERMEDIATE OUTCOMES	Knowledge, attitudes and beliefs on protective and risk factors for HIV	%young women and men aged 15–24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission
LONG TERM OUTCOMES	Behaviours that can influence HIV status	1.1 % students (13-15 years) who have ever had sexual intercourse 1.2 % students (13-15 yrs) who initiated sexual intercourse before age 13 years 1.3 % students (13-15 yrs) who had sexual intercourse with >= two people during their lifetime 1.4 Among students (13-15 yrs) who had sexual intercourse during the past 12 months, the percentage who used a condom the last time they had sexual intercourse 1.5 Condom use at last high risk sex among youth (age 15-24 years) 1.6 Median age at first sex among young men and women

1. BACKGROUND

In recent years the education sector has come to play an increasingly important role in the multi-sectoral response to HIV&AIDS. This priority placed on the education sector's response is based on evidence that education contributes to knowledge, attitudes and personal skills essential for the prevention of HIV, and protects individuals, communities and nations from the impact of AIDS². The 'social vaccine' of education reduces the vulnerability of girls, and each year of schooling offers them greater protective benefits. School-going children and youth are known to be less likely to become infected than those who do not attend school, even where HIV&AIDS is not integrated in the curriculum³. It is estimated that young people who fail to complete a basic education are more than twice as likely to become infected with HIV, and that some 7 million cases of HIV&AIDS could be avoided by the achievement of Education for All(EFA)⁴.

Education can also create understanding and tolerance that contribute to reduced stigma and discrimination against vulnerable and marginalised communities and people living with HIV.

However, the AIDS epidemic is also affecting the systems that can provide this 'social vaccine'. Especially in countries where the epidemic is generalized (i.e. <1% population prevalence), HIV has resulted in increased rates of teacher absenteeism and attrition, and created orphans and vulnerable children who are less likely to attend school and more likely to drop out. Affecting supply, demand, and quality of education, HIV&AIDS limits the capacity of education sectors to achieve EFA, and of countries to achieve the Millennium Development Goals (MDGs)⁵.

Thus governments and the education sector around the world are increasingly using their available resources to prevent HIV as well as to mitigate its effects within the education system. In sub-Saharan Africa alone, the most affected region in the world, 27 countries are now known to have education sector HIV&AIDS strategies, most of which have been incorporated into actionable plans for implementation⁶. Within EFA itself, Goal 3 seeks to respond to these concerns by "Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes."

Within countries, development partners have supported governments in their efforts to respond to HIV&AIDS. Regionally as well, partner agencies have supported networks of ministry of education HIV&AIDS coordinators, such as in sub-Saharan Africa and in the Caribbean. Globally, the UNAIDS Inter-Agency Task Team (IATT) on Education was formed in 2002, with the objective of accelerating and improving a

² UNESCO (2007). UNESCO's Strategy for Responding to HIV and AIDS

³ IATT on Education (2009) HIV&AIDS and Education A Strategic Approach.

⁴ GCE (2004) Learning to survive: How education for all would save millions of young people from HIV&AIDS. Global Campaign for Education: Belgium

⁵ World Bank (2002). Education and HIV&AIDS: A Window of Hope

⁶ Accelerate Initiative (2009) Accelerating the Education Sector Response to HIV&AIDS in Sub-Saharan Africa. A Rapid Situation Analysis of 34 Countries

coordinated and harmonised education sector response to HIV&AIDS across countries. The IATT on Education is convened by the United Nations Educational, Scientific and Cultural Organization (UNESCO) and brings together United Nations Joint Programme on HIV&AIDS (UNAIDS) cosponsors, bilateral agencies, private donors and civil society organizations⁷.

2. INTRODUCTION

In November 2007, the UNAIDS IATT on Education proposed setting up an Indicators Working Group to help guide the IATT, its member organizations and ministries of education on methods and instruments to measure the process and outcomes of education sector HIV&AIDS programmes. This was in response to the recognition that the contribution of the education sector to national AIDS responses has often been poorly appreciated as the behavioural data are limited and difficult to measure. It was recognised that improved access to process and outcome information would help ministries of education and their partners improve the quality and management of their HIV response programmes. It would also help them advocate for funding for education sector HIV response interventions. Thus, in line with the Paris Declaration on Aid Effectiveness, efforts would be more results focused and better monitored⁸ and help accelerate the achievement of the MDGs and the achievement of EFA.

Subsequently the Indicators Working Group was set up. Some of the main tasks the Group planned were to:

- Identify key questions that the education sector must address about its HIV&AIDS response programmes
- Identify key indicators that provide meaningful measures of progress on the identified questions
- Identify exemplary models of tools, questionnaires, and processes that have effectively measured progress on identified indicators in education programmes
- Provide realistic and user-friendly guidance on setting targets
- Provide user friendly guidance on linking processes and instruments with other assessments in education (curriculum referenced testing, etc.)

In order to assist the accomplishment of some of the main tasks of the Group, the Partnership for Child Development (PCD), one of the Group members, offered to conduct a review of indicators applicable to the education sector HIV response programmes during their November 2008 meeting. It was proposed that the review findings would be presented and discussed at a Working Group meeting, with an objective of developing a monitoring and evaluation (M&E) framework for education sector responses to HIV&AIDS. Following this, the Working Group would report back to IATT at its spring 2009 meeting, with specific suggestions for measuring the processes and outcomes of education sector HIV programmes.

⁷ For more information about the IATT on Education and its member organisations, visit <http://www.unesco.org/aids/iatt>

⁸ For more information on Paris Declaration visit http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

PCD's particular interest in undertaking this task arose from a study that it undertook with Save the Children USA on behalf of all FRESH partners⁹, to assess the need for a generic framework for the M&E of school-based health, nutrition and HIV programmes (SHN). The study, which was informed by national and international stakeholders in SHN (representing governments, NGOs/INGOs, UN agencies and academic institutions), found a strong demand for a generic M&E framework for SHN that would help synergise existing resources. It also found that common processes and outcomes exist across health interventions that can be used as a basis for consensus on a framework. Such a framework would provide M&E guidance to implementers, adaptable to local settings. These findings were presented at a meeting of FRESH partners held at the World Health Organisation (WHO) headquarters in Geneva on 8-9 September 2008. Partners confirmed the need for a generic M&E framework for school-based health interventions and discussed next steps for its development. The framework is currently being developed by FRESH partners, and is scheduled to be launched in late 2009.

In order to avoid duplication between the development of M&E framework for SHN programmes and the work of the Indicators Working Group, both FRESH partners and the Working group members have agreed that the review of indicators for education sector HIV responses and subsequent development of a results framework serve as a resource for the HIV&AIDS thematic section of the M&E framework for SHN. This review will therefore inform both; the M&E of education sector HIV response programmes as well as SHN programmes in general.

⁹ FRESH or Focusing Resources on Effective School Health is an internationally agreed framework for school-based health, nutrition and HIV&AIDS programmes. The framework calls for the integrated implementation of a core minimum set of activities in schools in low-income countries. FRESH partners are listed on http://portal.unesco.org/education/en/ev.php-URL_ID=34993&URL_DO=DO_TOPIC&URL_SECTION=201.html

3. PURPOSE AND METHODOLOGY

3.1 Purpose:

The purpose of this review of indicators for education sector HIV response programmes is to guide the production of user-friendly guidance to measure the coverage, outcomes and impact of education programmes on HIV&AIDS (particularly in low and middle income countries). The specific objective of the review is to:

- Provide an overview of key existing indicators that can be used to monitor and evaluate education programmes on HIV&AIDS in different epidemiological settings.
- Prioritise the usefulness of indicators based on different parameters such as relevance, international/national use and acceptability, practicality and ease of data collection.

Detailed terms of reference are in annex 1.

3.2 Methodology:

The following methods were used during the review in order to identify useful sources of indicators relevant to education sector HIV programmes:

- A desk review of literature and guidelines relevant to the monitoring and evaluation of HIV&AIDS education programmes. To draw on the expertise and experience of IATT members, an email was sent to the IATT mailing list requesting relevant documentation to be included in the review. The consultant also conducted online searches to obtain information on national-level and programme indicators, data collection methods, and relevant result frameworks. The list of literature reviewed is in annex 2.
- Discussion with key informants identified by PCD in collaboration with the Working Group – these took place by phone and email to obtain additional documentation and elicit further information on indicators, and data collection methods. The list of key informants is in annex 3.

Using the information that was identified/provided, a framework was used to define key education sector HIV process-outputs and outcomes and accordingly categorise indicators (see section 4.1 for details). Indicators were thus presented, with a short description of their purpose, epidemiological significance, calculation, and (frequency of) data collection. A set of criteria was used to analyse indicators for their usefulness to the education sector, organised by order of priority (from highest to lowest). Based on the relative strengths and limitations of indicators, recommendations were made for the M&E framework for education sector HIV responses (see section 4.4 and 4.5 for details).

A draft of this report was circulated to members of the Indicators Working Group prior to their meeting during the Spring 2009 IATT meeting (scheduled for 15-17 June 2009). The report was subsequently enriched further to their feedback, and inputs from others associated with the IATT.

4. FINDINGS AND DISCUSSION

4.1 Framework for processes and outcomes of education sector HIV responses

At the outset, a framework was considered necessary in order to define (and thus measure) the main process-outputs and outcomes of education sector HIV response programmes. A range of complementary frameworks on education sector HIV response programmes, promoted by various agencies/inter-agency initiatives, are known to be currently in use (see annex 4 for details). They include:

- the Accelerate, EDUCAIDS and Mobile Task Team (MTT) strategic frameworks, which aim to strengthen the capacity of national ministries of education and other education stakeholders to scale up their response to HIV;
- the EFAIDS framework that focuses on preventing and mitigating the effects of HIV on teachers; and
- the IATT on Education framework, which prioritises education sector response actions for different epidemic scenarios.

These were analysed in order to identify the key processes and outcomes for education sector HIV responses in primary, secondary and tertiary education, and in non-formal education.

Processes

The key components or processes of education sector responses to HIV&AIDS highlighted by the various frameworks are as follows. Output indicators were categorised by these main processes. They are described in more detail in section 4.4.

- A. Education sector policies, plans, and management
- B. Curricular and non-curricular modes of HIV prevention education to school-age children and youth (during non-formal, early childhood, primary, secondary and tertiary education)
- C. HIV prevention education and training for educators (during pre- and in-service training)
- D. Testing, care and support services (e.g. Voluntary Counselling and testing (VCT), psychosocial support, educational support services) to school-age children and youth, especially high-risk groups and orphans and vulnerable children
- E. Testing, care and support services to educators

Outcomes

Key intermediate outcomes of education sector HIV programmes are educators' and youths' knowledge and attitudes on protective factors such as abstinence, being faithful, condom use, later age of sexual debut, male circumcision etc and risk factors such as multiple concurrent partners, unsafe injection use etc .

Outcome indicators were categorised according to educators' and youths' actual actions and behaviours which directly affect a person's biological status relating to HIV.

Longer term outcomes (or impact) of education sector HIV programmes relate to HIV prevalence and incidence rates among educators and learners as well as educational outcomes (such as the demand, supply, participation and completion of education). However attributing these long-term impacts to sectoral HIV programmes is difficult during the M&E of interventions since these outcomes are influenced by several other factors (e.g. socioeconomic status, the media etc). Conducting a trial that would control for the various factors is complex and expensive and beyond the scope of resources for most education programmes¹⁰. Therefore, the review does not assess indicators relating to HIV prevalence and the long-term impact of education programmes upon it. It recommends that intermediate outcomes and behavioural indicators are used to evaluate education sector HIV programmes.

4.2 Selection of indicators

Indicators relevant to education sector HIV processes and outcomes were identified from a range of different literature. These included international surveys (e.g. UNICEF's Multiple Indicator Cluster Survey (MICS), or Measure's Demographic and Health Survey (DHS)) and M&E guidelines for national HIV programmes (e.g. UNGASS, MDG and UNAIDS guidelines); M&E guidelines for educational systems (including EMIS) that can impact on HIV; M&E guidelines for adolescent reproductive health/HIV programmes; M&E guidelines and tools for school-based health programmes; and documents on education sector HIV programmes. Documents and M&E guidelines for HIV programmes in individual countries (though collected in a minority of countries, such as Zambia, Jamaica and USA) were not analysed due to the priority given to international documents in the given time to complete the review. Therefore the review exercise should be followed by similar analyses of country level documents, especially during the development of country-level M&E frameworks.

Indicators thus selected were categorised by the identified key processes/components and expected outcomes of education sector HIV programmes. Each indicator includes a brief description, namely its definition, purpose, epidemiological scenario (i.e. generalized or non generalized epidemic) for which it is relevant¹¹, data collection method and frequency, and literature from which it was sourced.

4.3 Criteria for prioritising indicators

The usefulness of output and outcome indicators was prioritised based on a set of criteria (listed below). For each criterion, the review graded indicators on a subjective scale on the basis of available information. Thus the grading of indicators relied on

¹⁰ UNAIDS et al. 2004. *National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*. France: WHO
Webb, D., Elliott, L. 2002. *Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people*. Save the Children USA.

¹¹ UNAIDS and WHO categorise the AIDS epidemic as either *low-level*- where HIV prevalence is below 1% and HIV has not spread to significant levels within any sub-group; *concentrated* – where HIV prevalence is high in one or more sub-populations; or *generalised* – where prevalence is more than 1% in the general population.

current information on an indicator and its use, and may vary in the future or from country to country depending on the local context.

1. **Relevance and specificity to education sector HIV responses/outcomes:**

This was considered as the most important criterion for prioritising the usefulness of an indicator. The indicator's relevance to the education sector was graded as:

- a. *Complete*: if the indicator or its data was completely relevant to the education sector.
- b. *Partial*: if the indicator or its data only partly provided information on the education sector. Disaggregated data or supporting information may be needed for specific information on the education sector.

If an indicator was completely relevant to the education sector, it was prioritised over an indicator which was only partially relevant, regardless of the other criteria they met.

2. **National/international agreement on the indicator:**

UNAIDS recommends that as part of one national M&E system for HIV, each country should have a standardised set of national indicators endorsed by all stakeholders in country¹². Similarly a set of internationally agreed indicators contribute to better understanding of the global response to AIDS. Thus, the usefulness of indicators was prioritised on the basis of existing national or international agreements and recommendations. Categories used to describe an indicator's usefulness with regards to this criterion were:

- a. *Yes*: if one or more countries/UN agencies recommend use of the indicator.
- b. *No, don't think so*: if the indicator has only been proposed by an organisation/individual but not recommended by countries/UN agencies.
- c. *Unsure*: if it is not clear whether the indicator is recommended by countries/UN agencies.

3. **Use for national M&E and for international comparison of country responses:**

Since the objective of the review was to provide guidance for measuring the outputs and outcomes of education sector responses in countries, the usefulness of indicators for national-level M&E was considered an important criterion. In order to compare national education sector responses to HIV across countries it is important that indicators used are comparable, therefore the usefulness of the indicator for international comparison was also considered. Categories used to describe an indicator's usefulness for national or international M&E were:

- a. *Definitely*: signifies it can definitely be used for M&E
- b. *Possible*: signifies there is a possibility of using it for M&E, if certain conditions are met
- c. *Unsure*: signifies it difficult to comment based on available information.

