

IMPROVING THE QUALITY OF SRHR EDUCATION PROGRAMMES FOR YOUNG PEOPLE

Checklist for Programme Officers

INTRODUCTION

Comprehensive Sexual and Reproductive Health and Rights (SRHR) education for young people addresses adolescence, sexuality, gender, rights, and the prevention of health risks such as HIV/AIDS, other sexually transmitted infections (STIs), unintended pregnancies and sexual abuse. Its goal is to support young people to make their own, informed decisions, with a positive view on sexuality.

This checklist is a guide for programme officers of donor organisations who collaborate with partner organisations ‘in the South’ that implement SRHR education for young people. The programme officers can use the checklist to assess project proposals. It is also useful as a basis for discussions with their partner organisations. The checklist aims to contribute to improved quality of SRHR and HIV-prevention interventions for young people.

The checklist is a summary of the more elaborate ‘Evidence- and Rights-Based Planning & Support Tool for SRHR/HIV-Prevention Interventions for Young People’,¹ which was developed together with organisations in South Africa and Pakistan.

RIGHTS BASED AND EVIDENCE BASED APPROACHES

The checklist is based on two approaches – a rights-based approach and an evidence-based approach. A **rights-based approach** takes into account the sexual and reproductive rights of young people. These rights are formulated in a number of international conventions which have been signed by governments of almost all the countries in the world. They include the right to make your own decisions and the right to have support in your environment; the right to be yourself; the right to know; the right to protect yourself and be protected by others; the right to have access to health services; and the right to be involved². Gender equity is a key element in this approach.

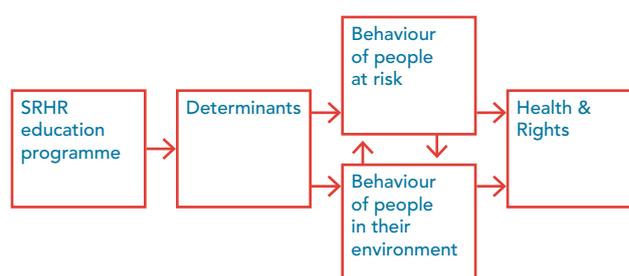


Figure 1: Health Promotion Model

An **evidence-based approach** makes use of evidence in all stages of intervention planning.³ In general, rights-based and evidence-based approaches support each other. For example, young people have the right to access youth-friendly health care, and evidence shows that when young people get these services, they live a healthier life. However, sometimes it may be important to stand up for people’s rights, without being sure whether it will be effective. For example, an evidence-based approach focuses on the most important factors which can be changed, while from a rights-based perspective, programmes can sometimes address topics that are controversial and may be difficult to change. Where necessary, the checklist explains these conflicts.

Evidence shows that SRHR programmes for young people that are based on **behaviour change models** are more likely to be effective. Behaviour change is a complex process with many factors playing a role.

Changing behaviour to promote health and rights

Behaviour change models provide a structure and create categories of factors which can be analysed and changed. These models state that all (*health and rights*) problems are ‘translated’ into behaviour. For example, there may be several reasons why a large number of young people have untreated sexually transmitted infections (STIs). One of these could be that young people who are infected don’t seek treatment (*behaviour of the people at risk*). But this, in turn, could be caused by the *behaviour of people* in their environment: health care providers don’t provide STI testing and treatment for young people, or policy makers don’t include the provision of these services in their policies⁴.

Determinants of behaviour

After identifying behaviour that contributes to or inhibits health and rights, the next step is to analyse why people do what they do: why do young people with STIs not seek treatment? And why do health care providers not provide STI testing and treatment to young people? Behaviour change models distinguish a number of factors that can influence behaviour (also referred to as *determinants*). Figure 2 shows a model with determinants that influence behaviour (Theory of Planned Behaviour⁵).

