Evidence and Rights-based

Planning and Support Tool

for Empowering Approaches to SRHR Education with Young People

Rutgers | For sexual and reproductive health and rights

STOP AIDS NOW!

Preface

This document was first published in 2009, with the aim of presenting, in a practical way, evidence about effective sexual and reproductive health and rights (SRHR) work with young people and related academic principles and topics. Following its publication STOP AIDS NOW! and Rutgers, with financial support from Oxfam Novib, Cordaid, HIVOS, ICCO, Educaids and Dance4Life , trained local trainers to enable organisations' use of the tool. The trainers have supported over 150 organisations in Africa, many of whom have used the tool to improve the quality of their SRHR interventions for young people.

In 2015 STOP AIDS NOW! and Rutgers realised the tool could usefully be updated with new evidence and feedback from users, and by taking a broader approach to SRHR and widening the focus from Africa to include Asia. This revised Planning and Support Tool is the result.

Our thanks remain for the contributions of organisations and individuals to the first edition, which was written by Joanne Leerlooijer. For this second edition, revised by Sue Holden and Jo Reinders, we are indebted to: Moffat Njatiyamphongo, Naomi Nandutu Muando and Vidalyne Akinyi Omolo who ran the focus groups with users; to the staff of SAIPEH (in Kenya), ACET Uganda, Makuyu CDC, Buyobo Child Development Centre (in Uganda) and YONECO, FAWEMA, SASO and Blantyre Teacher Training College (in Malawi) who took part in the focus group discussions; to Akampa Tanbull, Daniel Obi Peters, Albert Obbuyi, George Dam Laar and Alex Okwaput, who commented on the draft survey and to the users who filled in the online survey. We also thank the staff in The Netherlands who contributed their knowledge and experience, namely: Miriam Groenhof (STOP AIDS NOW!), Lisette Schutte (SOA AIDS), Miranda van Reeuwijk, Ruth van Zorge, Jo Reinders and Thilly de Boer (Rutgers), Olloriak Sawade (Oxfam Novib), Jorik van Enck and Nina Pavlovska (dance4life) and Doortje Braeken (IPPF). We also thank Petra Rohr-Rouendaal for making her illustrations available for free use in her publication "Where There is No Artist".

Two other documents were written in 2009 to go with this tool. One is much more elaborate: *the Intervention Mapping Toolkit for Planning Sexuality Education Programmes*[1]. It translates useful academic models, evidence, theories and other information into a practical 'cookbook', providing many tips, experiences and tools that have been used in projects in Africa and Asia. The second document, updated in 2016[2], is a summary of this planning and support tool. It consists of only a few pages – a checklist for programme officers at donor and other organisations when they are developing or assessing project proposals.

In 2016 the Dutch SRHR Alliance, with input from among others STOP AIDS NOW! and Rutgers, published the 2016 edition of the *Essential Packages Manual: Sexual and Reproductive Health and Rights Programmes for Young People*[3]. That manual is closely connected to this tool as it gives all the background, evidence, approaches, guidelines and resources for the different SRHR intervention issues that are central to this tool.

Also in 2016 Rutgers published *We All Benefit! The Whole School Approach for sustainable and scalable implementation of CSE*[4]. This manual explains and gives practical guidance about the whole school approach for improving implementation of CSE, upscaling and sustainability.

Rutgers and STOP AIDS NOW! welcome all efforts to apply or distribute this document and appreciate any comments for further improvement. We also provide training and support in both practical use of the tool and its underlying principles and approaches; for an overview and list of available trainers please go to: **stopaidsnow.org/quality-youth-programmes** and **www.rutgers.international/upscaling-cse**

Contents

Abbreviations

AIDS	acquired immune deficiency syndrome
CSE	comprehensive sexuality education
HIV	human immunodeficiency virus
IM	intervention mapping
M&E	monitoring and evaluation
NGO	non-governmental organisation
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
UNESCO	United Nations Scientific, Educational and Cultural Organisation
WHO	World Health Organisation

1. Introduction

More than half of the world's population consists of young people. Many of them face challenges when growing up such as low self-esteem, lack of control of their own sexuality, unintended teenage pregnancy, acquiring sexually transmitted infections (STIs) including HIV, gender inequality, sexual abuse, poverty and discrimination, particularly in developing countries.

This tool is designed to assist organisations that want to promote young people's sexual and reproductive health and rights (SRHR) and to empower them to enjoy their (sexual) development , relationships, attain their rights and have a greater sense of wellbeing. It focuses mainly on the strategy of SRHR education, also known as (comprehensive) sexuality education.

Summary: this section explains the meaning and aims of sexuality education. It also sets out more information about this tool, including its aims and uses, how it was developed, its 6 step structure, and how to use it.