School-level indicators that cannot be directly used at national level and depend on local context have not been included in the review.

¹² UNAIDS (2005) The "Three Ones" in action: where we are and where we go from here

4. **Presence of existing data, and general ease of data collection:** The presence of, and ease of access to, existing data, which can be referred to by the education sector, also determines the usefulness of an indicator. Data may be collected by the education sector itself or it may need to be collected by staff of other sectors e.g. health. The categories used to describe an indicator's usefulness with regards this criterion are: *yes* (if there is existing data or it is relatively easy to obtain data); *should be available/easy* (if data may be available or may be easily collected); *don't think so* (if it is unlikely to be able to obtain existing data or difficult to collect data), and *unsure*.
5. **Likelihood of errors during indicator data collection, due to measurement errors or biases:** The usefulness of an indicator also depends on its reliability and absence of measurement errors and biases. The categories used to describe an indicator's usefulness with regards to the likelihood of errors were *yes* (if data is usually reliable), *not really* (if reliability cannot be assured) and *unsure*, depending on documented as well as perceived limitations with the indicator.

The extent to which indicators met the different criteria determined their 'usefulness' ranking. It should be noted that the order of *criteria* given above does not imply prioritization of the criteria employed (i.e. most important criterion to least important criterion).

4.4 Process Indicators

- A. Education sector policies, plans and management: This component includes the presence of:
 - a. education sector HIV response policy and/or strategy integrated in the national HIV&AIDS strategy and/or policy and national education plans (including FTI);
 - b. HIV&AIDS workplace policies (either at the national or sector level) to ensure supportive and safe environments for educators and learners;
 - c. budgeted plan of action, access to financial resources through national AIDS authorities, and expenditure on education sector HIV responses;
 - d. HIV&AIDS management structures or committees to guide and monitor the education sector's response;
 - e. data management tools such as education management information systems (EMIS) and other methods to monitor, evaluate and assess the education sector response, such as school surveys, situation analyses and needs assessments;
 - f. tools for long-term planning such as projection models and impact assessments
 - g. strategic partnerships for coordination, advocacy and resource mobilisation

The main existing indicators identified on education sector policies, plans and management (in order of priority – from highest to lowest) are as follows¹³. Details of the indicators are in table 1.

1. Strategic plan and operational matrix for integrating HIV/AIDS education in MOE completed and disseminated to stakeholders
2. Management and school governing bodies
 - 3.1 National index on policy related to young people and HIV/AIDS
 - 3.2 National funds spent by government on HIV/AIDS prevention programmes for young people
 - 3.3 National Composite Policy Index
 - 3.4 Domestic and international AIDS spending by categories and financing sources

Strength, limitations and recommendations

Indicators identified are relevant to all countries regardless of epidemiological setting. Indicator 1 and 2 are directly relevant for education sector HIV programmes (they reflect components a. and d. above). However, they need to be further developed before they can be used. For example, they need to be clearly defined, made measurable and the data collection method needs to be specified. Also, they will need to be further refined (For example Indicator 2 would need to be read “Management and school governing bodies that address issues of HIV in the education sector/school). Since indicator 1 is an HIV programme indicator, in line with the 3-ones principle¹⁴, the national AIDS committee would need to be informed of its use for the national education sector programme.

Indicators 3.1 and 3.3 are composite measures for commitment to a national policy on HIV, while indicators 3.2 and 3.4 measure funding commitment to HIV responses. All four indicators encompass activities by education and other sectors; therefore only disaggregated components on each indicator are relevant to an education sector HIV programme manager. For example, under indicator 3.1, monitoring the existence of a policy promoting life-skills based education in schools (which is a disaggregated component of the indicator) could be a key interest of education sector programme. Since 3.1 and 3.3 have a similar scope of measurement and 3.2 and 3.4 also have a similar scope, one indicator from each of the two pairs may be short listed for the M&E framework, depending on which has greater utility.

Data for indicators 3.3 and 3.4 are collected by National AIDS Committees (NAC) using standard assessment formats, namely the National Composite Policy Index (NCPI) questionnaire and National AIDS Spending Assessment (NASA) respectively, and reported to UNAIDS using its Country Response Information System (CRIS) every two years. If the data collection formats are

¹³ The serial number of each indicator shows its position on the usefulness scale. Those indicators which are equally prioritised, for example as ‘x’, are numbered as x.1, x.2 etc

¹⁴ The three ones principle is that all stakeholders in country-level HIV/AIDS responses should use: **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners. **One** National AIDS Coordinating Authority, with a broad based multi-sector mandate. **One** agreed country level Monitoring and Evaluation System.

the same (or nearly similar) across countries then international M&E on these indicators is possible. Given NAC's regular reporting to UNAIDS, historical data on indicators 3.2 – 3.4 should also be available and accessible if required.

In addition to the national HIV M&E system coordinated by the NAC, the EMIS managed by ministries of education may also be tapped into for relevant information on HIV responses (e.g. management capacity, and funds). The information that can be sourced from the EMIS would depend on data being collected by the system and its capacity in each country.

Indicators to assess the quality of policies; implementation of workplace policies; presence of an active management structure; strategic partnerships and data management tools (for monitoring, evaluation and planning) were not found. These gaps would need to be considered for the proposed M&E framework.

Table 2 Indicators relevant to education sector HIV policies, plans and management

Policies, plans, and management					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Strategic plan and operational matrix¹⁵ for integrating HIV/AIDS education in MOE completed and disseminated to stakeholders-----1</p> <p><u>Definition:</u> Not provided</p> <p><u>Purpose:</u> to measure the planning and implementation and management capacity for HIV responses in the MoE</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> <i>Africa Bureau Brief. USAID Response to the impact of HIV/AIDS on basic education in Africa</i></p>	<p><i>Complete</i> – measures the presence of a national plan for HIV prevention education and its dissemination. Does not assess the quality/content of the national plan.</p> <p>Relevant for a national education sector HIV programme. Development partners supporting national policy development and dissemination may refer to this indicator.</p>	<p><i>No, Don't think so</i>, it is a proposed indicator.</p>	<p><i>Definitely</i> for national M&E;</p> <p><i>Possible</i> for international M&E. Comparison between countries may depend on the nature of the epidemic.</p>	<p>Existing data: <i>Not sure</i>, since is a proposed indicator.</p> <p>Ease of getting data: <i>should be easy</i>, if the plan and matrix exist.</p>	<p><i>Not really</i>, since presence of a plan verifiable, and dissemination verifiable through details of dissemination events.</p>
<p><u>Name/priority no. of Indicator:</u> management and school governing bodies¹⁶-----2</p> <p><u>Definition:</u> Not provided</p> <p><u>Purpose:</u> to track the presence of education management system</p>	<p><i>Partial</i> – a means of tracking the number of district management and school governing board members. Does not indicate the duration or</p>	<p><i>No, Don't think so</i>, it is a proposed indicator.</p>	<p><i>Possible</i> for national M&E;</p> <p><i>Unsure</i> for international M&E, since countries may</p>	<p>Existing data: <i>Not sure</i>, of presence existing data since is a proposed indicator.</p>	<p><i>Yes</i>, over-reporting possible.</p>

¹⁵ The term “operational matrix” is in need of clear definition – to many, it is not immediately clear what it is/ includes.

¹⁶ Reviewers have suggested that for this indicator to be functional, greater information is needed here about how these bodies impact upon HIV.

Policies, plans, and management					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p>staff members in sub-districts and schools. Details of sub-district inspectors and school governing body members by age, gender, days absent (by cause), and permanent absence (by cause)</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> monthly reports from the district manager.</p> <p><u>Source:</u> <i>Management of HIV/AIDS at the Education District Level: The Case for the Collection of Local Indicators</i></p>	<p>frequency of their effort towards education sector HIV responses.</p> <p>Relevant for both national and sub-national programmes.</p> <p>Development partners supporting management capacity at sub-national level may refer to this indicator.</p>		<p>differ w.r.t. size and administrative divisions.</p>	<p>Ease of getting data: <i>Unsure</i>, depends if there is an existing monthly reporting system for the district manager and a process of reporting sub-districts/schools.</p>	
<p><u>Name/priority no. of Indicator:</u> National index on policy related to young people and HIV/AIDS---3.1</p> <p><u>Definition:</u> Progress in the development of national-level HIV/AIDS policies and strategies in six key areas: 1. identification of HIV prevention among young people as a priority in the national strategic plan on AIDS; 2. application of a multi-sectoral approach to HIV prevention among young people; 3. existence of a policy or strategy to promote HIV information, education and communication (IEC) for young people; 4. existence of a policy promoting life-skills-based education in schools; 5. existence of a policy providing youth-friendly health services; 6. existence of a policy promoting young people's access to condoms</p>	<p><i>Partial</i> – education sector mainly responsible for key areas 2 and 4, while other sectors responsible for other areas.</p> <p>Relevant for a national education sector HIV programme. Development partners supporting policy development at national level may also refer to this indicator.</p>	<p><i>Yes</i>, recommended by WHO and other development partners.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Definite</i> for international M&E if the reporting format (involving all six key areas) is the same for any country.</p>	<p>Existing data: <i>Don't think so</i> since newly suggested.</p> <p>Ease of getting data: <i>should be easy</i>, national education sector HIV programme manager should have information on key area 4.</p>	<p><i>Not really</i>, since policies verifiable. However, indicator does not assess quality of policies.</p>

Policies, plans, and management					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Purpose:</u> To assess progress in the development and implementation of national level HIV&AIDS policies and strategies for youth.</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> suggestion to add to the national composite policy index questionnaire (see below); every two years</p> <p><u>Source:</u> <i>National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people</i> <i>Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012</i></p>					
<p><u>Name/ priority no. of Indicator:</u> National funds spent by government on HIV/AIDS prevention programmes for young people---3.2¹⁷</p> <p><u>Definition:</u> The amount of national funds spent by governments on HIV/AIDS prevention programmes for young people</p> <p><u>Purpose:</u> To track how funds are spent at national level for HIV</p>	<p><i>Partial</i> – funds spent may be for school-based activities as well as non-school youth activities that are not part of the education sector.</p> <p>Relevant for a national</p>	<p><i>Yes</i>, it is recommended by the WHO and other international agencies.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> for international M&E, though epidemiological situation in countries</p>	<p>Existing data: <i>Yes</i>, assuming it can be disaggregated from yearly National AIDS Spending Assessments (NASA).</p>	<p><i>Yes</i>, potential for double counting, and missing costs if education sector expenses are not accounted</p>

¹⁷ Reviewers of this document have suggested that Page: 23 this indicator needs to show volume of national funds and percentage of national funds to be meaningful as to what priority funding to HIV prevention programmes is given in relation to other areas.

Policies, plans, and management					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p>youth programmes and where funds originate from. Three main expenditure categories: 1. life-skills-based education through schools; 2. IEC campaigns targeted at young people; 3. Programmes for the provision of condoms.</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> Suggested data collected during National AIDS Spending Assessment (NASA); every year</p> <p><u>Source:</u> <i>National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people</i></p>	<p>education sector HIV programme. Development partners providing funding support at national level may also refer to this indicator.</p>		<p>may need to be considered during cross-country comparison.</p>	<p>Ease of getting data: <i>should be easy</i>, due to NASA.</p>	<p>for during National AIDS Spending Assessments.</p>
<p><u>Name/ priority no. of Indicator:</u> National Composite Policy Index¹⁸---3.3</p> <p><u>Definition:</u> Not provided</p> <p><u>Purpose:</u> To assess progress in the development and implementation of national level HIV&AIDS policies and strategies</p> <p><u>Epidemiological setting:</u> Any country</p>	<p><i>Partial</i> – overall national policies on HIV assessed. Section on prevention assess if HIV integrated in school curricula and if prevention education provided to out of school youth.</p>	<p><i>Yes</i>, it is an UNGASS indicator.</p>	<p><i>Definitely</i> for national M&E; <i>Unsure</i> for international M&E because formats used may not be comparable across countries.</p>	<p><i>Yes</i>, data collected every two years.</p>	<p><i>Yes</i>, since it is qualitative information filled by officials; however potential for missing information and under/ over reporting.</p>

¹⁸ As an aggregate indicator, this indicator may give only limited information about how education figures in the strategy/policy

Policies, plans, and management					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Data collection method and frequency:</u> Literature review and interviews reported to UNAIDS via the Country Response Information System (CRIS) every 2 years.</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators</i></p>					
<p><u>Name/ priority no. of Indicator:</u> Domestic and international AIDS spending by categories and financing sources¹⁹-----3.4</p> <p><u>Definition:</u> Not provided</p> <p><u>Purpose:</u> To track how AIDS funds from domestic and international sources are spent at national level. Eight expenditure categories (with sub-categories): 1. Prevention; 2. Care and treatment; 3. Orphans and vulnerable children; 4. Programme management and administration strengthening; 5. Incentives for human resources; 6. Social protection and social services (excluding OVC); 7. Enabling environment and community development; and 8. Research (excluding operations research under programme management).</p> <p><u>Epidemiological setting:</u> Any country</p>	<p><i>Partial</i> – for example when HIV prevention and orphans and vulnerable children expenditures highlight school-based spending.</p>	<p><i>Yes</i>, it is an UNGASS indicator.</p>	<p><i>Definitely</i> for national M&E. <i>Unsure</i> for international M&E.</p>	<p>Existing data: <i>Yes</i>, mainly yearly National AIDS Spending Assessments (NASA). Ease of getting data: <i>should be easy</i>, due to NASA.</p>	<p><i>Yes</i>, potential for double counting expenses, and missing information if education sector expenses are not accounted for during National AIDS Spending Assessments.</p>

¹⁹ Reviewers of this document have suggested that Page: 25 this indicator needs to show volume of national funds and percentage of national funds to be meaningful as to what priority funding to HIV prevention programmes is given in relation to other areas.

Policies, plans, and management					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Data collection method and frequency:</u> A standard National AIDS Spending Assessment (NASA) reported to UNAIDS using CRIS every 2 years</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012</i></p>					

2. Curricular and non-curricular modes of HIV prevention education to students:
This process/component includes the presence of:
 - a. a national curriculum which uses a life skills approach;
 - b. grade and age specific curricular content- for primary, secondary and tertiary education;
 - c. life skills education/teaching part of formal and non-formal curriculum
 - d. peer education to in and out-of-school youth
 - e. outreach education to out-of-school youth
 - f. community involvement in curriculum development and revision to ensure ownership and support

The main existing indicators found on curricular and non-curricular modes of HIV prevention education to school-age children and youth (in order of priority – from highest to lowest²⁰) are as follows:

1. Percentage of schools that provided life skills-based HIV education in the last academic year.
 - 2.1 Number (%) of young people aged 10–24 years reached by life skills-based HIV education in schools.
 - 2.2 Number (%) of countries that have “comprehensive and correct knowledge about HIV prevention” in national school leaving examinations at primary and secondary level of education.
- 3.1 Number (%) of peer educators/centres/schools/colleges organising activities related to HIV/AIDS/STD education and prevention.
- 3.2 Number of primary schools offering a Family Life Skills course as a proportion of all primary schools.
- 3.3 Number of secondary schools offering a Family Life Skills course as a proportion of all secondary schools.
- 4.1 Curriculum in primary/secondary education systems to develop young people’s knowledge, attitudes and skills for health
- 4.2 Proportion of schools integrating life skills education into the wider curriculum
- 4.3 Proportion of schools in target area having active anti-AIDS clubs.
5. Percentage of emergency schools and learning spaces that provide life skills-based HIV education.
6. Timetabling of the education as prescribed or recommended.