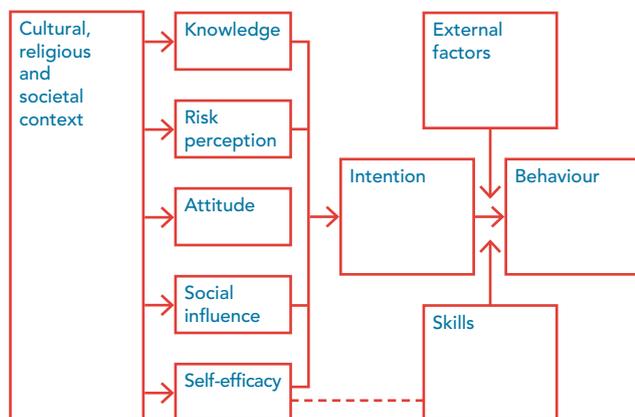


Figure 2: Theory of planned behaviour; determinants of behaviour

We use an example of young people who don't seek treatment to explain the model:

1. **Knowledge:** young people have no information about STIs or misconceptions, or they are not aware of services where they can get tested and be given treatment.
2. **Risk perception:** they don't see it as their personal risk, or are not aware of the risks of untreated STIs.
3. **Attitude (advantages and disadvantages):** they have a negative attitude towards STI services and visiting the service. Attitudes are often influenced by people's personal values.
4. **Social influence (support, norms, peer pressure):** the norm among young people that it's not 'cool' to go to STI services or that an STI is a sign of promiscuous behaviour.
5. **Skills & self-efficacy are closely linked:** a relevant skill in this example is the skill to resist peer pressure. Self-efficacy is the self-confidence to actually use these skills, even in difficult situations. For example, being confident enough to go to the service, even if your friends would laugh at you.
6. **Intention to perform a behaviour or not:** for example, the intention to visit a service within the next week or month. Intention is shaped by all of the above. If someone has the knowledge, or even sees the risks, but has a negative attitude or is strongly influenced by others, he or she is not likely to go. And even if someone intends to go, lack of skills or external factors (no service available) may prevent him/her from going.
7. **External factors:** someone intends to go to a clinic, but if there is no clinic nearby, or the clinic does not provide (friendly) services to unmarried young people, he/she may not go. External factors relate to legislation, affordability, availability and accessibility.
8. **The cultural, religious and societal context influences all the above-mentioned determinants:** what people know, value and are used to, plus their norms, are still influenced by their environment.

Two categories of determinants

Two categories of determinants can be distinguished: *personal determinants* (belonging to the person themselves) and *environmental determinants* (that a person has no control over). The environmental determinants include social influence and external factors, as well as the cultural, religious and societal context. The personal determinants are the starting point for designing an SRHR programme: what has to change in terms of knowledge, risk perception, attitudes, skills and self-efficacy. The environmental determinants are analysed and this may result in a specific action or programme targeting others in the young people's environment (training for health care providers, for example). Sometimes, however, an organisation cannot do anything about environmental factors.

BACKGROUND TO THE CHECKLIST

When programme officers communicate with partner organisations or look at project proposals, they can use the 12 criteria below to assess the quality of the *planning process* (A), and the *content* (B) of SRHR programmes for young people. Which criteria can or cannot be met will depend on the particular circumstances or context.

A. Planning SRHR programmes for young people

Planning SRHR programmes for young people includes various tasks. It starts with involving relevant stakeholders. Then, after the problems and solutions have been analysed, objectives can be defined before the programme materials and activities are developed. Finally, the programme is implemented, monitored and evaluated. The criteria in this section relate to the whole planning process.

1. Are young people and facilitators actively involved in planning?

Many programmes are developed by planners in their offices, without the involvement of the beneficiaries and those implementing the programme. The quality of a SRHR programme improves if representatives of the young people and facilitators (such as teachers) are involved from the start. They can provide feedback and suggestions on needs, messages, activities and materials. This results in a programme that addresses the actual needs of young people and ensures that the facilitators feel comfortable about implementing the activities. Many programmes involve young people as peer educators. However, there is little evidence that shows that this kind of SRHR education is effective. Peer education is only effective if specific conditions are met, such as extensive training and follow up.