1.1 SRHR/sexuality education

Box 1 provides a definition of sexuality education and a list of its aims. Many programmes are part of SRHR/sexuality education, for example life skills programmes, information education and communication (IEC) materials, pregnancy prevention, HIV & AIDS prevention, abstinence programmes, and comprehensive sexuality education. The scope and approaches underlying these programmes may vary a lot, but all aim to prevent particular health problems and promote young people's wellbeing.

Sexuality education is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information[5, p 2].

Sexuality education has the following aims (adapted from[6, p. 27])**:**

1. To contribute to a social climate that is tolerant, open and respectful towards sexuality, sexual rights, various lifestyles, attitudes and values.
2. To empower people to make informed choices based on understanding, and acting responsibly towards oneself and others, especially in sexual relationships.
3. To be aware of and have knowledge about the human body, its development and functions, in particular regarding sexuality.
4. To be able to develop healthily as a sexual being, meaning to learn to express feelings and needs, to show empathy, to experience sexuality in a pleasurable manner, and to develop one's own gender roles and sexual identity.
5. To have gained appropriate information about physical, cognitive, social, emotional, spiritual and cultural aspects of sexuality, contraception, prevention of STIs including HIV and sexual coercion and abuse as basis for own decision-making.
6. To have the necessary life skills to deal with all aspects of sexuality and relationships.
7. To have information about provision of and access to counselling and medical services, particularly in the case of problems and questions related to sexuality.
8. To reflect on sexuality and diverse norms and values with regard to human rights in order to develop one's own critical thinking and attitudes.
9. To respect gender differences and sexual diversity and to be aware of one's own sexual identity and gender roles.

Box 1: Meaning and aims of sexuality education

10. To be able to build (sexual) relationships in which there is mutual understanding and respect for one another's needs and boundaries and to have equal relationships free from prejudices, discrimination and stigma. This contributes to the prevention of sexual harassment, abuse, violence and stigma due to e.g. disability, being HIV positive, and differences in sexual and gender identity.
11. To be able to communicate about sexuality, emotions and relationships.
12. To feel empowered to contribute to an enabling environment, practise responsible citizenship and maintain their rights.

There is strong evidence that comprehensive approaches to sexuality education help young people both to withstand the pressures to have sex too soon and to have healthy, responsible and mutually protective relationships when they do become sexually active. There is no evidence so far that education which promotes abstinence-only-until-marriage has any lasting effect on delaying sexual activity among teenagers[7,8].

Sexuality education aims to enable young people to enjoy relationships.

1.2 Aim and uses of the tool

To improve young people's quality of life and (sexual) health we need effective programmes, but developing and implementing them is not easy. However, experience and evidence gained from work all over the world shows what contributes to effectiveness and what doesn't. This tool summarises the most important evidence in a logical and easy to use way (much of it comes from research by Kirby and colleagues into HIV and sexuality education programmes around the world[8,9]). It aims to help organisations to take well-informed decisions about the planning, development, implementation and evaluation of SRHR programmes, and to modify their work as needed. The outcome of using the tool should be more effective interventions which are empowering and rights- and evidence-based.

You can use the tool to **analyse existing interventions,** in order to identify what is already going well and what needs improvement. You can also use it to assist with **designing new interventions.** Box 2 lists all the uses that organisations have made of this tool. However, this framework should not oblige you to implement programmes completely according to the tool; the particular context, implementation setting or mandate of your organisation may require choices that are not in line with the tool.

Box 2: Examples of how the tool has been used

Users have used the tool for various purposes:

- Analysing existing SRHR education programmes
- Designing of new SRHR education programmes
- As a framework to guide discussion with donor organisations
- Capacity building and improvement of their projects or programmes
- Documenting intervention planning afterwards
- Modifying an existing intervention to use in a different context
- Assessing project proposals
- For defining advocacy strategies
- Linking and learning between different organisations

You can use the tool to analyse or plan a variety of SRHR interventions, for example: school-based and out-of-school interventions; large and small projects; with different SRHR focuses; targeting children, younger or older people; for orphans and vulnerable children; or for young people who are at work.

The tool can be used by professionals and organisations without any guidance or interaction, but the best option is to get training with a network of organisations on how to use the tool **(stopaidsnow.org/quality-youth-programmes).** This has proved to be a good way of learning from other organisations and trainers, and helpful in effectively sharing experiences.

1.3 Developing the tool

The tool was developed by RutgersWPF, STOP AIDS NOW! and Maastricht University and primarily based on global evidence, including studies from developing countries, as reviewed by Kirby and colleagues[8, 9].