Strength, limitations and recommendations

All of the above indicators are relevant to education sector HIV programmes, though most are pertinent to formal education. Indicator 3.1 on peer educators and centres and indicator 6 on timetabling may be tailored for non-formal education. However in order to be considered for the M&E framework, both indicators need to be clearly defined and their measurement method specified.

Indicators 1, 4.1, 4.2 and 5 measure the coverage of life-skills education in schools, each with a slightly different emphasis. Indicator 1 is internationally recognised and requires life-skills coverage for primary and secondary schools to

²⁰ The serial number of each indicator shows its position on the usefulness scale. Those indicators which are equally prioritised, for example as ‘x’, are numbered as x.1, x.2 etc

be reported separately (in addition to being reported as a combined score). Furthermore it implies a completed action, as opposed to the ambiguity of 'offering'. Therefore it is preferred over 4.1 or 4.2 for the M&E framework.

Since indicators 1 and 2.1 are internationally recommended, it should be possible to use them for regional or international monitoring. Indicators 3.1- 3.3 may also be used for international monitoring and cross-country comparison, if they are clearly defined and the data collection method and frequency used is comparable across countries.

Indicator 2.2 is a useful indicator for international monitoring. It not only measures if life skills HIV education is examinable, but also indicates if it is part of the national curriculum. The indicator may, however, underestimate the implementation of life-skills education in countries where HIV education is part of the national curriculum but questions on HIV may not have been included in school leaving examinations. Therefore this indicator should preferably be used in combination with indicator 1 for a more complete picture. Moreover, since 2.2 is an indicator for international monitoring, a linking national level indicator can be developed for the M&E framework. All other indicators can be used for sub-national and national programme monitoring.

In many countries, school inspectors survey all schools during the academic year. The school surveys may thus serve as a useful entry point to collect data for HIV indicators, as is the case with indicator 1. Data for indicators 2.1, 3.3, and 5 may also be collected during school surveys. All the same, school surveys are expensive, and in countries/situations where resources are limited and school surveys are not regular, it may not be easy to get data on indicators.

Finally, since most of these indicators rely on interview data, reporting bias on the extent of implementation is likely. Therefore, where possible, an additional means of verification, such as evidence of taught lesson or examination, may need to be considered.

Specific indicators to assess grade and age specific curriculum content; peer and outreach education to out-of-school youth; non-formal HIV prevention education; and community involvement in curriculum development and use were not found. These gap areas would need to be considered for the proposed M&E framework.

Table 3 Indicators relevant to curricular and non-curricular modes of HIV prevention education to school-age children and youth

Curricular and non-curricular modes of HIV prevention education to school-age children and youth					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Percentage of schools that provided life skills-based²¹ HIV education in the last academic year.----1</p> <p><u>Definition:</u> Number of schools that provided life skills-based HIV education in the last academic year (i.e. 30 hrs to each grade) divided by number of schools surveyed</p> <p><u>Purpose:</u> to assess progress towards implementation of life skills-based HIV education in all schools, based on reported coverage</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> school surveys done and reported through the Country Response Information System (CRIS) to UNAIDS every 2 years</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012</i></p>	<p><i>Complete</i> – provides a picture of national coverage of life skills HIV education. Quality of life-skills education as such not measured. Relevant for national and sub-national programmes.</p>	<p><i>Yes</i>, it is a UNGASS indicator.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> for international M&E.</p>	<p><i>Should be available</i>, every two years countries are required to report to UNAIDS (though often do not).</p> <p>Ease of data collection, <i>should be easy</i> if information is collected during routine school surveys.</p>	<p><i>Yes</i>, relies on reported coverage, so reporting bias possible, unless there are additional means of verification (e.g. exam results)</p>
<p><u>Name/priority no. of Indicator:</u> No. (%) Young people aged 10–24 years reached by life skills-based HIV education in schools ---2.1</p>	<p><i>Complete</i> - provides coverage of</p>	<p><i>Yes</i>, recommended by GFATM</p>	<p><i>Definitely</i> for national M&E</p>	<p>Existing data, <i>don't think so</i>, since only</p>	<p><i>Yes</i>, relies on reported coverage, so</p>

²¹ Many different terms are used in the area of “life skills” – life skills education, family and life health education etc. Greater clarity is needed with respect to definition of terms and content.

Curricular and non-curricular modes of HIV prevention education to school-age children and youth					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Definition:</u> Number of young people reached through any effort to affect change, including peer education, class room, small group, and/or one-on-one information, education and communication or behaviour change communication to promote change in behaviour in a school setting divided by Number of young people attending targeted schools</p> <p><u>Purpose:</u> to measure coverage of life skills-based HIV education in schools</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> proposed for quarterly collection, and review every two years</p> <p><u>Source:</u> <i>Monitoring and Evaluation Toolkit HIV, Tuberculosis and Malaria and Health Systems Strengthening</i></p>	<p>skills based HIV education. Quality of education is not measured through this indicator.</p>		<p><i>Possible</i> for international M&E</p>	<p>recommended</p> <p>Ease of data collection, <i>don't think so</i>, unless information collected routinely in schools.</p>	<p>reporting bias possible, unless there are additional means of verification (e.g. IEC material).</p> <p>Avoid double counting if using secondary data from programme monitoring reports of different organisations.</p>
<p><u>Name/priority no. of Indicator:</u> Number (%) of countries that have “comprehensive and correct knowledge about HIV prevention” in national school leaving examinations at primary and secondary level of education.— 2.2</p> <p><u>Definition:</u> Number of countries with HIV prevention knowledge as part of national school leaving examinations at primary and secondary school levels divided by number of countries having provided information on their national school leaving examinations</p> <p><u>Purpose:</u> To assess progress towards implementation of life skills-based HIV</p>	<p><i>Complete</i> - measures the number of countries where life skills HIV education is examined and thus been part of the curriculum.</p>	<p><i>Don't think so</i>, since it is a newly proposed indicator.</p>	<p>Not relevant for national M&E.</p> <p><i>Definite</i> for international M&E.</p>	<p>Existing data: <i>Don't think so</i>, since it is a newly proposed indicator.</p> <p>Ease of data collection: <i>should be easy</i>, since data collection depends on</p>	<p><i>Yes</i>, extent of implementation may be underestimated where countries have not included questions on HIV in school leaving exam even though students might be taught and</p>

Curricular and non-curricular modes of HIV prevention education to school-age children and youth					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p>education in all schools worldwide</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> Yearly observation of national school leaving examination question paper</p> <p><u>Source:</u> <i>EFA Info Indicator</i></p>				<p>observation of examination questions.</p>	<p>examined on HIV in other grades.</p>
<p><u>Name/priority no. of Indicator:</u> Number/percent peer educators/centres/schools/colleges organising activities related to HIV/AIDS/STD education and prevention---3.1</p> <p><u>Definition:</u> Not defined (type of activities need to be defined)</p> <p><u>Purpose:</u> to track implementation of non-curricular HIV education activities</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> not mentioned (time period e.g. in the last year, needs defining)</p> <p><u>Source:</u> <i>Program Evaluation: Life skills-based education. Measures and Indicators</i></p>	<p><i>Complete</i> – can be used by national and sub-national programmes. Development partners supporting non-curricular HIV education activities can contribute data on their activities.</p>	<p><i>No, Don't think so</i>, it is a proposed indicator.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> for international M&E.</p>	<p>Existing data: <i>don't think so</i>, it is a proposed indicator.</p> <p>Ease of getting data: <i>should be easy</i> for centres, schools, and colleges if rely on existing surveys. <i>Don't think so</i> for data on peer educators.</p>	<p><i>Yes</i>, if it relies only on interviews, reporting bias possible. Other means of verification required.</p>

Curricular and non-curricular modes of HIV prevention education to school-age children and youth

Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Number of primary schools offering a Family Life Skills course as a proportion of all primary schools----3.2²²</p> <p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> To assess progress towards implementation of life skills-based HIV education in all schools</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> Africa Bureau Brief. USAID Response to the impact of HIV/AIDS on basic education in Africa</p>	<p><i>Complete</i> - Provides a picture of national coverage of life skills HIV education in primary schools. Quality of life-skills education as such not measured.</p> <p>Can be used by national programmes.</p>	<p><i>No, don't think so</i>, it is only a proposed indicator</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> for international M&E</p>	<p>Existing data: <i>Not sure</i>, need to check with USAID African Bureau</p> <p>Ease of data collection: <i>Don't think so</i>, since it requires school surveys. Easy if integrated in ongoing school surveys.</p>	<p><i>Yes</i>, if it relies only on interviews, reporting bias possible. Other means of verification (e.g. test results) required.</p>
<p><u>Name/priority no. of Indicator:</u> Number of secondary schools offering a Family Life Skills course as a proportion of all secondary schools----3.3</p> <p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> To assess progress towards implementation of life skills-based HIV education in all schools</p>	<p><i>Complete</i> - Provides a picture of national coverage of life skills HIV education in</p>	<p>Same as above</p>	<p>Same as above</p>	<p>Same as above</p>	<p>Same as above</p>

²² Page: 32

A limitation of this indicator is that it is unclear whether 'offering' (wording of indicator) implies whether the life-skills course is actually being delivered, or if it is just available.

Curricular and non-curricular modes of HIV prevention education to school-age children and youth					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> Africa Bureau Brief. USAID Response to the impact of HIV/AIDS on basic education in Africa</p>	secondary schools. Quality of life-skills education as such not measured. Relevant for national programmes.				
<p><u>Name/priority no. of Indicator:</u> Curriculum in primary/secondary education systems to develop young people's knowledge, attitudes and skills for health--- 4.1</p> <p><u>Definition:</u> The percentage of time within primary/secondary curriculum during which health promoting knowledge and skills are taught</p> <p><u>Purpose:</u> to track allocation of time to teaching of life skills within the curriculum</p> <p><u>Epidemiological setting:</u> any country (though not specified)</p> <p><u>Data Collection method and frequency:</u> Curriculum development centres</p> <p><u>Source:</u> UNICEF. Guidelines for the Asia and Pacific Education for All Mid-Decade Assessment: Identifying and reaching the unreached</p>	Complete – relevant for national and sub-national education sector HIV programmes.	No, Don't think so, it is a proposed indicator.	Definitely for national M&E. Possible for international M&E.	Existing data: no, don't think so, since it is a proposed indicator. Ease of data collection: <i>should be easy</i> if collected from MoE	No, since it is a measure of the curriculum. How much the curriculum is actually implemented is another matter.
<p><u>Name/priority no. of Indicator:</u> Proportion of schools integrating life skills education into the wider curriculum--- 4.2</p>	Complete – relevant for	No, Don't think so, it is	Definitely for national M&E.	Existing data: no, don't think so,	Yes, if it relies only on

Curricular and non-curricular modes of HIV prevention education to school-age children and youth					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> to track implementation of HIV education in the wider curriculum</p> <p><u>Epidemiological setting:</u> any country (though not specified)</p> <p><u>Data Collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> <i>Program Evaluation: Life skills-based education. Measures and Indicators</i> <i>Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people</i></p>	national and sub-national education sector HIV programmes.	a proposed indicator.	<i>Possible</i> for international M&E.	since it is a proposed indicator. Ease of data collection: <i>should be easy</i> if part of existing school survey.	interviews, reporting bias possible. Other means of verification (e.g. test results) required.
<p><u>Name/priority no. of Indicator:</u> Proportion of schools in target area having active anti-AIDS clubs---4.3</p> <p><u>Definition:</u> Not mentioned</p> <p><u>Purpose:</u> To track coverage of anti-AIDS clubs in schools</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data Collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> <i>Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people</i></p>	<i>Complete</i> – relevant for national and sub-national programmes. Development partners supporting anti-AIDS clubs can contribute data on their activities.	<i>No, don't think so</i> , it is a proposed indicator.	<i>Definitely</i> for national M&E. <i>Possible</i> for international M&E	Existing data: no, <i>don't think so</i> , since it is a proposed indicator. Ease of data collection: <i>should be easy</i> if part of existing school survey.	<i>Yes</i> , if it relies only on interviews, reporting bias possible. Other means of verification (e.g. test results) required.
<p><u>Name/priority no. of Indicator:</u> Percentage of emergency schools and learning spaces that provide life skills-based HIV education---5</p>	<i>Complete</i> - measures the	<i>No, don't think so</i> ,	<i>Definitely</i> for national M&E.	Existing data: <i>don't think so</i> ,	<i>Yes</i> , relies on reported

Curricular and non-curricular modes of HIV prevention education to school-age children and youth

Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Definition:</u> Number of emergency schools / learning spaces that provided life skills-based HIV education in the last quarter (min 12 hrs to each grade) divided by number of emergency schools / learning spaces surveyed</p> <p><u>Purpose:</u> To assess progress towards implementation of life skills-based HIV education in emergency schools and learning spaces</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> interviews with senior education personnel in each school, quarterly</p> <p><u>Source:</u> <i>Education Indicators (HIV and Education in Emergencies)</i></p>	<p>coverage of schools providing life skills HIV education in emergency situations. Does not measure the content or quality.</p>	<p>since recently suggested as an HIV in Emergency indicator.</p>	<p><i>Unsure</i> for international M&E.</p>	<p>since recently suggested.</p> <p>Ease of data collection: <i>don't think so</i>, since involves interviews with personnel in each school, therefore will be expensive, unless part of an existing survey.</p>	<p>coverage, therefore reporting bias possible.</p>
<p><u>Name/priority no. of Indicator:</u> Timetabling of the education as prescribed or recommended---6.2</p> <p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> To track implementation of HIV education in the school curriculum</p> <p><u>Epidemiological setting:</u> not mentioned (should be relevant to any country)</p> <p><u>Data Collection method and frequency:</u> Not mentioned</p> <p><u>Source:</u> <i>Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people</i></p>	<p><i>Complete</i> - Relevance for national or sub-national programme depends on the definition and data collection method of the indicator.</p>	<p><i>No, Don't think so</i>, it is a proposed indicator</p>	<p><i>Possible</i> for national M&E</p> <p><i>Unsure</i> for international M&E</p>	<p>Existing data: no, <i>don't think so</i>, since it is a proposed indicator</p> <p>Ease of data collection: <i>unsure</i>, depends on the method of collection</p>	<p><i>Unsure</i>, depends on definition and data collection method used. Means of verification required.</p>

3. HIV prevention education and training for educators: This component includes:
 - a. pre- and in-service training for teachers, education staff and non-formal educators on life-skills HIV education and to protect themselves from HIV;
 - b. appropriate learning and teaching materials and aids for participatory learning;
 - c. supervision, peer coaching and mentoring by experienced teachers.