2. Are the relevant decision-makers actively involved in planning?

Involving relevant decision-makers from the start is essential. Not only to obtain their approval, but also to increase their commitment for sustainable implementation and upscaling, and to link the SRHR programme to existing programmes and policies. A possible method of involvement is to set up an advisory board with representatives of the most important stakeholders. The board can provide feedback and advice. It could include *policy makers* (e.g. Ministry of Education/Health/Youth); *community* organisations or individuals (e.g. parents, religious leaders, school board, health care providers, youth-based organisations); and specialists in education and SRHR (e.g. teachers' union, curriculum advisors, national AIDS commission, family planning association, relevant NGOs).

3. Does the programme start with relevant analysis of the needs and the situation?

Many projects start with a baseline analysis. This is often very general and restricted to health figures, without analysing young people's needs and the environment they live in. To be able to design programmes aiming at behaviour change, behaviours and determinants should also be analysed. This will help to address actual needs of young people in the programme. This analysis is called a **needs assessment**: assessing the capacities and needs of beneficiaries (young people). It can start with a literature review of SRHR for young people in the specific context (HIV/AIDS, STIs, pregnancy, rights, etc.).

The most relevant aspects to study are young people's sexual behaviour (e.g. abstinence, condom use, the onset of having sexual intercourse, sexual abuse) and its determinants (knowledge, attitude, skills, self-efficacy, environmental factors). Data on behaviours and determinants can be collected using a short questionnaire, using group discussions and/or individual interviews. The needs assessment should take into account the differences between sub-groups (i.e. age, boy/girl, rural/urban).

Other relevant information for programme planners can be gained from a **situation analysis**. This explores existing structures, capacities and resources in the community which can be used to address the problem. Generally, it is a review of reports and literature, including: 1. Relevant laws, *policies* and regulations related to young people and SRHR; 2. Values and *social norms in the community*; 3. *Available resources* and facilities such as health care, other services, contraceptives, and collaboration with other organisations; 4. Opportunities and barriers in the *implementation setting* (e.g. school, staff time, resources); 5. Needs of the *facilitators* (e.g. teachers' skills) to enable them to implement the programme; 6. *Existing SRHR education programmes* (including materials).

4. Is there a logical link between the analysis, objectives, and programme activities and materials?

Using a 'logical approach' in planning programmes improves their quality. This means that there should be a direct link between 1. Needs assessment/situation analysis (which may show, for example, that very few young people use condoms, because they don't have the skills to use them correctly); 2. Objectives (e.g. improved skills for using condoms); 3. Activities and materials (e.g. exercise with broom to learn how to put on condom).

Even when a baseline analysis has been conducted, the findings are often not reflected in the programme objectives, content, activities, materials, messages and implementation. Sometimes, activities and materials are selected because they 'look nice', 'are innovative' or 'feel good', but not because they address real needs. Actually writing down the link between analysis, objectives, and activities and materials can help planners to remember to include important topics in their programme.

5. Has the programme been tested among young people and facilitators?

Testing programmes on a relatively small scale can greatly improve effectiveness but is rarely done. It enables planners to test whether the materials and activities are suitable for both target group and facilitators and whether they cause adverse effects. Many planners (and donor agencies) tend to start with full-scale implementation once the programme materials have been produced.

Two different ways to test a programme are: 1. *Pre-test* - evaluating some complex, sensitive or questionable activities and materials on a small scale, e.g. with 10-20 young people and some facilitators; 2. *Pilot* - implementing the complete programme among a relatively small audience (e.g. three schools).

If necessary, the activities and materials can be adapted on the basis of the findings. For example, the pre-test or pilot may show that facilitators cannot implement the skills-building exercises on condom use because they are too difficult for them. These exercises may need to be replaced by easier exercises, or the facilitators may need to receive different training.

6. Do the facilitators get sufficient training and support to implement the programme?

A well-developed programme is generally not sufficient for creating change. Equally important is the selection, training and support of facilitators, enabling them to communicate all the key messages as intended by the planners. The training and support that facilitators receive should include information sharing (on sexuality and SRHR-related topics); interactive teaching skills and participatory educational techniques; communication skills for discussing sexuality with young people in a non-judgemental and open way; understanding attitudes and values regarding young people's rights; confidence-building for implementing activities. This can be done through training sessions before and/or during implementation; review/feedback meetings; individual supervision and monitoring, and on-the-job support and feedback.