It was tested in South Africa and Pakistan and then improved based on feedback from those tests. One lesson learned was that when the tool is introduced, it needs to be made clear it is not an external evaluation tool imposed by donors, but simply a self-assessment instrument.

This 2016 revision of the tool involved the following: comparing the tool with similar tools; conducting a literature review of relevant papers published since 2009; interviewing experts in empowerment, the rights-based and the gender transformative approach, and SRHR programming; gathering feedback and suggestions for improvements from users in Kenya, Malawi and Uganda; revising the tool; and creating an excel (spreadsheet) version of the tool.

1.4 Intervention mapping

The tool is structured using the intervention mapping (IM) model[10], which helps planners to systematically design health programmes and encourages them to involve stakeholders and take evidence-based decisions. SRHR education for young people is more likely to be effective if the issues and problems are addressed systematically, based on evidence and theory.

Intervention mapping is used all over the world and emphasises the use of **evidence**: information about the needs, rights and problems of a target group, the context and available structures and resources to address these needs, and information about what works and what doesn't (effectiveness), in terms of approaches and methodology.

Intervention mapping encourages programme developers to work in a **systematic** way. It consists of 6 steps that are closely linked, and which form the basis for this tool:

Step 1: **Involve relevant people and organisations** as needed for expertise, quality of programme delivery, representation, ownership and sustainability;

Step 2: **Undertake research and analysis** to fully understand all aspects of the issues and needs, context, existing interventions and the available resources;

Step 3: **Define the goals and objectives** to address the aspects of the issues and problems that you are focusing on;

Step 4: **Design the intervention** and pre-test and pilot it so that the activities, chosen methods and materials lead to outcomes which should result in meeting the objectives;

Step 5: **Implement the intervention** based on an implementation plan, including addressing any barriers to its adoption, and training facilitators to implement fully and to a good standard, aiming for sustainability and (if effective) upscaling;

Step 6: **Monitor and evaluate** in order to modify implementation as necessary, to learn about its impact, and to evaluate the overall process of design and implementation.

Although the six steps make sense in that order, one after another, in practice they may be more like a dance, moving backwards and forwards, rather than only stepping in one direction! For example, you need to think about implementation and sustainability from the start, not only after Step 4, and you might need to do more research (Step 2) during implementation (Step 5).

Intervention mapping is often used to focus closely on specific health promoting behaviours. In this tool we encourage you to use it in a broader way, embracing wider aspects of empowerment, while not losing sight of the risk behaviours.

1.5 This tool and the logical framework approach

Many organisations use logical frameworks or other project management models for planning, monitoring and evaluating their interventions.

This tool does not replace those models – it's an add-on. The logical framework is a useful but very general approach which can be used for any project. Unlike intervention mapping, it does not support users to explore factors influencing quality of life, or to develop programme activities and materials. Using this tool can therefore be a useful addition to your logical framework, helping you plan to use empowerment and a rights-based approach for promoting SRHR, and providing suggestions for the content of SRHR interventions as well as the steps to create an effective intervention.

1.6 How to use this tool

Inform your colleagues and form a team: Your self-assessment should not be done by an individual but by a small team of people who know or are involved in the intervention and the context, and which includes a manager. Note also that you will need to trust and be honest with each other in order to give low scores where necessary, so that you can then improve your work.

Read Section 2 to learn about the approaches used in this tool: These are the rights-based approach, the theory- and evidence-based approach, and the inclusion of empowerment and gender transformative working.

Use Section 3 to conduct your self-assessment: This is the 'core' of the tool. It contains 28 questions based on characteristics of effective SRHR programmes with young people, arranged in IM's 6 steps. Each of the 28 characteristics has sub-questions to which you give a score. These are divided into 'what' questions (what was/will be done or included in the intervention and what was/will not?) and 'how' questions (how was/will be its quality, or how was/will it be included?)

Note, for convenience you can **download and print off** copies of Section 3 from **stopaidsnow.org/quality-youth-programmes** so that each member of your team has a copy to write on.

Another option is to **download the spreadsheet version of this tool** from **stopaidsnow.org/quality-youth-programmes** and fill in Section 3 in the excel document. Your answers will automatically create charts which present your assessment results.

Read the background information: In Section 4 you can read more information about each of the 28 characteristics, including references to documents and literature.

Read additional information: All the way through the text, we have inserted reference numbers, for example:[3]; these link to the **References** section at the end of this document, which lists all the documents and where you can find them on the internet.

Summarise your results: At the end of Section 3 you can complete Tables Q and P to summarise your results and identify the next steps to take.

Discuss, share and plan: Do others agree with your conclusions and the next steps you have identified? Consult with colleagues and stakeholders, and jointly make a plan to implement the next steps.