The few main existing indicators relevant to HIV prevention education and training of educators identified, in order of priority of usefulness (from highest to lowest²³), are as follows:

- 1.1 Number and percentage of major teacher training institutions providing HIV&AIDS prevention and skills building to protect teacher trainees out of total number of teacher training institutions
- 1.2 Number and percentage of major teacher training institutions preparing teacher trainees to teach Family Life Skills course out of total number of teacher training institutions.
2. Number and percentage of teachers who have been trained in HIV&AIDS/life skills curriculum

Strengths, limitations and recommendations

None of the indicators are clearly defined. Therefore, before they can be considered for the M&E framework, they need to be defined and the data collection method clarified. Existing tools, such as annual education sector surveys or school census, or facility surveys and resources required for data collection on indicators need to be considered.

Since these indicators rely on reported coverage of teacher training, reporting bias on the extent of implementation is likely. Therefore, where possible, an additional means of verification to measure the presence and quality of education needs to be considered.

Indicators 1.1 and 1.2 measure pre-service training on HIV prevention and life skills education. Indicator 2 would include teachers who may have been trained both pre- and in-service. All may be used for national and international monitoring.

Indicators to measure in-service training of teachers and other education staff; learning and teaching materials; and peer education among teachers were not found. These gaps would need to be considered for the proposed M&E framework. Also gaps exist with respect to M&E of instructional aids, supervision and mentoring of teachers.

²³ The serial number of each indicator shows its position on the usefulness scale. Those indicators which are equally prioritised, for example as 'x', are numbered as x.1, x.2 etc

Table 4 Indicators relevant to HIV prevention education and training for educators

HIV prevention education and training for educators					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E??	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Number and percentage of major teacher training institutions providing HIV/AIDS prevention and skills building to protect teacher trainees out of total number of teacher training institutions---1.1</p> <p><u>Definition:</u> not provided</p> <p><u>Purpose:</u> to assess the education sector capacity to develop HIV prevention skills among its workforce</p> <p><u>Epidemiological setting:</u> any country (though not specified)</p> <p><u>Data collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> <i>Africa Bureau Brief. USAID Response to the impact of HIV/AIDS on basic education in Africa</i></p>	<p><i>Complete</i> – measures the coverage of HIV prevention skills education in teacher training institutes. Does not measure the quality of education.</p> <p>Relevant for national and sub-national programmes Relevant for development partners involved in teacher training, to report on progress to the government.</p>	<p><i>No, don't think so,</i> suggested indicator by USAID Africa Bureau in 2002.</p>	<p><i>Definitely</i> for national M&E</p> <p><i>Possible</i> for international M&E since content may vary.</p>	<p>Existing data: <i>unsure</i></p> <p>Ease of data collection: <i>Don't think so,</i> interviews with the head of teacher training institutes may be required with collection of other verifiable data.</p>	<p><i>Yes,</i> if rely only on interview data and do not have another means of verification.</p>
<p><u>Name/priority no. of Indicator:</u> Number and percentage of major teacher training institutions preparing teacher trainees to teach Family Life Skills course out of total number of teacher training institutions---1.2</p> <p><u>Definition:</u> not provided</p> <p><u>Purpose:</u> to assess the education sector capacity to train its workforce to teach family life skills education</p>	<p><i>Complete</i> – measures the coverage of training on family life skills education in teacher training institutes. Does not measure the quality of education.</p> <p>Relevant for national and sub-national programmes</p>	<p><i>No, don't think so,</i> suggested indicator by USAID Africa Bureau in 2002.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> for international M&E since content may vary.</p>	<p>Existing data: <i>unsure.</i></p> <p>Ease of data collection: <i>Don't think so,</i> interviews with the head of teacher training institutes may be</p>	<p><i>Yes,</i> if rely only on interview data and do not have another means of verification.</p>

HIV prevention education and training for educators					
Indicator and its features	Relevance to education sector HIV response?	National/ International agreement?	Use for national or international M&E??	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Epidemiological setting:</u> Not mentioned (should be relevant to any country)</p> <p><u>Data collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> Africa Bureau Brief. USAID Response to the impact of HIV/AIDS on basic education in Africa</p>	<p>Relevant for development partners involved in teacher training, to report on progress to the government.</p>			<p>required with collection of other verifiable data.</p>	
<p><u>Name/priority no. of Indicator:</u> Number (percent) of teachers who have been trained in HIV/AIDS/life skills curriculum²⁴ --2</p> <p><u>Definition:</u> Not mentioned</p> <p><u>Purpose:</u> To track the coverage of qualified teachers for HIV education</p> <p><u>Epidemiological setting:</u> Not mentioned (should be relevant to any country)</p> <p><u>Data Collection method and frequency:</u> Not mentioned</p> <p><u>Source:</u> Program Evaluation: Life skills-based education. Measures and Indicators</p>	<p><i>Complete</i> – measures the presence of trained teachers on an HIV/AIDS curriculum.</p> <p>Relevant for sub-national programmes and should be relevant for national programmes as well. Development partners involved in teacher training may also use this indicator and provide data to the sub-national and national programmes.</p>	<p><i>No, don't think so</i>, it is a proposed indicator.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Unsure</i> about international monitoring since requirements between countries may vary.</p>	<p>Existing data: <i>don't think so</i>.</p> <p>Ease of getting data: <i>Unsure</i>, depends on the data collection method. If during existing school survey then may be easy. If collected from training institutes then it may be easier.</p>	<p><i>Yes</i>, if it relies only on interviews, reporting bias possible. Other means of verification (e.g. test results) required. Quality of trained teachers is not assessed.</p>

²⁴ Reviews of this document have suggested that this indicator would be improved if a reference population was specified (i.e. whether the % of teachers trained in HIV/AIDS/life skills curriculum is calculated among all the teachers who received a training or among all the teachers)

4. Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children. This process/component includes the following:
 - a. Youth-friendly clinics for voluntary counselling and testing, treatment of sexually transmitted infection (STIs) and condom distribution.
 - b. Psychosocial counselling and other school health services.
 - c. Educational support such as subsidised payments, conditional cash transfers, and free tuition, to remove barriers to education.

The main existing indicators relevant to testing, care and support services to youth (especially high-risk groups and orphans) in order of priority of usefulness (from highest to lowest²⁵), are as follows:

- 1.1 Sexually active young women and men aged 15–24 years who received an HIV test in the last 12 months and know their results.
- 1.2 Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results.
- 2.1 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.
- 2.2 Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child.
- 2.3 Estimated number of health facilities with arrangements in place to provide youth-friendly services.
- 2.4 Use of specified health services by young people.
3. Young injecting drug users (IDUs) reached by HIV/AIDS prevention services.
- 4.1 Number (percentage) of youth counselled in reproductive health (in facilities).
- 4.2 Number (percentage) of youth served by facility who report favourably on the key service.
- 4.3 Number of youth first clinic visits by type of reproductive services provided (e.g. STI screening/treatment, HIV testing, contraceptive counselling, nutritional counselling, pre/post natal services).
- 4.4 Number of youth follow-up clinic visits by type of reproductive services provided (e.g. STI screening/treatment, HIV testing, contraceptive counselling, nutritional counselling, pre/post natal services).

Strengths, limitations and recommendations.

All of the above indicators involve youth who are in secondary or tertiary education or who are out-of-school. Still, with all of the above it is likely that data collected only partially reflect education sector HIV responses since services may be provided by health or other sectors. In order to better assess the output of education sector programmes, data on indicators from 1.1 to 2.2, which are nationally reported, may be supplemented with supporting information on education sector involvement. If possible, disaggregated data

²⁵ The serial number of each indicator shows its position on the usefulness scale. Those indicators which are equally prioritised, for example as 'x', are numbered as x.1, x.2 etc

on indicators should be assessed. For example, indicator 2.2 should be disaggregated by age and type of support in order to determine the percentage of school-age orphans and vulnerable children whose households received education support.

Indicators 1.1 and 1.2 measure the same output, namely the reported usage of VCT services, though the target group under consideration is slightly different. They are both equally useful for the education sector. However since indicator 1.1 primarily involves youth, it should be selected over indicator 1.2 for the M&E framework.

Data for indicator 2.1 on most-at-risk population is difficult to collect since populations that engage in high risk behaviour are difficult to access and appropriately sample. Therefore existing tools such as behaviour surveillance surveys (BSS) that assess the target group should be tapped into and requested for the required data.

Data for indicators 1.1, 1.2, 2.2, and 2.4 require population-based surveys. Since population-based surveys are expensive to conduct, national education programme managers should liaise with existing national surveys, such as the AIDS Indicator Survey (AIS) or DHS, to request for relevant information. If the sampling method and sample characteristics are similar across the various surveys, data from different countries may also be used for international monitoring.

A disadvantage with large surveys is that since they are mostly household surveys, they may not appropriately represent groups such as out-of-school youth or orphans who live on streets, constitute a mobile population or are institutionalised. Another disadvantage with collecting data on process indicators that require population-based surveys is that information may only become available after a gap of two or more years, which makes it difficult for ongoing monitoring of programmes. Therefore facility-based survey and routine data collection indicators, which are reported more frequently and easily, may be used for ongoing monitoring in the M&E framework, while indicators relying on population-based survey are used for monitoring at longer intervals. Indicators 2.3 and 3 to 4.4 are examples of indicators that rely on routine data collection and facility-based surveys. These indicators may however not be suitable for international monitoring, because provision of services and sampling methods may vary between countries.

Other than the indicator on educational support to orphans and vulnerable children, indicators to measure services provided to primary school age children were not found. This gap may need to be considered for generalised epidemics in the proposed M&E framework.

Table 5 Indicators relevant to testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Sexually active young women and men aged 15–24 years who received an HIV test in the last 12 months and know their results ---1.1</p> <p><u>Definition:</u> The number of respondents aged 15–24 years who had an HIV test in the last 12 months and who know their results divided by the number of respondents aged 15–24 years who have had sexual intercourse in the last 12 months</p> <p><u>Purpose:</u> To measure reported VCT usage among sexually active youth</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> population-based survey such as the AIS or DHS every two years</p> <p><u>Source:</u> <i>Monitoring and Evaluation Toolkit HIV, Tuberculosis and Malaria and Health Systems Strengthening Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012</i></p>	<p><i>Partial</i> – measures usage of VCT service, which may be provided by the education or other sector, among tertiary and out of school youth and those who may have completed education. More useful, if possible, to disaggregate by age, and education status. Indicator is a measure of education sector as well as general HIV response.</p>	<p><i>Yes</i>, recommended by UNAIDS and by WHO.</p>	<p><i>Definitely</i>, as a national indicator.</p> <p><i>Possible</i> as an international indicator.</p>	<p><i>Should be available/ easy</i>, if AIS and DHS survey collect relevant data.</p>	<p><i>Yes</i>, reporting bias likely since youth may not want to admit to being sexually active/having had a test - and may be unwilling to say they know their results, fearing they may be forced to disclose status.</p>
<p><u>Name/priority no. of Indicator:</u> Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results ----1.2</p> <p><u>Definition:</u> Number of respondents aged 15–49 who have been</p>	<p><i>Partial</i> – may be relevant for VCT programmes targeted at tertiary level and out-of- school youth. Data disaggregated by age</p>	<p><i>Yes</i>, UNGASS indicator, also recommende</p>	<p><i>Definitely</i> as a national indicator.</p> <p><i>Possible</i> as an international</p>	<p><i>Should be available/ easy</i>, if AIS and DHS survey collect relevant data.</p>	<p><i>Yes</i>, reporting bias likely since person may not want to admit to being sexually</p>

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<p>tested for HIV during the last 12 months and who know their results divided by all respondents aged 15-49 yrs</p> <p><u>Purpose:</u> to assess progress of implementing VCT services to adult population, including youth between 15-24</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> Population-based surveys (DHS, AIS, MICS or other representative survey)</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators</i></p>	<p>and education status will be useful. Indicator is a measure of education sector as well as general HIV response.</p>	<p>d by GFATM.</p>	<p>indicator.</p>		<p>active/having had a test - and may be unwilling to say they know their results, fearing they may be forced to disclose status.</p>
<p><u>Name/priority no. of Indicator:</u> Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results--2.1</p> <p><u>Definition:</u> Number of most-at-risk population respondents (i.e. sex workers, injecting drug users and men who have sex with men) who have been tested for HIV during the last 12 months and who know the results divided by the number of most-at-risk population included in the sample</p> <p><u>Purpose:</u> to assess progress of implementing VCT services to MARP, including those above and below 25 years</p> <p><u>Epidemiological setting:</u> countries with low prevalence and concentrated epidemics</p>	<p><i>Partial</i> – may be relevant for special programmes that target high risk out-of-school youth in a non-formal education setting. Age disaggregation below 25 years required. Indicator is a measure of education sector response as well as specific responses to high-risk groups. Relevant to sub-national and national programmes.</p>	<p>Yes, UNGASS indicator, also recommended by GFATM.</p>	<p><i>Definitely</i> for national M&E. <i>Possible</i> for international M&E.</p>	<p>Existing data: <i>Should be available</i> where behaviour surveys have been conducted.</p> <p>Ease of data collection: <i>Don't think so</i>, since tracking most at risk populations may be difficult.</p>	<p>Yes, reporting bias likely and difficult to measure progress due to hidden nature of target group.</p>

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<p><u>Data collection method and frequency:</u> Behavioural surveillance or other special surveys, every two years</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators</i></p>					
<p><u>Name/priority no. of Indicator:</u> Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child--2.2</p> <p><u>Definition:</u> Number of orphaned and vulnerable children aged 0–17 who live in households that received at least one of the four types of support (medical, schooling, counselling, or socioeconomic support) for each child divided by total number of orphaned and vulnerable children aged 0–17</p> <p><u>Purpose:</u> assess progress in providing support to households that are caring for orphaned and vulnerable children aged 0–17</p> <p><u>Epidemiological setting:</u> generalised and hyper-endemic countries</p> <p><u>Data collection method and frequency:</u> Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators,</i></p>	<p><i>Partial</i> – Indicator measures educational and other support received by pre-school and school-age orphans and vulnerable children. Assumes that households with orphans and vulnerable children need external support.</p> <p>Data disaggregated by age and type of support will be useful to measure educational support..</p>	<p><i>Yes,</i> UNGASS indicator, also recommended by GFATM.</p>	<p><i>Definitely</i> as a national indicator.</p> <p><i>Possible</i> as an international indicator.</p>	<p><i>Should be available/ easy,</i> if AIS and DHS survey collect relevant data.</p>	<p><i>Yes,</i> reporting bias likely since data based on household interviews and does not look at actual record.</p>