7. Are implementation and the impact on behavioural determinants monitored and evaluated?

During monitoring and evaluation, most planners don't measure the impact of the programme in terms of behaviour change. Measuring behaviour change among young people is usually not possible in the time-span of a project. Change takes time. Some young people may only become sexually active after several years, and only then will they apply what they've learnt for example about condom use. However, it is possible to measure a change in the *determinants of behaviour* by asking young people about their knowledge, risk perception, attitudes and skills, and intentions for future sexual behaviour. This can be done with a questionnaire before and after implementation. It can also be done by using qualitative methods such as focus group discussions (FGDs), in-depth Interviews (IDIs) and/or class observations. In addition to impact evaluation, planners should closely monitor the implementation on different levels: beneficiaries (young people), facilitators (e.g. teachers), and the implementing organisation (e.g. CBO, NGO, government).

B. Content of SRHR programmes for young people

The second category of criteria for developing effective SRHR interventions relates to the content of the programme: how and by whom it is implemented, messages, activities and materials.

This may not be explicit in all project proposals but can be discussed with partner organisations.

8. Does the programme address the behaviours and determinants that are the most relevant and changeable?

Many SRHR programmes for young people address factors that cannot easily be changed (e.g. social norms), or those that have little impact on behaviour (knowledge-only programmes), but do not address the most relevant behaviours (e.g. condom use). Addressing factors that were found in the needs assessment to be important behavioural determinants is what makes a programme effective. Many programmes can be greatly improved if they include activities to tackle personal risk awareness, attitude change, and skills building, rather than only focusing on information transfer (in leaflets and posters).

According to a rights-based approach (the right to complete and correct information), it may sometimes be necessary to address topics that are difficult to change, but young people have the right to know about. For example, attitudes on sensitive topics such as abortion or homosexuality may be difficult to change, but important to address in the programme.

9. Does the programme encourage active learning?

Many programmes are implemented using one-way communication - through radio or TV messages, or in written material (such as leaflets, booklets and posters). This gives young people information, but it doesn't stimulate them to actively process any of the information. Effective programmes are those that encourage young people to learn in an active way by looking for or thinking about the information (in quizzes, for example), discussing it with others (in small groups), and practising required skills (with role-play or homework assignments).

10. Are the activities and materials appropriate for the beneficiaries and based on evidence?

Programme materials and activities are not always based on well thought out plans, teaching principles or evidence about what does or doesn't work for a particular target group. It is often simply a matter of 'what we have always done' or 'what others do too'. This can seriously reduce the effectiveness of programmes. Some principles really do need to be taken into account. Programme planners should therefore select activities and materials that:

- Match the beneficiaries and the context, and consider gender issues (design, language, tone of voice, examples)
- Provide factual information that is based on evidence and not on values (about rights, sexuality, masturbation, condoms, etc.)
- Increase risk awareness; not with fear-based information, but by giving young people insight into the risk to their own health plus the confidence to do something about it
- Change attitudes; for example, by effectively leading group discussions and providing persuasive arguments
- Improve skills; with role-play, individual practice and positive feedback

11. Does the programme explicitly communicate about sensitive issues in a safe atmosphere?

One of the most difficult aspects of SRHR programmes is being explicit about sexuality and related topics. This means that the programme materials and the facilitators need to openly address issues such as masturbation, abortion, condom use, pleasure, abuse, sex before marriage and taboos. It has to be done in a positive, non-judgmental way. This requires a safe and confidential atmosphere, created by facilitators such as teachers in a classroom. It is important that they don't impose their own norms on young people. They must simply enable young people with sufficient information and guidance to make their own well-informed decisions.

Evidence provided by many evaluation studies worldwide shows that open communication about condom use and sexual behaviour does NOT result in more sexual activity among young people. On the contrary, this evidence shows that it can actually delay the first sexual experience and increase safe sex among young people who are already sexually active. There is hardly any evidence that shows that abstinence-only programmes increase safe sexual behaviour of young people.