2. Rights, Evidence and Empowerment

Summary: this sub-section explains how a rights-based approach starts not with what young people's needs or problems are, but with the rights that they are entitled to. It sets out key elements of a rights-based approach to SRHR work with young people, definitions for sexual and reproductive rights, the need to address diversity and gender and to take a holistic approach.

This section explains the thinking and approaches which we use in this tool.

2.1 Using a rights-based approach

The rights-based approach to the sexual and reproductive health of young people is based on internationally agreed human rights, starting with the 1948 Universal Declaration of Human Rights. The Declaration states, among other things, that all people have a right to self-determination, education, health care, protection, support and freedom of expression and participation[11]. These rights provide a framework of how things should be. And because young people have the right to participate in decision making about their lives, the approach involves **empowering them and strengthening their capabilities,** in addition to giving them more access to opportunities and services, and providing them with safe and supportive environments. A rights-based approach aims to enable young people to improve their capacity to act independently and take control of their own sexual and reproductive lives.

In 1989, the Convention on the Rights of the Child introduced a rights-based approach to the sexual and reproductive health of young people[12]. 194 governments have signed and approved this convention. By doing so they have bound themselves to respect and promote young people's sexual and reproductive rights, and to ensure that all children and young people below the age of 18 survive, grow, are protected and participate as active members of society.

Box 3: Definition of SR rights (adapted from[13])

Sexual and reproductive rights
The fulfilment of sexual and reproductive health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual and reproductive rights embrace certain human rights that are already recognised in international and regional human rights documents and other consensus documents and in national laws.

Rights critical to the realisation of SRH include the rights:

- to equality and non-discrimination;
- to be free from torture or to cruel, inhumane or degrading treatment or punishment;
- to privacy;
- to the highest attainable standard of health (including sexual and reproductive health), health care and social security;
- to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage;
- to access to safe, affordable, acceptable forms of fertility regulation;
- to decide the number and spacing of one's children;
- to information, as well as education;
- to participate in and affect policy and programme development and implementation;
- to freedom of opinion and expression;
- to make decisions concerning reproduction free of discrimination, coercion and violence; and
- to an effective remedy for violations of fundamental rights.

United Nations conventions since then have reinforced and further elaborated on the rights of young people. As a result young people are now recognised internationally as sexual beings with a right to self-determination, education and information, youth-friendly services, protection and participation[14]. By signing conventions, governments of almost all the countries in the world have committed themselves to expanding adolescents' access to comprehensive sexual and reproductive health information and services, and to promoting young people's wellbeing and social equality.

There is evidence that using a rights-based approach to sexuality education results in more positive attitudes about relationship rights, more communication with parents and greater self-efficacy to manage risky situations, compared to sex education which does not include rights[15]. Key parts of an empowering rights-based approach to young people's sexual and reproductive health are:

- young people's right to make their own, well-informed decisions about their sexuality and having sex;
- the duty of others to give them accurate and complete information about SRHR, including the changes they go through during adolescence, the risks they face, and ways to realise, gain and protect their health and wellbeing;
- the right to have access to accessible, affordable, confidential and youth-friendly sexual and reproductive services which provide counselling and contraceptives, including condoms;
- the right to freedom from discrimination, stigma and sexual harassment, abuse and violence;
- the participation of young people at all levels of decision-making, to try to ensure that policies, programmes and services meet their needs;
- the message that all people are equal and have the same rights whether male or female or intersex, whatever their sexual orientation or gender identity, and regardless of disability, education, wealth and health;
- recognising the diversity that exists among young people;
- encouragement to take action when rights are violated, such as stigma and discrimination against people with disabilities, of a different gender or sexual identity, living with HIV, or in cases of sexual abuse.
- knowing that our rights also come with responsibilities, including to respect and not abuse other people's rights.

They are not too young for sexuality education!

We usually think of adolescents when considering young people's SRH rights, but they apply equally to children who have not reached puberty. Indeed, there is some evidence[16, p. 88] and growing support[17, 18, 19] for beginning sexuality education whilst 'young people' are children. UNESCO's International Technical Guidance on Sexuality Education[5] proposes an age-appropriate set of topics and learning objectives for CSE work with children from the age of five, while WHO's standards[6, p. 24] start at birth.

Being explicit about gender and power

It is not possible to adopt a rights-based approach without putting emphasis on the issues of gender and power. For example, it is not sufficient to simply explain that everyone has the same rights. We need to be explicit about these issues because they have a big influence, not only on sexual and reproductive health and relationships, but on many other aspects of life such as family life, education, work and wellbeing.