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<i>Monitoring and Evaluation Toolkit HIV, Tuberculosis and Malaria and Health Systems Strengthening</i>					
<p><u>Name/priority no. of Indicator:</u> Estimated number of health facilities with arrangements in place to provide youth-friendly services²⁶ ----2.3</p> <p><u>Definition:</u> Number of health facilities with a specific policy on treatment of young clients and with at least one health care provider trained in youth-friendly services divided by the number of health facilities surveyed</p> <p><u>Purpose:</u> To assess efforts in the provision of youth friendly services</p> <p><u>Epidemiological setting:</u> Any country, but should be relevant to countries with generalised epidemics</p> <p><u>Data Collection method and frequency:</u> nationally representative survey of health facilities, such as the one run by the National Adolescent Friendly Clinic Initiative (NAFCI); frequency not mentioned</p> <p><u>Source:</u> <i>National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people</i>²⁷</p>	<p><i>Partial</i> - The education sector may or may not be directly involved in all youth friendly services.</p> <p>Relevant for national and sub-national programmes. Information on the number (%) of facilities which are youth-friendly and supported by the education sector should be mentioned.</p>	<p><i>Yes</i>, recommended by the WHO and other partners.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> for international M&E (provided criteria for measurement of youth friendliness are standard). Need to provide disaggregated information on number (%) of facilities which are youth friendly and supported by the education sector as well.</p>	<p>Existing data: no, <i>Don't think so</i>, it is a recently recommended indicator.</p> <p>Ease of getting data: <i>Should be easy</i>, involves interviews with facility director to ask about youth friendliness. Easier to collect data if interviews conducted as part of existing surveys of health facilities (e.g. NAFCI surveys).</p>	<p><i>Not really</i>, set criteria are used to classify youth friendliness. In addition to interview information, other evidence of youth-friendliness need to be collected.</p>

²⁶ This indicator would be strengthened if it were expressed as a percentage of a reference population

²⁷ An almost identical indicator was suggested in UNICEF. Guidelines for the Asia and Pacific Education for All Mid-Decade Assessment: Identifying and reaching the unreached

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Use of specified health services by young people²⁸ ----2.4</p> <p><u>Definition:</u> For facility based survey: the number of young people using a specified health service (i.e. HIV testing, STI diagnosis and treatment, and family planning/contraceptive use) in a defined period divided by total clients using a specified health service in a defined period.</p> <p>For population based survey: the number of young people who report receiving any of the specified health services (HIV testing, STI diagnosis and treatment, and family planning / contraceptive use) in the preceding 12 months divided by young people surveyed who report being sexually active (have ever had sex).</p> <p><u>Purpose:</u> to track the number of young people seeking specified health services (STI testing/Rx, family planning/ contraceptive use, HIV testing)</p> <p><u>Epidemiological setting:</u> Any country, but should be relevant to countries with generalised epidemics</p> <p><u>Data Collection method and frequency:</u> facility based survey done quarterly or population based survey done every 2-5 years.</p>	<p><i>Partial</i>, the education or other sectors may be involved in the promotion of specified health services for youth.</p> <p>Relevant for national and sub-national programmes. Development partners supporting the promotion of health services for youth can report on this indicator.</p> <p>For facility based surveys, indicator can be disaggregated to display usage of services by youth in those facilities supported by the education sector.</p>	<p>Yes, recommended by the WHO and other partners.</p>	<p><i>Definitely</i> for national M&E</p> <p><i>Possible</i> for international M&E, however level of specificity to the education sector needs to be highlighted.</p>	<p>Existing data: <i>No, don't think so</i>, since recently recommended.</p> <p>Ease of getting data: <i>Should be easy</i> if data collected as part of existing facility or population based survey.</p>	<p><i>Not really</i>, if records in the health facility are complete.</p> <p>There is a potential for reporting bias in population-based surveys.</p>

²⁸ This indicator would be strengthened if it were expressed as a percentage of a reference population

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<p><i>Source: National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people</i></p>					
<p>Name/priority no. of Indicator: Young injecting drug users (IDUs) reached by HIV/AIDS prevention services²⁹ -----3</p> <p>Definition: The number of young IDUs who in the past month were reached by outreach prevention services, plus the number of IDUs receiving drug-dependence treatment (either long-term drug-free or substitution therapy) divided by estimated number of young IDUs who are regularly injecting.</p> <p>Purpose: to track the reach of prevention outreach services for young IDUs</p> <p>Epidemiological setting: Concentrated epidemic and sub-epidemics within generalised epidemics</p> <p>Data collection method and frequency: service statistics, frequency not mentioned</p> <p><i>Source: National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people</i></p>	<p><i>Partial</i> – services may be provided by the education or other sectors. Therefore information on the type of service provider should be included if possible. Does not measure the quality of services.</p> <p>Relevant for sub-national programmes, and may be collated at the national level.</p>	<p><i>Definite</i>, recommended by WHO and other development partners.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Unsure</i> about international M&E.</p>	<p>Existing data: <i>don't think so.</i></p> <p>Ease of getting data: <i>should be easy</i>, if service statistics already collect data.</p>	<p><i>Yes</i>, depends on the reference population used for the denominator.</p>
<p>Name/priority no. of Indicator: Number(%) of youth</p>	<p><i>Partial</i> - helps track</p>	<p><i>Don't think</i></p>	<p><i>Possible</i> for</p>	<p>Existing data:</p>	<p><i>Not really</i>, unless</p>

²⁹ This indicator would be strengthened if it were expressed as a percentage of a reference population

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<p>counselled in reproductive health ----4.1</p> <p><u>Definition:</u> If % number of youth who received reproductive health services X 100 and divided by all youth in coverage area</p> <p><u>Purpose:</u> to track implementation of counselling services</p> <p><u>Epidemiological setting:</u> Any county ((though not specified))</p> <p><u>Data collection method and frequency:</u> Proposed for monthly routine collection from facilities</p> <p><u>Source:</u> <i>A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs</i></p>	<p>delivery of counselling service by the education and other service facilities. Does not measure the quality of the session.</p>	<p><i>so</i>, since it is a proposed indicator.</p>	<p>national M&E.</p> <p><i>Unsure</i> for international M&E.</p>	<p><i>unlikely</i>.</p> <p>Ease of data collection: <i>should be easy</i>, because relies on routinely collected data from service facility.</p>	<p>over-reporting of those counselled and incorrect estimate of youth in coverage area.</p>
<p><u>Name/priority no. of Indicator:</u> Number (%) of youth served by facility who report favourably on the key service ----4.2</p> <p><u>Definition:</u> If %: No. of youth served by facility who report favourably on key service X 100 and divided by all youth in coverage area served by facility who have received key services</p> <p><u>Purpose:</u> to track customer satisfaction</p> <p><u>Epidemiological setting:</u> Any county ((though not specified))</p> <p><u>Data collection method and frequency:</u> Proposed for monthly client opinion survey from facilities</p>	<p><i>Partial</i> - helps track satisfaction with the service which may be provided by the education sector or by other providers</p>	<p><i>Don't think so</i>, since it is a proposed indicator</p>	<p><i>Possible</i> for national M&E</p> <p><i>Unsure</i> for international M&E</p>	<p>Existing data: <i>unlikely</i></p> <p>Ease of data collection: <i>should be easy</i>, relies on client opinion survey done at the service facility</p>	<p><i>Not really</i>, unless real data are not reported. Could be biased where respondents are unlikely to question or 'criticise' services - especially where the political regime is</p>

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<i>Source: A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs</i>					authoritarian. Local context is therefore significant.
<p><u>Name/priority no. of Indicator:</u> No. of youth first clinic visits by type of reproductive services provided (e.g. STI screening/treatment, HIV testing, contraceptive counselling, nutritional counselling, pre/post natal services)---4.3</p> <p><u>Definition:</u> no definition found</p> <p><u>Purpose:</u> to determine the demand for various reproductive health services by new visitors to clinics.</p> <p><u>Epidemiological setting:</u> Any county ((though not specified)</p> <p><u>Data collection method and frequency:</u> Proposed for monthly routine collection from facilities</p> <p><u>Source:</u> <i>A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs</i></p>	<i>Partial</i> - provides information on demand for various services at youth friendly and other clinics. Measures new demand but not overall demand for the various services, especially where follow-up is required- e.g. pre/ post diagnostic counselling.	<i>Don't think so</i> , it is a proposed indicator.	<i>Possible</i> for national M&E. <i>Unsure</i> about international M&E.	Existing data: <i>don't think so</i> . Ease of getting data: <i>should be easy</i> if data routinely recorded.	<i>Not really</i> , unless real data is not reported.
<p><u>Name/priority no. of Indicator:</u> No. of youth follow-up clinic visits by type of reproductive services provided (e.g. STI screening/treatment, HIV testing, contraceptive counselling, nutritional counselling, pre/post natal services).----4.4</p> <p><u>Definition:</u> no definition found</p> <p><u>Purpose:</u> to determine the demand for various reproductive</p>	<i>Partial</i> - provides information on demand for various reproductive health services at youth friendly and other clinics. Measures demand for the various services, especially where follow-	<i>Don't think so</i> , it is a proposed indicator.	<i>Possible</i> for national M&E. <i>Unsure</i> about international M&E.	Existing data: <i>don't think so</i> . Ease of data collection: <i>should be easy</i> if data routinely recorded.	<i>Not really</i> , unless real data is not reported.

Testing, care and support services to youth, especially high-risk groups, orphans and vulnerable children					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of data collection?	Presence of errors/bias during measurement?
<p>health services by follow-up visitors to clinics.</p> <p><u>Epidemiological setting:</u> Any county (though not specified)</p> <p><u>Data collection method and frequency:</u> Proposed for monthly routine collection from facilities</p> <p><u>Source:</u> <i>A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs</i></p>	<p>up is required- e.g. pre/post diagnostic counselling.</p>				

5. Testing, care and support services to educators. This component includes the presence of:
 - a. support for HIV-positive educators through teachers unions' and positive teacher networks
 - b. support for voluntary counselling and testing and treatment.

Strengths, limitations and recommendations

The review did not find any directly relevant indicators for monitoring care and support services to educators. Therefore key stakeholders involved in activities in this area need to be consulted for the proposed M&E framework.

Indicator 1.2 under testing and care and support services to youth (percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results) may be relevant for measuring VCT usage by educators. However existing data on the indicator typically does not present information on the profession of the sample population. Programme managers of national education sector HIV programmes may therefore liaise with DHS and AIS survey administrators to request for information disaggregated by profession.

4.5 Outcome indicators

As mentioned earlier, knowledge, attitudes and beliefs about issues relating to HIV and behaviours that may directly affect HIV status are considered as key outcomes for evaluating education sector HIV programmes (see section 4.1). The former are intermediate outcomes of HIV programmes while the latter are longer-term outcomes.

Intermediate outcome indicators

The main intermediate outcome indicators relevant to education sector HIV programmes identified (in order of priority – from highest to lowest) are as follows³⁰. They measure the knowledge and attitudes of people on protective (e.g. use of condoms) and risk factors (e.g. unsafe sex, presence of multiple concurrent partners) for HIV:

1. Percentage of young women and men aged 15–24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission
2. Knowledge of a formal source of condoms among young people
3. Percentage of youth who demonstrate knowledge of relevant adolescent reproductive health topic
4. Number and percentage of working teachers and teacher trainees in selected areas aware of professional policies on codes of conduct out of total number of working teachers and teacher trainees in selected areas
- 5.1 Adult support of education on condom use for prevention of HIV/AIDS among young people
- 5.2 Accepting attitudes - female teacher who is HIV+ but not sick should be allowed to continue teaching in school
- 5.3 Accepting attitudes – a) caring and b) approving teachers
6. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Strengths, limitations and recommendations

Indicators 1, 2, and 3 measure youths'³¹ knowledge on risky and protective factors relating to HIV transmission and infection. While providing baseline information on the level of knowledge in a sample youth population, they can also, if measured over time, reflect the impact of HIV prevention efforts. Since prevention programmes are provided by the education or other sectors, the data usually reflects the impact of different interventions. Where possible, it is useful to disaggregate data by educational status, to observe any trends due to difference in educational status.

Indicator 4 aims to measure teachers' and teacher trainees' awareness of professional policies and regulation, which include workplace issues in relation to HIV. The

³⁰ The serial number of each indicator shows its position on the usefulness scale. Those indicators which are equally prioritised, for example as 'x', are numbered as x.1, x.2 etc

³¹ between the ages of 10 and 24 years

indicator needs to be clearly defined and data collection method elaborated before it can be used.

Indicators 5.1 to 5.3 measure attitudes of communities towards HIV&AIDS, and are either reported or recommended for measurement by ongoing nationally representative population surveys such as DHS, AIS, MICS or BSS. Where possible, these surveys should be referred to for data that might either inform the planning or assessment of programmes. Moreover, indicators which are reported by national population surveys should be considered for the M&E framework on education sector HIV programmes since they have been internationally approved for use across many countries.

The above list of indicators does not specifically measure the knowledge of children of primary school age. This gap may need to be considered during the development of the framework.

Behavioural outcome indicators

The main behavioural outcome indicators relevant to education sector HIV programmes identified (in order of priority – from highest to lowest) are as follows³². They measure the behaviours and practices of people on issues relating to HIV:

- 1.1 Percentage of students (13-15 years) who have ever had sexual intercourse
- 1.2 Percentage of students (13-15 yrs) who initiated sexual intercourse before age 13 years
- 1.3 Percentage of students (13-15 yrs) who have had sexual intercourse with two or more people during their lifetime
- 1.4 Among students (13-15 yrs) who had sexual intercourse during the past 12 months, the percentage who used a condom the last time they had sexual intercourse
- 1.5 Condom use at last high risk sex among youth (age 15-24 years)
- 1.6 Median age at first sex among young men and women
2. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15
 - 3.1 Sex before the age of 18.
 - 3.2 Percentage of never married young women and men aged 15–24 years who have never had sex
- 4.1 Sex before the age of 15 (proportion of orphans and vulnerable children to non-orphans and vulnerable children)
- 4.2 Safe practices among young injecting drug users (aged 15-24 years)

Strengths, limitation and recommendations

All of the above indicators are relevant to education sector HIV programmes. They either cover students or youth who are in secondary or tertiary education or those out of school. Where possible, indicators, such as 1.5 to 4.2, should be disaggregated by age and educational status so that information is relevant to programmes targeting different age-groups and children in different educational setting (formal or non-formal education) and in order to indicate whether the outcomes observed are

³² The serial number of each indicator shows its position on the usefulness scale. Those indicators which are equally prioritised, for example as 'x', are numbered as x.1, x.2 etc

attributable to education sector interventions. Also in order to be relevant to sub-national programmes, all indicators need to be disaggregated by location as far as possible.

Indicators 1.2, 1.6, 2 and 3.1 track delay of first sexual encounter among youth. Indicator 1.2 specifically measures sexual debut among in-school youth between 13 and 15 years of age, while 1.6, 2, 3.1, and 4.1 (all of which are internationally recommended) survey those between 15 and 24 years of age. Depending on the presence of available data in country, either 1.6, 2, 3.1 or 4.1 may be used.

Collecting data without referring to existing surveys can be very expensive and duplicative. Where possible, programmes must refer to existing national population surveys in order to make data collection easy. However, in case of indicators such as 4.1 and 4.2 which target vulnerable groups, household surveys may not present a true picture due to reporting and selection bias. Therefore data from special surveys such as BSS which target these populations should be used in order to ensure data is representative. WHO and CDC's Global School Based Student Health Survey (GSHS) which targets school children aged 13-15 years in many countries is a useful resource for in-school interventions. In countries where enrolment and school participation is high, GSHS results may be representative of the overall 13-15 year old population.