12. Does the programme include options for individual follow-up?

SRHR education programmes may make individual questions, worries and needs apparent (the need for condoms or other contraceptives, for example). They may also lead to recognition of individual challenges or health problems, such as STIs, HIV/AIDS, unintended pregnancy, sexual orientation or sexual abuse. It is therefore necessary and right that young people should be provided with facilities or other opportunities to find help for their particular needs and questions. If the implementing organisation cannot provide this support, a system can be set up to refer young people to other health service providers (e.g. HIV testing facilities), appropriate counsellors or, for instance, a helpline or magazine where they can ask questions about anything bothering them. Creating a safe and supportive environment should help young people make use of what they've learnt in the programme in their everyday lives.

CHECKLIST

The 12 criteria below can be used to assess the quality of the *planning process* (A), and the *content* (B) of SRHR programmes for young people.

A. Planning SRHR programmes for young people		++ + +/- -- x	Comments and suggestions for improvement
1. Are young people and facilitators actively involved in planning?	1a. Young people	_____	_____
	1b. Facilitators	_____	_____
2. Are the relevant decision-makers actively involved in planning?	2a. Policy makers	_____	_____
	2b. Community	_____	_____
	2c. SRHR education specialists	_____	_____
3. Does the programme start with relevant analysis of the needs and the situation?	3a. Needs assessment, including behaviour and determinants	_____	_____
	3b. Situation analysis	_____	_____
4. Is there a logical link between the analysis, objectives, and programme activities and materials?	4a. Objectives are based on the analysis	_____	_____
	4b. Objectives are linked with programme activities and materials	_____	_____
5. Has the programme been tested among young people and facilitators?	5a. Pre-test	_____	_____
	5b. Pilot	_____	_____
6. Do the facilitators get sufficient training and support to implement the programme?	6a. Selection	_____	_____
	6b. Sufficient and quality training	_____	_____
	6c. Sufficient other support	_____	_____
7. Are implementation and the impact on behavioural determinants monitored and evaluated?	7a. Effect on behavioural determinants	_____	_____
	7b. Monitoring of implementation	_____	_____

++ excellent + fair +/- needs improvement -- is not done at all x not applicable

B. Content of SRHR programmes for young people		++ + +/- -- x	Comments and suggestions for improvement
8. Does the programme address the behaviours and determinants that are the most relevant and changeable?	8a. Most relevant and changeable behaviours	_____	_____
	8b. relevant and changeable determinants, and not knowledge-only	_____	_____
9. Does the programme encourage active learning?	9a. Looking for/ thinking about information	_____	_____
	9b. Discussing with others	_____	_____
	9c. Practising skills	_____	_____
10. Are the activities and materials appropriate for the beneficiaries and based on evidence?	10a. Target group (gender) and context-specific	_____	_____
	10b. Factual information	_____	_____
	10c. Not fear-based	_____	_____
	10d. Focus on attitude change	_____	_____
	10e. Include skills-training	_____	_____
11. Does the programme explicitly communicate about sensitive issues in a safe atmosphere?	11a. Explicit communication	_____	_____
	11b. Positive, non-judgemental communication	_____	_____
	11c. Creation of safe atmosphere	_____	_____
12. Does the programme include options for individual follow-up?	12a. Referral system	_____	_____
	12b. Youth friendly counselling	_____	_____

++ excellent + fair +/- needs improvement -- is not done at all x not applicable

Endnotes

- 1 World Population Foundation (WPF) and Stop AIDS Now! (August 2009). *Evidence- and Rights-Based Planning & Support Tool for SRHR/HIV-Prevention Interventions For Young People*. See www.stopaidsnow.org or www.wpf.org for a digital copy.
- 2 See IPPF website for more information about 'Young People's Sexual and Reproductive Rights': www.ippf.org
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Colofon

The Netherlands, December 2009

Developed by

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In cooperation with

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Save the Children Netherlands and the STOP AIDS NOW!
partners Cordaid, Oxfam Novib, ICCO

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Dance4Life, Targeted Aids Intervention,
Catholic Institute of Education, South African Scouts
Association, Stellenbosch University, God's Golden Acre

Pakistan

AAHUNG, IHDCS, AMAN Foundation, AAS, PAVNHA,
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