Effective SRHR work with young people that addresses power and gender[20, p. 36] includes:

- supporting young people to explore and think critically about how gender norms and imbalance of power in relationships affect people's rights;
- exploring how norms are not fixed and how they can change;
- learning to take the perspective of a person with a different gender, to feel empathy and to act to promote rights;
- developing skills to communicate effectively in order to negotiate and assert oneself within a relationship;
- fostering personal reflection about one's own attitudes and behaviours;
- fostering valuing oneself and recognising our own power and how we can change.

Of course, there are other forms of power which affect young people's quality of life, such as imbalances related to age, ability, wealth, status, caste and ethnic group. These play a role in sexual harassment and abuse, and underlie stigma and discrimination and issues such as child marriage. In general they may not be part of the scope of a SRHR project, but might become a focus for action by empowered young people when fighting for their rights and trying to contribute to an enabling environment.

Using a holistic approach

Interventions are likely to work best if they are not stand alone but are integrated or part of a wider approach[21, p. 24].

In terms of **content**, a holistic approach to adolescent SRHR takes a wide view of the situation and the responses that are needed. Instead of focussing only on very specific health promoting behaviours it takes in wider issues of wellbeing, rights and equity. Taking a holistic approach avoids narrowing our content focus to individuals and their sexual acts or to abstinence from them. Sexuality education concerns so much more, such as: young people's wellbeing; becoming well-informed about how their bodies work and how to attain pleasure; positive feelings and thoughts about sex and equitable relationships; changing gender norms; sexual diversity; communication; preventing sexual aggression; becoming more socially and sexually competent; and family and community wellbeing. Taking a holistic approach also directs our M&E towards wider effects on, for example, self-confidence, relationship quality wellbeing, benefits of CSE which may otherwise be missed[52, p. 6].