The lack of indicators measuring behaviour change among educators is a gap which may need to be considered for the proposed M&E framework.

Table 6 Intermediate outcome indicators

Intermediate outcome indicators					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Percentage young women and men aged 15–24 who correctly identify ways of preventing³³ sexual transmission of HIV and who reject major misconceptions about HIV transmission ----1</p> <p><u>Definition:</u> Number of respondents aged 15-24 years who gave the correct answer to all five questions on HIV prevention divided by Number of all respondents aged 15–24</p> <p><u>Purpose:</u> To assess progress towards universal knowledge of the essential facts about HIV transmission among youth</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> Population-based survey (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012</i></p>	<p><i>Complete</i>- provides details on reported knowledge on HIV. Covers those in secondary and tertiary education and out of education. Only those in the 15-24 age-group are tracked, and the data is not disaggregated by age.</p> <p>Relevant for sub-national and national education sector HIV programmes.</p>	<p><i>Yes</i>, UNGASS , MDG indicator, recommended by WHO as well.</p>	<p><i>Definite</i> for both national and international M&E since it is being used by national HIV programmes and is internationally agreed.</p>	<p>Existing data: <i>should be available</i>, but varies from country to country.</p> <p>Ease of getting data: <i>should be easy</i> since existing population surveys (e.g. DHS, AIDS Indicator Survey, MICS or other representative Survey) collect data on the indicator.</p>	<p>Not really, knowledge tested so chances of error few. Sample may not be representative.</p>
<p><u>Name/priority no. of Indicator:</u> Knowledge of a formal source of condoms among young people----2</p>	<p><i>Complete</i> – provides details on reported</p>	<p><i>Yes</i>, recommended</p>	<p><i>Definite</i> for national M&E.</p>	<p>Existing data: <i>Unsure</i>,</p>	<p><i>Not really.</i> Sample must be</p>

³³ Greater clarity required about which/ the number of ways of prevention envisaged.

Intermediate outcome indicators					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Definition:</u> Percentage of young people age 15-24 who know of at least one formal source of condoms.</p> <p><u>Purpose:</u> to assess youth's knowledge on sourcing a condom and outcome of an education programme</p> <p><u>Epidemiological setting:</u> generalised or low level epidemic.</p> <p><u>Data collection method and frequency:</u> Nationally representative general population survey, every 3-5 years</p> <p><u>Source:</u> <i>HIV/AIDS Survey Indicators Database</i></p>	<p>knowledge among youth on protective measures against HIV. Covers those in secondary and tertiary education and out of education. Only those in the 15-24 age-group are tracked, and the data is not disaggregated by age.</p> <p>Relevant for sub-national and national education sector HIV programmes.</p>	<p>d by the WHO and other partner agencies.</p>	<p><i>Unsure</i> for international M&E. Education on sourcing of condoms may only be provided in some countries.</p>	<p>recommend data is collected by a population survey. Ease of collecting data: <i>Unsure</i>, it depends on the measurement method.</p>	<p>representative.</p>
<p><u>Name/priority no. of Indicator:</u> % of youth who demonstrate knowledge of relevant adolescent reproductive health topics---3</p> <p><u>Definition:</u> No. of youth (10-19 years) who demonstrate knowledge of relevant adolescent reproductive health topics x 100 divided by all youth in target population</p> <p><u>Purpose:</u> to assess knowledge of adolescent reproductive health topics among youth</p> <p><u>Epidemiological setting:</u> Not mentioned (though should be applicable to any country)</p> <p><u>Data collection method and frequency:</u> a comprehensive youth survey proposed</p>	<p><i>Complete</i> – provides information on knowledge of youth in primary, secondary and tertiary education and those out of school. If possible, information should be disaggregated by education status.</p> <p>Relevant to sub-national and national education sector HIV programmes.</p>	<p><i>No, don't think so</i> since it is a proposed indicator.</p>	<p><i>Definite</i> for national M&E. <i>Should be possible</i> for international M&E if measurement method is similar across countries.</p>	<p>Existing data: don't think so, since it is a proposed indicator. Ease of getting data: <i>Don't think so</i>, since a special survey is required. Unless incorporated in existing surveys.</p>	<p>Not really, knowledge tested so chances of error are few. Sample may not be representative.</p>

Intermediate outcome indicators					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Source:</u> <i>A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs</i></p>					
<p><u>Name/priority no. of Indicator:</u> Number and percentage of working teachers and teacher trainees in selected areas aware of professional policies on codes of conduct out of total number of working teachers and teacher trainees in selected areas---4</p> <p><u>Definition:</u> Not mentioned</p> <p><u>Purpose:</u> To assess the knowledge of work-place policies and rights among teachers</p> <p><u>Epidemiological setting:</u> any country, especially generalised and hyperendemic countries</p> <p><u>Data collection method and frequency:</u> not mentioned</p> <p><u>Source:</u> <i>Africa Bureau Brief. USAID Response to the impact of HIV/AIDS on basic education in Africa</i></p>	<p><i>Partial</i> - measures awareness of specific rights among teachers and teacher trainees but does not show if this leads to changed practices.</p> <p>Relevant for sub-national and national education sector HIV programmes.</p>	<p>No, don't think so. It is a proposed indicator.</p>	<p><i>Definite</i> for national M&E.</p> <p><i>Unsure</i> about international M&E since country epidemiology and response may vary between countries.</p>	<p>Existing data: <i>unlikely</i>, it is a proposed indicator.</p> <p>Ease of getting data: <i>don't think so</i>, as may need to conduct a survey.</p>	<p><i>Not really</i>, survey of teachers can also test their knowledge of policies. Does not show if the knowledge has any impact.</p>
<p><u>Name/priority no. of Indicator:</u> Adult support of education on condom use for prevention of HIV/AIDS among young people-5.1</p> <p><u>Definition:</u> Percentage of adults (>=18years) who are in favour of young people being educated about using a condom to prevent HIV/AIDS.</p> <p><u>Purpose:</u> to measure the acceptance in a community for condom</p>	<p><i>Partial</i> – measures accepting attitude among adults towards condom education for youth. Condom education may or may not be provided by the education sector.</p>	<p>Yes, recommended by the WHO and partners.</p>	<p><i>Definite</i> for national M&E.</p> <p><i>Possible</i> for international M&E, since indicator internationally</p>	<p>Existing data: <i>should be available</i> if country DHS has started to collect data.</p> <p>Ease of getting</p>	<p><i>Yes</i>, reporting bias is possible.</p>

Intermediate outcome indicators					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p>education to youth</p> <p><u>Epidemiological setting:</u> Not mentioned (but should be relevant for generalised epidemics)</p> <p><u>Data collection method and frequency:</u> proposed for DHS, so conducted every 3-5 years</p> <p><u>Source:</u> <i>HIV/AIDS Survey Indicators Database</i></p>	<p>Relevant to both sub-national and national programmes.</p>		<p>recommended and data collection involves a population based survey which is likely to be representative.</p>	<p>data: <i>should be easy</i> to get through DHS.</p>	
<p><u>Name/priority no. of Indicator:</u> Accepting attitudes - female teacher who is HIV+ but not sick should be allowed to continue teaching in school---5.2³⁴</p> <p><u>Definition:</u> The percent of respondents who say that a female teacher who is HIV+ but not sick should be allowed to continue teaching in school</p> <p><u>Purpose:</u> to measure the absence of discrimination against HIV and the presence of a positive attitude</p> <p><u>Epidemiological setting:</u> not mentioned (though should be relevant for a generalised epidemic)</p> <p><u>Data collection method and frequency:</u> UNAIDS general population survey; DHS AIDS Module; FHI BSS (adult); FHI BSS (youth); MICS (UNICEF), every 3-5 years</p>	<p><i>Partial</i> – measures lack of discrimination towards a HIV positive educator in a community.</p> <p>Changes in attitudes may be reflective of education sector or community based interventions.</p>	<p>Yes, reported by UNAIDS general population survey; DHS AIDS Module; FHI BSS (adult); FHI BSS (youth); MICS (UNICEF).</p>	<p><i>Definite</i> for national M&E.</p> <p><i>Possible</i> for international M&E, since internationally reported and data collection involves a population based survey which is likely to be representative.</p>	<p>Existing data: yes, since data collected by ongoing population surveys.</p> <p>Ease of getting data: <i>should be easy</i>, since data already collected by ongoing population surveys.</p>	<p>Yes, likely as there may be some reporting bias.</p>

³⁴ It is by no means clear why this indicator refers to female teachers only rather than all teachers.

Intermediate outcome indicators					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<i>Source: HIV/AIDS Survey Indicators Database</i>					
<p><u>Name/priority no. of Indicator:</u> Accepting attitudes - a) caring and b) approving teachers ---5.3</p> <p><u>Definition:</u> Percent of respondents who say that they would be willing to care for a family member sick with the AIDS virus, that a female teacher³⁵ who is HIV+ but who is not sick should be allowed to continue teaching in school.</p> <p><u>Purpose:</u> to measure lack of discrimination against people living with HIV</p> <p><u>Epidemiological setting:</u> Not mentioned (though should be relevant for a generalised epidemic)</p> <p><u>Data collection method and frequency:</u> reported by UNAIDS, DHS, FHI and UNICEF surveys every 3-5 years</p> <p><i>Source: HIV/AIDS Survey Indicators Database</i></p>	<p><i>Partial</i> – measures lack of discrimination towards a HIV positive educator in a community.</p> <p>Changes in attitudes may be reflective of education sector or community based interventions.</p>	<p>Yes, reported by UNAIDS, DHS, FHI and UNICEF surveys every 3-5 years</p>	<p><i>Definite</i> for national M&E.</p> <p><i>Possible</i> for international M&E, since internationally reported and data collection involves a population based survey which is likely to be representative.</p>	<p>Existing data: <i>Yes</i>, should be available from ongoing population surveys.</p> <p>Ease of getting data: Should be easy if data is collected by ongoing surveys.</p>	<p><i>Yes</i>, reporting bias is likely.</p>
<p><u>Name/priority no. of Indicator:</u> Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission---6</p> <p><u>Definition:</u> Number of most-at-risk population respondents who</p>	<p><i>Partial</i> – includes most-at-risk-populations above and below 25 years.</p> <p>Data concerning to most-at-risk-populations below</p>	<p>Yes, UNGASS indicator.</p>	<p><i>Definite</i> for national M&E.</p> <p><i>Should be possible</i> for international M&E since it is</p>	<p>Existing data: <i>Should be available</i> since being collected by BSS.</p> <p>Ease of getting</p>	<p><i>Yes</i>, since it is difficult to locate most-at-risk populations, there is a possibility of sampling bias.</p>

³⁵ Again, it is not clear why this indicator refers to female teachers only.

Intermediate outcome indicators					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p>gave the correct answers to all five questions on HIV prevention divided by number of most-at-risk population respondents who gave answers, including “don’t know”, to all five questions</p> <p><u>Purpose:</u> To assess progress in building knowledge of the essential facts about HIV transmission among MARP</p> <p><u>Epidemiological setting:</u> low level or concentrated epidemics, and sub-epidemics within generalised epidemics</p> <p><u>Data collection method and frequency:</u> Special behavioural surveys such as the Family Health International Behavioural Surveillance Survey, every 2 years</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators</i></p>	<p>25 years who are part of the education sector is relevant.</p> <p>Can be referred for both sub-national and national education sector HIV programmes.</p>		<p>a standardised UNGASS indicator.</p>	<p>data: <i>should be easy</i> where BSS is conducted regularly.</p>	

Table 7 Behavioural Outcome Indicators

Behavioural outcome indicators					
Indicator and its features	Relevance to education sector?	National/ International agreement?	Use for national or international M&E?	Presence of existing data & ease of getting data?	Presence of errors/bias during measurement?
<p><u>Name/priority no. of Indicator:</u> Percentage of students (13-15 years) who have ever had sexual intercourse---1.1</p>	<p><i>Complete</i> – measures sexual behaviour among in-school youth in secondary schools.</p>	<p><i>Yes</i>, reported by the WHO in collaboration with CDC.</p>	<p><i>Definitely</i> for national M&E. <i>Possible</i> since</p>	<p>Existing data: <i>Yes</i>, is available for countries where it has been</p>	<p><i>Yes</i>, reporting bias on the age of first sexual encounter likely.</p>

<p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> To track sexual behaviour among school children</p> <p><u>Epidemiological setting:</u> Not mentioned (should be suitable for any country, esp. those with generalised epidemics)</p> <p><u>Data collection method and frequency:</u> Global School Health Survey, every 5 years</p> <p><u>Source:</u> <i>Global school-based student health survey</i></p>	<p>Useful if indicator disaggregated by region.</p> <p>Relevant for sub-national and national education sector HIV programmes.</p>		<p>indicator is internationally reported and surveys conducted in many countries. Need to ensure measuring method is the same before comparing countries.</p>	<p>conducted.</p> <p>Ease of getting data: <i>should be easy</i> where the surveys have already been done. <i>Don't think so</i> for countries not covered by the survey.</p>	<p>In countries where school enrolment is low, the percentage is not representative of the school-age population.</p>
<p><u>Name/priority no. of Indicator:</u> Percentage of students (13-15 yrs) who initiated sexual intercourse³⁶ before age 13 years---1.2</p> <p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> To assess the delay of first sex among school children</p> <p><u>Epidemiological setting:</u> Not mentioned (though should be suitable for any country, esp. those with generalised epidemics)</p> <p><u>Data collection method and frequency:</u> Global School Health Survey, every 5 years</p> <p><u>Source:</u> <i>Global school-based student health survey</i></p>	<p><i>Complete</i> - measures early onset of sexual activity among in-school youth in secondary schools.</p> <p>Relevant for sub-national and national education sector HIV programmes. More useful if indicator disaggregated by sub-national regions.</p>	<p>Yes, reported by the WHO in collaboration with CDC.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> since indicator is internationally reported and surveys conducted in many countries. Need to ensure measuring method is the same before comparing countries.</p>	<p>Existing data: <i>Yes</i>, is available for countries where it has been conducted.</p> <p>Ease of getting data: <i>should be easy</i> where the surveys have already been done. <i>Don't think so</i> for countries not covered by the survey.</p>	<p>Yes, likely to overestimate the age of sexual onset due to reporting bias.</p>
<p><u>Name/priority no. of Indicator:</u> Percentage of</p>	<p><i>Complete</i> – measures</p>	<p>Yes, reported by the</p>	<p><i>Definitely</i> for</p>	<p>Existing data: <i>Yes</i>,</p>	<p>Yes, reporting</p>

³⁶In many cases, sex by young people may not so much be “initiated” as something that happens to them/ is forced upon them.

<p>students (13-15 yrs) who have had sexual intercourse with two or more people during their lifetime ----1.3</p> <p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> To track high risk sexual behaviour among school children</p> <p><u>Epidemiological setting:</u> Not mentioned (should be suitable for any country, esp. those with generalised epidemics)</p> <p><u>Data collection method and frequency:</u> Global School Health Survey, every 5 years</p> <p><u>Source:</u> <i>Global school-based student health survey</i></p>	<p>risky sexual behaviour among in-school youth in secondary schools.</p> <p>Useful if indicator disaggregated by region.</p> <p>Relevant for sub-national and national education sector HIV programmes.</p>	<p>WHO in collaboration with CDC.</p>	<p>national M&E.</p> <p><i>Possible</i> since indicator is internationally reported and surveys conducted in many countries. Need to ensure measuring method is the same before comparing countries.</p>	<p>is available for countries where it has been conducted.</p> <p>Ease of getting data: <i>should be easy</i> where the surveys have already been done. <i>Don't think so</i> for countries not covered by the survey.</p>	<p>bias on number of sexual partners. In countries where school enrolment is low, the percentage is not representative of the school-age population.</p>
<p><u>Name/priority no. of Indicator:</u> Among students (13-15 yrs) who had sexual intercourse during the past 12 months, the percentage who used a condom the last time they had sexual intercourse---1.4</p> <p><u>Definition:</u> not mentioned</p> <p><u>Purpose:</u> To track safe sex practice among school children</p> <p><u>Epidemiological setting:</u> Not mentioned (should be suitable for any country, esp. those with generalised epidemics)</p> <p><u>Data collection method and frequency:</u> Global School Health Survey, every 5 years</p>	<p><i>Complete</i> – measures safe sexual behaviour among in-school youth in secondary schools.</p> <p>Useful if indicator disaggregated by region.</p> <p>Relevant for sub-national and national education sector HIV programmes.</p>	<p>Yes, reported by the WHO in collaboration with CDC.</p>	<p><i>Definitely</i> for national M&E.</p> <p><i>Possible</i> since indicator is internationally reported and surveys conducted in many countries. Need to ensure measuring method is the same before comparing countries.</p>	<p>Existing data: <i>Yes</i>, is available for countries where it has been conducted.</p> <p>Ease of getting data: <i>should be easy</i> where the surveys have already been done. <i>Don't think so</i> for countries not covered by the survey.</p>	<p><i>Yes</i>, reporting bias on use of a condom likely. In countries where school enrolment is low, the percentage is not representative of the school-age population.</p>

<p><u>Source:</u> <i>Global school-based student health survey</i></p>					
<p><u>Name/priority no. of Indicator:</u> Condom use at last high risk sex³⁷ among youth (age 15-24 years)---1.5</p> <p><u>Definition:</u> percentage of young people ages 15–24 reporting the use of a condom during the last sexual intercourse with a non-regular sexual partner in the previous 12 months.</p> <p><u>Purpose:</u> to measure the use of condoms in non-regular partnerships</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> general population survey (DHS, BSS), frequency not mentions (expect every 3-5 years)</p> <p><u>Source:</u> <i>Indicators for Monitoring the Millennium Development Goals: Definitions, Rationale, Concepts, and Sources</i></p>	<p><i>Complete:</i> measures reported use of condom during high risk sex among youth in secondary and tertiary education and those out of school. Useful if data disaggregated by sub-regions for sub-national monitoring, and by age/educational status for programmes targeting youth in different educational institutes.</p>	<p><i>Yes, UNGASS and MDG indicator.</i></p>	<p><i>Definite</i> for national monitoring and evaluation.</p> <p><i>Possible</i> for international M&E, since indicator is internationally reported by standardised surveys.</p>	<p>Existing data: Should be available in countries that have had DHS, and BSS and which included this indicator.</p> <p>Ease of getting data: <i>should be easy</i> if data is being collected in ongoing population surveys.</p>	<p><i>Yes, reporting bias. Moreover, condom use at last sex may not be a clear indicator of consistent use of a condom.</i></p>
<p><u>Name/priority no. of Indicator:</u> Median age at first sex among young men and women---1.6</p> <p><u>Definition:</u> The age by which one half of young people aged 15-24 have had penetrative sex (median age).</p>	<p><i>Complete</i> – measures age by which most secondary and tertiary school youth and those out of school have had sex. Relevant to national and sub-national programmes.</p>	<p><i>Yes, recommended by UNAIDS.</i></p>	<p><i>Definite</i> for national monitoring and evaluation.</p> <p><i>Possible</i> for international M&E, since indicator is</p>	<p>Existing data: Should be available in countries that have had DHS, UNAIDS survey, and BSS.</p>	<p><i>Yes, reporting bias due to underreporting of true age of first sexual encounter.</i></p>

³⁷ This term requires definition.

<p><u>Purpose:</u> To assess the delay of first sex among youth</p> <p><u>Epidemiological setting:</u> Not specified (should be suitable for any country, esp. those with generalised epidemics)</p> <p><u>Data collection method and frequency:</u> UNAIDS general population survey; DHS AIDS module; FHI BSS (youth), every 3-5 years</p> <p><u>Source</u> <i>HIV/AIDS Survey Indicators Database</i></p>	<p>Useful if data disaggregated by sub-regions for sub-national monitoring, and by age/ educational status for programmes targeting youth in different educational institutes.</p>		<p>internationally reported by standardised surveys.</p>	<p>Ease of getting data: <i>should be easy</i> if data is being collected in ongoing population surveys.</p>	
<p><u>Name/priority no. of Indicator:</u> Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15---2</p> <p><u>Definition:</u> Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years divided by Number of all respondents aged 15–24 years</p> <p><u>Purpose:</u> To assess the delay of first sex among youth</p> <p><u>Epidemiological setting:</u> Any country</p> <p><u>Data collection method and frequency:</u> Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) every 4-5 years</p> <p><u>Source:</u> <i>Monitoring the Declaration of Commitment</i></p>	<p><i>Complete</i> – measures those youth in secondary and tertiary education and those out of school who had sex before 15 years. Relevant to national and sub-national programmes. Useful if data disaggregated by sub-regions for sub-national monitoring, and by age/ educational status for programmes targeting youth in different educational institutes.</p>	<p>Yes, a UNGASS indicator and recommended by the GFATM.</p>	<p><i>Definite</i> for national monitoring and evaluation.</p> <p><i>Possible</i> for international M&E, since indicator is internationally reported by standardised surveys.</p>	<p>Existing data: <i>Should be available</i> in countries that have had DHS, UNAIDS survey, and BSS.</p> <p>Ease of getting data: <i>should be easy</i> if data is being collected in ongoing population surveys.</p>	<p><i>Yes</i>, reporting bias due to underreporting of true age of first sexual encounter.</p>

<p><i>on HIV/AIDS: Guidelines on Construction of Core Indicators</i> <i>Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012</i></p>					
<p><u>Name/priority no. of Indicator:</u> Sex before the age of 18.---3.1</p> <p><u>Definition:</u> Percentage of young people 20-24 who have had sex before the age of 18.</p> <p><u>Purpose:</u> To assess the delay of first sex among youth</p> <p><u>Epidemiological setting:</u> Not mentioned (should be suitable for any country, esp. those with generalised epidemics)</p> <p><u>Data collection method and frequency:</u> proposed for a general population survey, every 3-5 years</p> <p><u>Source</u> <i>HIV/AIDS Survey Indicators Database</i></p>	<p><i>Complete</i> –measures the initiation of sexual activity during secondary school years among those out of school or in tertiary education. Relevant to national and sub-national programmes. Useful if data disaggregated by sub-regions for sub-national monitoring, and by age/ educational status for programmes targeting youth in different educational institutes.</p>	<p>Yes, it is a UNGASS indicator and recommended by the WHO.</p>	<p><i>Definite</i> for national M&E. <i>Possible</i> for international M&E, since the indicator is internationally accepted. Need to ensure that measurement method is same across countries.</p>	<p>Existing data: <i>Don't think so</i>, unless data already being collected by a survey. Ease of getting data: <i>Should be easy</i> if data being collected by existing population survey.</p>	<p><i>Yes</i>, reporting bias due to underreporting of true age of first sexual encounter.</p>
<p><u>Name/priority no. of Indicator:</u> Percentage of never married young women and men aged 15–24 years who have never had sex---3.2</p> <p><u>Definition:</u> Number of never married young women and men who have never had sexual intercourse divided by number of never married young women and men aged 15–24 years surveyed</p> <p><u>Purpose:</u> to track abstinence among unmarried youth</p> <p><u>Epidemiological setting:</u> any country</p>	<p><i>Complete</i> – measures the prevalence of abstinence among youth in secondary, tertiary education and those out of school. Relevant to national and sub-national programmes. Useful if data disaggregated by sub-regions for sub-national monitoring, and by age/</p>	<p><i>Yes</i>, recommended by GFATM.</p>	<p><i>Definite</i> for national M&E. <i>Possible</i> for international M&E if survey and sampling methodology used is the same.</p>	<p>Existing data: don't think so, since recently proposed indicator. Ease of getting data: should be easy if data being collected by a population survey, else it can be expensive to</p>	<p><i>Yes</i>, over-reporting likely due to reporting bias.</p>

<p><u>Data collection method and frequency:</u> Proposed for a population based survey</p> <p><u>Source:</u> <i>Monitoring and Evaluation Toolkit HIV, Tuberculosis and Malaria and Health Systems Strengthening</i></p>	<p>educational status for programmes targeting youth in different educational institutes.</p>			<p>conduct.</p>	
<p><u>Name/priority no. of Indicator:</u> Sex before the age of 15 (proportion of orphans and vulnerable children to non-orphans and vulnerable children) -- -4.1</p> <p><u>Definition:</u> Ratio of the proportion of orphans and vulnerable children compared to non-orphans and vulnerable children aged 15-17 who had sex before age 15.</p> <p><u>Purpose:</u> To assess early sexual debut among orphans and vulnerable children compared to non-orphans and vulnerable children.</p> <p><u>Epidemiological setting:</u> Not mentioned (though relevant for generalised epidemics)</p> <p><u>Data collection method and frequency:</u> generalised population survey, every 3-5 yrs.</p> <p><u>Source:</u> <i>HIV/AIDS Survey Indicators Database</i></p>	<p><i>Complete</i> – measures early sexual debut among school-age orphans compared to non-orphans.</p> <p>Useful if data disaggregated by sub-national region and by educational status (in or out of school status). Relevant for national and sub-national monitoring.</p>	<p>Yes, proposed by UNICEF OVC guide.</p>	<p><i>Definite</i> for national M&E.</p> <p><i>Possible</i> for international M&E if survey methods used are similar and country epidemic situation is similar.</p>	<p>Existing data: <i>Don't think so</i>, since it a proposed indicator, unless it has already been incorporate in a population survey.</p> <p>Ease of getting data: <i>should be easy</i>, however population surveys may not be representative of all orphans.</p>	<p><i>Yes</i>, reporting bias by survey respondents. Orphans may not be representative of all orphans since many live on streets and are not captured by household-based population surveys.</p>
<p><u>Name/priority no. of Indicator:</u> Safe practices among young injecting drug users (aged 15-24 years)---4.2</p> <p><u>Definition:</u> number of respondents who report not having shared injecting equipment during the</p>	<p><i>Complete</i> – measures safe injection and sexual behaviour among secondary and tertiary school-age injecting drug</p>	<p>Yes, UNGASS indicators and recommended by the WHO.</p>	<p><i>Definite</i> for national M&E.</p> <p><i>Possible</i> for international M&E,</p>	<p>Existing data: Unsure, depends if a BSS already done in a country and includes this</p>	<p><i>Yes</i>, reporting bias likely and it may difficult to get a representative</p>

<p>preceding month and who also report that a condom was used the last time they had sex during this month divided by the number of respondents who report injecting drugs and having sexual intercourse during the preceding month</p> <p><u>Purpose:</u> to assess the proportion of young IDUs who have adopted behaviour intended to avoid HIV transmission</p> <p><u>Epidemiological setting:</u> concentrated epidemics (additional indicator for other countries)</p> <p><u>Data collection method and frequency:</u> BSS, frequency not mentioned (expect every 2-5 years)</p> <p><u>Source:</u> <i>National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people</i></p>	<p>users. Useful if data disaggregated by sub-national region and by educational status (in or out of school status) and age.</p>		<p>however need to ensure survey methodology used across countries is comparable.</p>	<p>information. Ease of getting data <i>Don't think so,</i> even with an existing survey such as BSS, difficult to locate high-risk groups and to get a representative sample.</p>	<p>sample.</p>
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CONCLUSION

At the outset, the review found that a commonly agreed framework needed to be developed in order to outline and measure the main programme outputs and outcomes of education sector HIV responses. A range of conceptual frameworks on education sector HIV response programmes, promoted by various agencies/inter-agency initiatives, were identified to be in use and on analysis, they were found to complement each other. A framework thus summarising the key programme outputs and outcomes of education sector HIV responses was used to review indicators (see figure below). It should be noted that the framework constructed did not include long-term impact indicators on HIV prevalence and educational outcomes that affect HIV prevalence (such as demand for, supply and quality of education) for a number of reasons. Firstly, because collecting such data is usually beyond the capacity and resources of most programmes. Secondly, because these outcomes are affected by a whole range of inputs and outcomes, not only those of the education sector response to HIV. Also, because these data are routinely collected as part of national health and education statistics. They are therefore not discussed in the review.

LEVEL OF M&E	DESCRIPTION OF PROGRAMME COMPONENT/ OUTCOME
Process monitoring	
OUTPUTS	Education sector policies, plans, and management
	Curricular and non-curricular HIV prevention education to school-age children and youth
	HIV prevention education and training for educators
	Testing, care and support services to youth
	Testing, care and support services to educators
Outcome evaluation	
INTERMEDIATE OUTCOMES	Knowledge, attitudes and beliefs on protective and risk factors for HIV
LONG-TERM OUTCOMES	Behaviours that can influence HIV status

The review found that many internationally-agreed process and outcome indicators, which are already in use as part of education or HIV programmes, are relevant to sector-specific responses. These indicators should be prioritised over other indicators which may be similar but do not have international approval. The indicators may either be used directly or modified to measure sector-specific outputs and outcomes in the proposed M&E framework. For example the indicator ‘percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child’ may be disaggregated by age and type of support to record educational support to school-age orphans. In general indicators disaggregated by age, gender, educational status and geographical location provide useful information for sectoral HIV responses. Where indicators are not internationally approved but considered for the M&E framework, it is important they are clearly

defined and their measurement method specified after carefully considering various tools for data capture.

Different tools currently being implemented may be utilised to capture data on indicators were identified during the review. These include assessment formats such as NASA which is used to report AIDS funding to UNAIDS; Ministry of Education tools such as annual school surveys, school census and EMIS; well-established population surveys such as DHS and MICS; and special surveys such as the GSHS on health behaviours and protective factor among school children, and BSS among special target groups. Since these tools have already been defined and are being used to collect data, it is easier to capture data on relevant indicators they report rather than identifying new indicators and setting up a special survey or data collection system.

A few methodological considerations for using indicators were identified by the review. First, population surveys for process indicators mean a longer time-lag between measurements, which makes it difficult for ongoing monitoring. Therefore indicators measured through facility-based survey and routine data collection, which are reported more frequently and easily, may be used for ongoing monitoring in the M&E framework while indicators relying on population-based survey are used for monitoring at longer intervals.