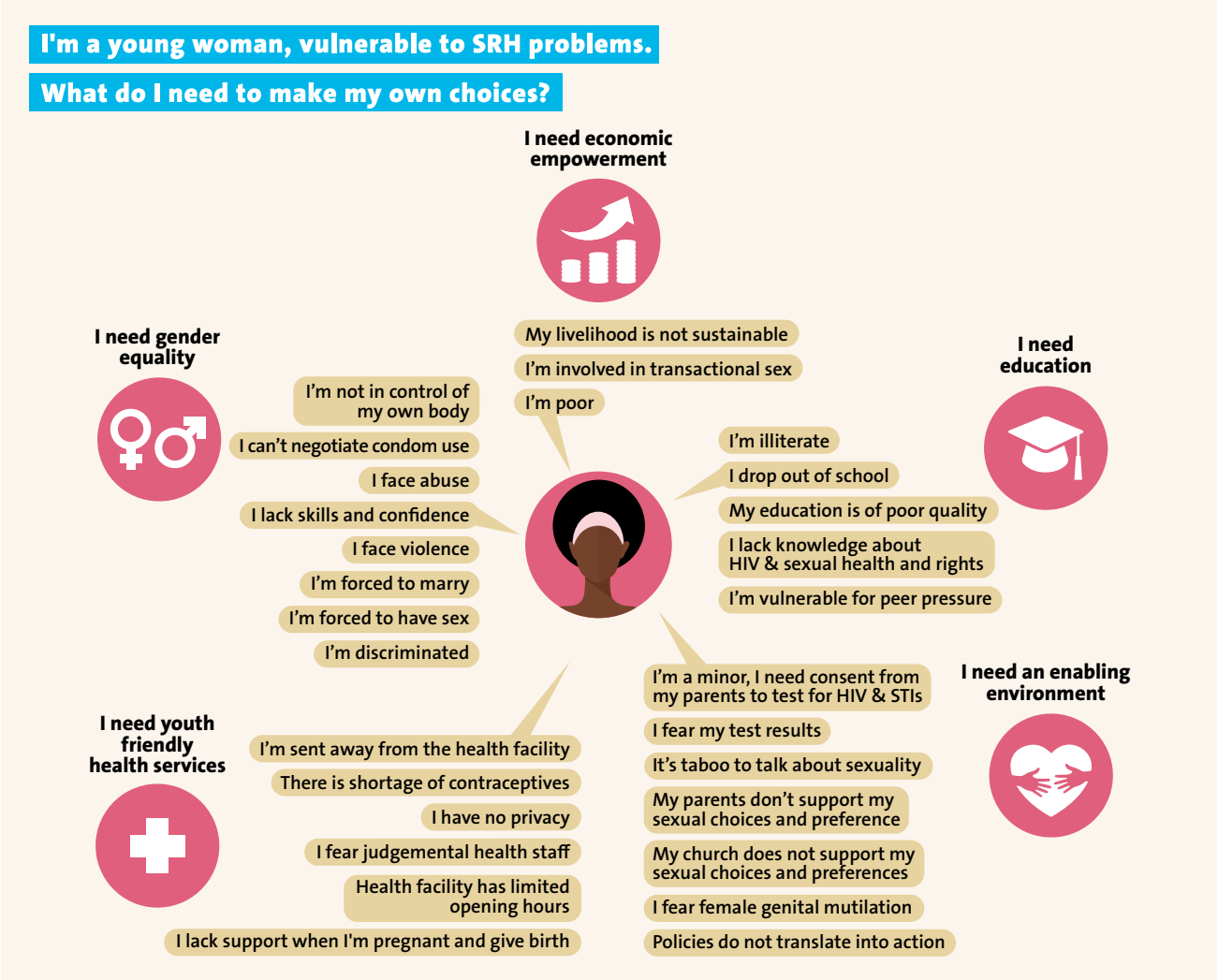


Figure 1: A young woman's needs with regard to SRH

A holistic approach also aims to address young people's **context**. Instead of focussing only on young people themselves it also takes in their relationships (friends, peers, parents, teachers), community and wider society. To be effective school-based sexuality education needs to take place in an enabling school environment, where each person feels safe to talk about sexuality and where people treat each other with respect. In many schools students have to deal with bullying, violence, sexual abuse and harassment, occurrences which undermine their education, SRHR and wellbeing. Part of a holistic approach is to create a safer atmosphere and a safer physical environment, in which students can learn and benefit including from sexuality education. For example, by establishing clear and fair school rules, and providing lockable and clean toilets.

Of course, young people's context is not limited to the school environment. For a holistic approach we need to bring parents, and community and religious leaders on board, and create and sustain lively linkages with local – and preferably youth friendly - health services and professionals. This strategy can strengthen and ensure a broad support network for schools, teachers and students. For young people who are not in school, attending to the context of their peers and others that they relate to is even more important.

We can view a holistic approach as having three components: CSE, SRH services for young people, and efforts to create an enabling environment[3, pp. 11-12].

As Figure 1 illustrates with the example of vulnerability to SRH problems young people may have a wide range of needs which go beyond sexual health needs. Equally a wide range of interventions may help them. In fact, we know that the 'non-health' actions of providing free school uniforms and cash transfers **enable young people to stay in school** and have positive consequences for young people's SRHR, such as reducing rates of unwanted pregnancy[22, p. 20, 23, p. 6, 18, p. 9]. Similarly vocational training, creating economic opportunities, microfinance and income generating activities can support better SRHR[24, 25].

For users of this tool, whose starting point is SRHR work, a holistic approach builds outwards from CSE, embracing more than delivery of a curriculum, and measuring more than effects on risk behaviours[52 p. 6]. One important strategy is **linking education to health.** Sexuality education programmes and health services can collaborate, so that the services become more youth-friendly, provide counselling and information and instruction on sensitive issues such as condom and contraceptive use, while both parties support young people's use of health services. These actions can lead to increased quality of health services and more use of them by young people[26]. The most effective approach seems to be a combination of health workers' training, youth-friendly improvements to facilities, and information and promotion regarding those through schools, the community and mass media[27].

To create an enabling environment schools have to act against violence

A more systematic approach to creating an enabling environment is the **whole school approach.** It involves students, school management, teaching and non-teaching staff, parents and others in a wide process of creating ownership, sustainability and a supportive school environment, with CSE as one element of the work. Benefits in recent Rutgers' pilot projects in Kenya and Uganda include young people feeling more safe due to less violence within school, less punishment by teachers, improved toilet facilities, and better attendance and performance in their studies[28, pp. 6-8]. Cooperation between the school and health services also enables young people to access counselling, condom demonstrations and services. Please see Rutger's We All Benefit! toolkit for detailed information about how to use the whole school approach[4].

2.2 Using a theory- and evidence-based approach

Summary: this sub-section explains that a theory- and evidence-based approach means using theory and evidence to guide decisions throughout project planning. It outlines the use of models for systematic consideration of all the factors that affect people's behaviour, factors known as determinants. It presents the Theory of Planned Behaviour, and gives an example of how to apply that theory to the issue of young people not seeking treatment for STIs.

A theory- and evidence-based approach applies evidence and theory to every stage in programme planning. It means referring to all known information that either supports or opposes the decisions that have already been taken or are being considered.

Evidence can be derived from experiences in other projects, baseline research, needs assessments, publications in scientific journals, reports, good practices, interviews with experts, or the Internet. An important source of evidence for this tool was the global review of the results of HIV and sex education interventions by Kirby and his colleagues, from which they found common characteristics of effective programmes[8, 9]. Remember that you need to check if evidence from one setting is applicable in your situation. For example, evidence from Africa cannot automatically be used in Asian contexts, but evidence from a similar country to your own may be applicable.