Second, while national data on many indicators (especially those internationally agreed) may be used for international monitoring, it is important to ensure that the sampling/survey methodology and country situations are comparable. Finally, since many indicators rely on interview data, reporting and selection bias is likely. Therefore, where possible, an additional means of verification should inform an indicator's value.

Indicators for some components of processes and outcomes were not found during the review. These gaps would therefore need to be considered during the development of the M&E framework. They include indicators to assess:

- Quality of policies; implementation of workplace policies; presence of an active management structure; strategic partnerships and presence of data management tools (for monitoring, evaluation and planning)
- Grade and age specific curriculum content; peer and outreach education to out-of-school youth; non formal HIV prevention education; and community involvement in curriculum development and use.
- In-service training of teachers and other education staff; learning and teaching materials; and peer education among teachers
- Care and support services to educators and primary school-age children.
- Knowledge among primary school-age children and behaviour change among educators

Other gaps identified during the review related to the needs of children affected by conflict/violence, the implementation of community-school links, the impact of gender and power dynamics, the needs of children with disabilities and HIV positive youth.

Key stakeholders involved in activities covering these areas need to be consulted for the proposed M&E framework. Moreover, literature that could not be assessed during the review (such as individual country documents) needs to be consulted to fill in the gaps. In line with the ‘Three Ones’ principles, the National AIDS Committee may need to be informed about any additional HIV indicators proposed for use by a national education sector HIV response programme.

In conclusion, the review has demonstrated that considerable common ground exists that could enable the development of an internationally recognized M&E framework for education sector HIV responses, created under the auspices of the UNAIDS IATT on Education. For such a framework to be agreed, agreement will be needed with respect to a number of questions:

- Is the M&E framework proposed here appropriate?
- Are the criteria employed here for the prioritisation of indicators to be included in such a framework sufficient? Is there a need for the criteria themselves to be prioritised?
- Can agreement be reached on the prioritization that has occurred in this review?
- Are there gaps which need to be filled?

Further agreement will be required with respect to the indicators identified:

- Can the indicators identified be refined so that they give information that is clear, unambiguous and enlightening?
- How can common terms and definitions be agreed (e.g. in the area of “life skills”)
- How can indicators be comparable (e.g. in showing differences in the extent and quality of teaching or services provided)

It is proposed that the next step now required is a meeting of stakeholders with an interest in developing an internationally agreed M&E framework for HIV and AIDS. Such a gathering would spend time thinking through and reaching consensus answers to the questions posed above, resulting in the agreement of an M&E framework and an set of corresponding indicators. Endorsement of such work by groups such as the FRESH partners and the UNAIDS IATT on Education would enable the adoption of a common M&E framework for use by countries, governments, programmes and projects around the world, driving forward, the most necessary work in the education sector’s response to HIV and AIDS.

ANNEXES

1. Terms of Reference for the Review

Aim and Objectives

The aim of this review of HIV&AIDS indicators for the UNAIDS Inter-Agency Task Team on Education is to guide the production of user-friendly guidance to measure the coverage, outcomes and impact of education programmes on HIV&AIDS in low income countries. The specific objectives of the review are to:

- Provide an overview of the key indicators that are currently used to monitor and evaluate education programmes on HIV&AIDS, primarily at the national and sub-national level, and highlight linkages between indicators if any.
- Review data needs for different settings (including different epidemiological scenarios), and data collection methods used for the key indicators in use. This could include routine as well as survey methods of data collection.
- Prioritise the usefulness of the different indicators on different parameters such as relevance, international/national use and acceptability, practicality and ease of data collection.

Background to this activity

The UNAIDS Inter-Agency Task Team (IATT) on Education was created in 2002 with a goal to support accelerated and improved education sector responses to HIV&AIDS globally. The IATT membership includes the UNAIDS co-sponsoring agencies, bi-lateral agencies and private donors, and civil society (see www.unesco.org/aids/iatt for more details).

The Indicators Working Group, one of the six working groups within the UNAIDS Inter-Agency Task Team (IATT) on Education, is responsible for providing guidance to the IATT and member organisations on methods and instruments to measure the impact of education sector programmes on HIV&AIDS. Some of the main tasks of the Working Group are to identify:

- key questions that the education sector must address about its impact on HIV&AIDS;
- key indicators that provide meaningful measures of progress on the identified questions
- exemplary models of tools, questionnaires, and processes that have effectively measured progress on identified indicators in education programmes

The Partnership for Child Development, one of the Indicators Working Group members, was identified as a focal point of the Group during its meeting in November 2008. During the meeting, in order to assist the accomplishment of the main tasks of the Group, PCD offered to seek relevant input from members and others to enable a review of HIV&AIDS indicators applicable to the education sector. It was proposed that the review findings would be presented and discussed at a Working Group meeting with the objective of developing a results framework for education sector responses to HIV&AIDS. Following this, the Working Group would report back to IATT at its Spring meeting, with specific suggestions for measuring the outcomes of education sector programmes on HIV&AIDS.

PCD's particular interest in undertaking this task arose from work that it undertook with Save the Children USA on behalf of all FRESH partners³⁸, to assess the need for a generic framework for the monitoring and evaluation (M&E) of school-based health, nutrition and HIV programmes (SHN). This work was undertaken through the medium of a participative study which was informed by national and international stakeholders in SHN (representing governments, NGO/ INGO, UN agencies and academic institutions), and by resources collected from them. The study found a strong demand for a

generic M&E framework for SHN that would help synergise existing resources. It also found that common processes and outcomes exist across health interventions that can be used as a basis for consensus on a framework. Such a framework would provide M&E guidance to implementers, adaptable to local settings. These findings were presented at a meeting of FRESH partners held at the WHO headquarters in Geneva on 8-9 September 2008. Partners confirmed the need for a generic M&E framework for school-based health interventions and discussed next steps for its development. The framework is currently being developed by FRESH partners, and is scheduled to be launched in late 2009.

The review on HIV&AIDS indicators to be undertaken by the IATT group would also inform the HIV&AIDS thematic section of the M&E framework for SHN, thus serving both, efforts on HIV&AIDS in the education sector and the M&E of SHN.

Specific Terms of Reference

It is proposed that a consultant experienced in school-based health, nutrition and HIV programmes and knowledgeable about their monitoring and evaluation, work with the Partnership for Child Development to undertake the review. The expectations for the consultant are as follows:

- Conduct a desk review of literature and guidelines on the monitoring and evaluation of HIV&AIDS education programmes. To draw on the experience of IATT members, PCD will send an email to the IATT listserv requesting relevant documentation to be included in the review. The Consultant is also expected to conduct online searches to obtain information on country and programme indicators, data collection methods, and existing result frameworks in this area.
- Conduct key informant interviews with relevant persons (10-15 expected, list to be compiled by PCD in collaboration with the Working Group) to obtain additional documentation and elicit further information on indicators, and data collection methods.
- Produce a draft report and presentation for consideration by the Partnership for Child Development and other members of the Indicators Working Group. This report would include: a background section describing the rationale for the effort; the methodology for the review (with a list of persons consulted in an annex); an analysis of the range of indicators used to monitor education HIV & AIDS programmes, the level of their use (e.g. indicators of national commitment and action; indicators of national programme and behaviour; indicators of impact), the context of their use, and their gender specificity; recommendations around prioritisation of indicators and identification of any gaps; and the suggested results framework.
- Revise the report following the Indicators Working Group meeting, based on feedback and comments from Group members.
- Finalise the report after the IATT Spring meeting (scheduled 15-17 June) with input from the full IATT.

Management Arrangements

The consultant will be supervised and managed by the Director of the Partnership for Child Development.

Deliverables

Deliverable	Duration	Timeframe
Development of the draft review report: - contacting IATT listserv members for literature; - online search; - conducting key informant interviews; - analysis of data and write up of report	20 days	20 April – 13 May
Meeting of Working Group Members	1 day	Proposed date: 29 May, to be held at Imperial College
Revision of the report based on input from Working Group members	3 days	2-4 June
Finalisation of the report after the IATT meeting	4 days	22-25 June

2. List of Review Literature

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3. List of Key Informants

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4. Education Sector HIV Response Frameworks

1. Accelerate framework: It includes key regional responses (also known as objectives of the Accelerate programme) across countries and as well as specific action areas for national education sector responses. The emphasis of the review is on indicators for national responses, thus the main thematic areas for national responses were considered. These include policy and strategies, planning and management, prevention and mitigating the impact on orphans and vulnerable children.

(source: <http://www.schoolsandhealth.org/Pages/default.aspx>)

2. EFAIDS programme framework: The EFAIDS programme framework is implemented through teachers unions across many countries. The main working areas of the framework are: research, as an advocacy tool; development of policies (such as on workplace issues); advocacy to ministries of education; publicity or raising awareness; and teacher training on HIV prevention.

The key objectives (also called goals) of the programme are to:

- Prevent new HIV infections among teachers and learners: this is pursued through teacher training on HIV prevention
- Mitigate the negative effect of AIDS on achieving EFA goals: this is sought through research work
- Increase the number of learners completing basic education: this is sought through research, advocacy and public awareness raising

(source: http://www.ei-ie.org/ef aids/en/about_activities.php)

3. MTT Strategic Response Framework- is a flexible framework that ministries can use to plan and implement sector-wide responses, based on their vulnerability to HIV. The three important themes that the framework recommends as part of a strategic response are: prevention, treatment care and support and impact mitigation. Impact mitigation includes the sub-themes of workplace issues, and management of the response.

(source: <http://www.mtt aids.com/site/awdep.asp?dealer=5562&depnum=8675#4>)

4. EDUCAIDS framework

The EDUCAIDS framework supports comprehensive national education sector response to HIV&AIDS through five essential components:

- Quality education (one which is rights-based, gender-responsive, scientifically accurate, culturally sensitive, age-specific, delivered in a safe environment, and focused on and tailored to various groups, including vulnerable groups, and promoting involvement of those living with HIV&AIDS);
- Curriculum content and learning materials (which is adapted and appropriate for various ages, levels and settings (including formal and non-formal), integrated into the national curriculum; begins early, before the onset of sexual activity; builds knowledge and skills to adopt protective behaviours (i.e. delaying the onset of sexual activity, reducing the number of sexual partners, and increasing condom use) and reduce vulnerabilities; focused on prevention, while also including relevant care, treatment and support issues; addresses stigma and discrimination, gender inequality and other structural drivers of the epidemic; involves communities in curriculum development and revision to ensure ownership and support);

- Educator training and support (which includes pre- and in-service programmes for teachers and support for non-formal educators; deepens educators' technical knowledge on HIV&AIDS, confidence and experience in interactive and participatory learning methodologies; addresses educators' own vulnerability to HIV infection and the impact of HIV and AIDS; is complemented by appropriate learning and teaching materials and aids; is reinforced through supervision, peer coaching and mentoring by experienced teachers; involves communities to share knowledge, build support and encourage dialogue; provides support for HIV-positive educators through teachers unions' and positive teacher networks);
- Policy, management and systems (with inclusion of the education sector response in the national HIV&AIDS strategy; sectoral policies and strategies on HIV&AIDS integrated into the national education plan; HIV&AIDS workplace policies that ensure supportive and safe environments for educators and learners; HIV&AIDS management structures or committees to guide and monitor the sector's response; Education management information systems, situation analyses and needs assessments; planning for human capacity, impact assessment and projection models; strategic partnerships for coordination, advocacy and resource mobilisation; monitoring, evaluating and assessing outcomes and impact;
- Approaches and illustrative entry points (such as sex, HIV and relationships education; school health and school feeding programmes; peer education; communications and media; community-based learning and outreach including for out-of-school young people; life skills education; adult education and literacy; HIV&AIDS treatment education)

5. IATT on education framework

Epidemiological Situation	In all Settings	Key elements of the education sector HIV response
<p>Low level</p> <ul style="list-style-type: none"> • HIV prevalence among general population < 1%. • HIV prevalence not spread significantly in any sub-group (UNAIDS, 2007c). Risk is diffuse (low levels of partner exchange or of non-sterile injecting equipment) or virus only recently introduced. 	<p>At all levels, a priority focus on ensuring quality education for all</p>	<ul style="list-style-type: none"> • Collaborating on strategic information (i.e. research and surveillance data) related to the progression and impact of HIV&AIDS. • Focusing on children/young people with additional vulnerabilities and high-risk behaviours (injecting drug users, men who have sex with men, commercial sex workers etc.) with information, skills and access to services (HIV and substance abuse prevention, treatment and care programmes). • Integrating HIV&AIDS information and skills across school and teacher curricula. • Ensuring that education promotes an environment of tolerance and respect reduces stigma and discrimination, to gender and other inequalities, and promotes human rights.
<p>Concentrated</p> <ul style="list-style-type: none"> • HIV prevalence high in population sub-groups. • Epidemic fuelled by key risk behaviours, e.g. unsafe injecting drug use, unprotected male-to-male sex, and unprotected sex in the context of sex work. • Virus not circulating at high levels in 'general population' (UNAIDS, 2007c). 		<p>All of the above and also:</p> <ul style="list-style-type: none"> • Strengthening links of the education sector with other <i>service providers</i> to reduce risky behaviours among young people and provide those at risk with free and equitable access to counselling and testing, and referrals. • Ensuring the education sector is an integral and active part of the national response to HIV&AIDS and participates in <i>planning and reviewing</i> progress. • Supporting HIV&AIDS mainstreaming into national education plans through <i>capacity building</i> and organizational strengthening. • <i>Advocating</i> to managers and leaders in the sector to generate awareness, to strengthen knowledge and enhance commitment to addressing HIV • Regular <i>monitoring and evaluation</i> of sectoral responses to understand drivers of risk behaviours, and for decision-making and revised/updated approaches.
<p>Generalised</p> <ul style="list-style-type: none"> • 1-15% of pregnant women attending antenatal clinics are HIV-positive. • HIV is present in general population and 		<p>All of the above and also:</p> <ul style="list-style-type: none"> • Ensuring a comprehensive approach to HIV&AIDS that encompasses prevention, care and support (including access to treatment), impact mitigation, workplace issues and management of the response.

<p>spreading widely (UNAIDS, 2007c).</p>	<ul style="list-style-type: none"> • Focusing on all young people, with <i>comprehensive sex and HIV education programmes</i> based on life skills, covering delay of sexual debut, sexual orientation, sexual risk behaviour, condom use, HIV testing, reduction of concurrency and number of partners, drug use, male circumcision, prevention of mother-to-child transmission and gender and other inequalities. • <i>Teacher training on HIV</i> prevention to increase knowledge on HIV, awareness, on vulnerability, and skills for risk-reductive behaviours. • <i>Community and parental involvement</i> for reducing risk/vulnerability among young people (esp. girls, intergenerational sex, out of school youth, stigma and discrimination) and promoting social change in the community and in schools. • Working with other sectors to meet the demand for care and protection for children and young people. • Collaborating with health systems to make sexual and reproductive health services, including VCT, available to learners and staff. • Establishing or linking to services and support for teachers and other education sector staff, including supporting networks of teachers living with HIV. • Monitoring longer-term impact (such as teacher morbidity, mortality, attrition and absenteeism and attendance of orphans and other vulnerable children) and planning for human capacity.
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