Information can also be obtained from proven **theories**. Some theories try to explain behaviour and the factors that influence quality of life, while others give principles for effectively choosing health promoting behaviour or the causes of certain behaviour. If we apply proven principles, our interventions are more likely to lead to health promoting behaviour. A useful guide that can be downloaded from the Internet gives a clear explanation of some health promotion theories and how they can be put into practice[29].

Health promoting behaviour models

Evidence shows that SRHR programmes for young people that are based on **health promoting behaviour models** are more likely to be effective[9 p. 31, 10]. These models state that all (health and rights) outcomes link back to behaviours. For example, there may be several behaviours behind young people having untreated sexually transmitted infections (STIs). Perhaps young people who have symptoms of an infection don't seek treatment due to fear of stigma or the cost of treatment *(behaviour of the people at risk)*. Perhaps treatment is not available because decision makers have not included provision of STI treatment for youth in their services *(behaviour of people in their environment)*. The situation may be quite complex.

The advantage of using health promoting behaviour models is that they help us to consider the relevant behaviours and factors for explaining and achieving a health improvement or solving a problem. Models can identify factors on different levels, and also show how these factors are related. First we need a clear idea of the improvement we seek. Then we need to understand the factors that determine the behaviours that lead to the current situation , known as **determinants**. Then we can design an intervention that attempts to address the determinants, and is are more likely to create learning and/or change. This is shown in Figure 2.

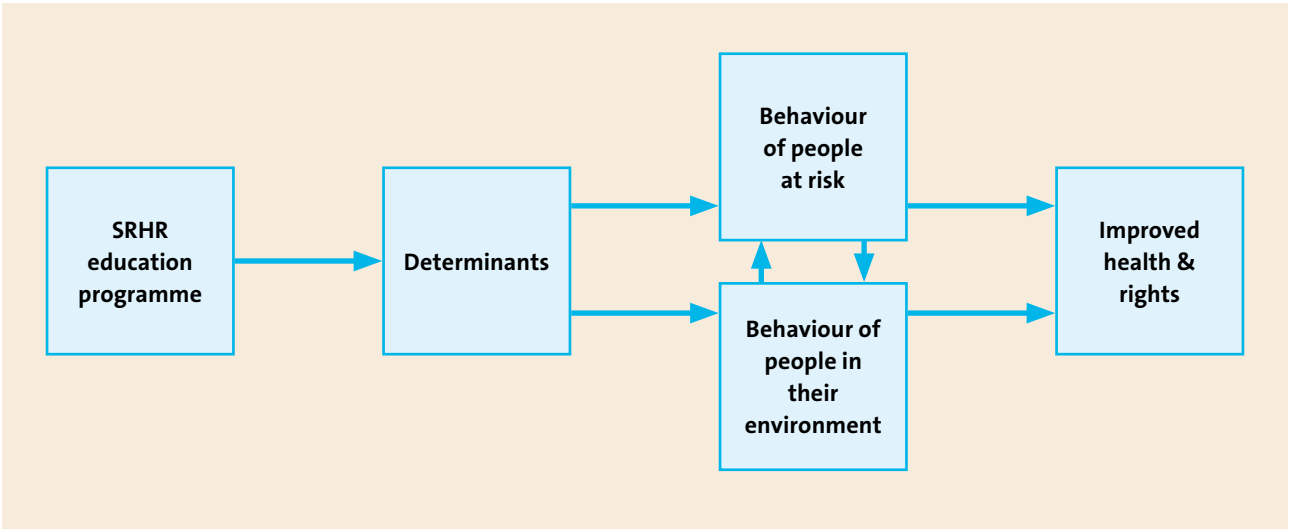


Figure 2: Health promotion model

The term 'health promoting behaviour' seems to imply that models can only be applied if change is sought. However, they can also be used to gain an understanding of how to **sustain behaviour** that contributes to the promotion of health and rights. For example, to understand why some young people *do* go for STI testing and treatment, and to support them to keep doing so.

Understanding determinants of behaviour

After identifying the key behaviours that contribute to or inhibit health and rights, we need to analyse why people do what they do: for example, why do some young people with STIs not seek treatment? And why do health care systems not provide good quality STI testing and treatment to them?

Figure 3 shows a model (based on the Theory of Planned Behaviour[30]) with several categories of determinants that influence behaviour. The categories fall into two groups: **personal determinants** (elements belonging to the person, that they have some influence over) and **environmental determinants** (that a person has less or no control over). Below we set out the types of questions that the model suggests if, in the 'Behaviour' box, we are considering the behaviour of young people not seeking treatment for STIs.

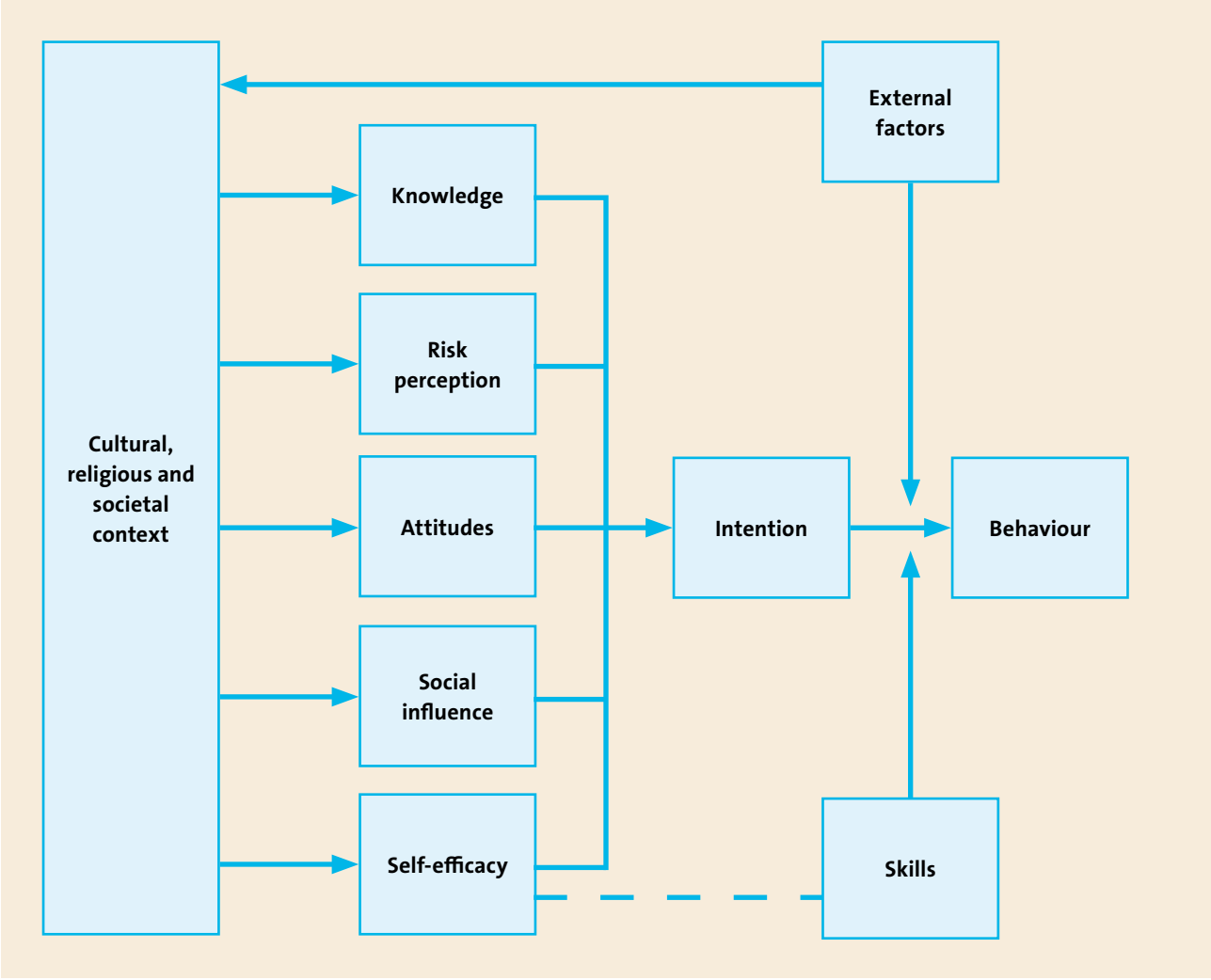


Figure 3: Theory of Planned Behaviour

Cultural, religious and societal context: how does young people's environment encourage or discourage them from seeking STI treatment? What norms exist? What do religious leaders say about young people who have sex before they are married? How does society judge a young person with an STI? Is the judgement different for males and females? Context influences the personal determinants: what people know, their values and norms. This is why ideally SRH programmes work not only with youth but also with people in their environment who influence young people's health promoting behaviours, such as parents, teachers, community and religious leaders, formal and informal health workers and policy makers.

Knowledge: do young people have accurate information about STIs, and where to access testing and treatment services? Do they know about their right to services?

Risk perception: do they understand the likelihood of acquiring an STI, the symptoms of STIs, and the risks of leaving STIs untreated?

Attitudes: what are their attitudes towards STI services and their staff? Do they prefer alternatives such as seeking advice from peers or treatment from informal providers? Do they value their health? Do they know about their right to confidentiality?

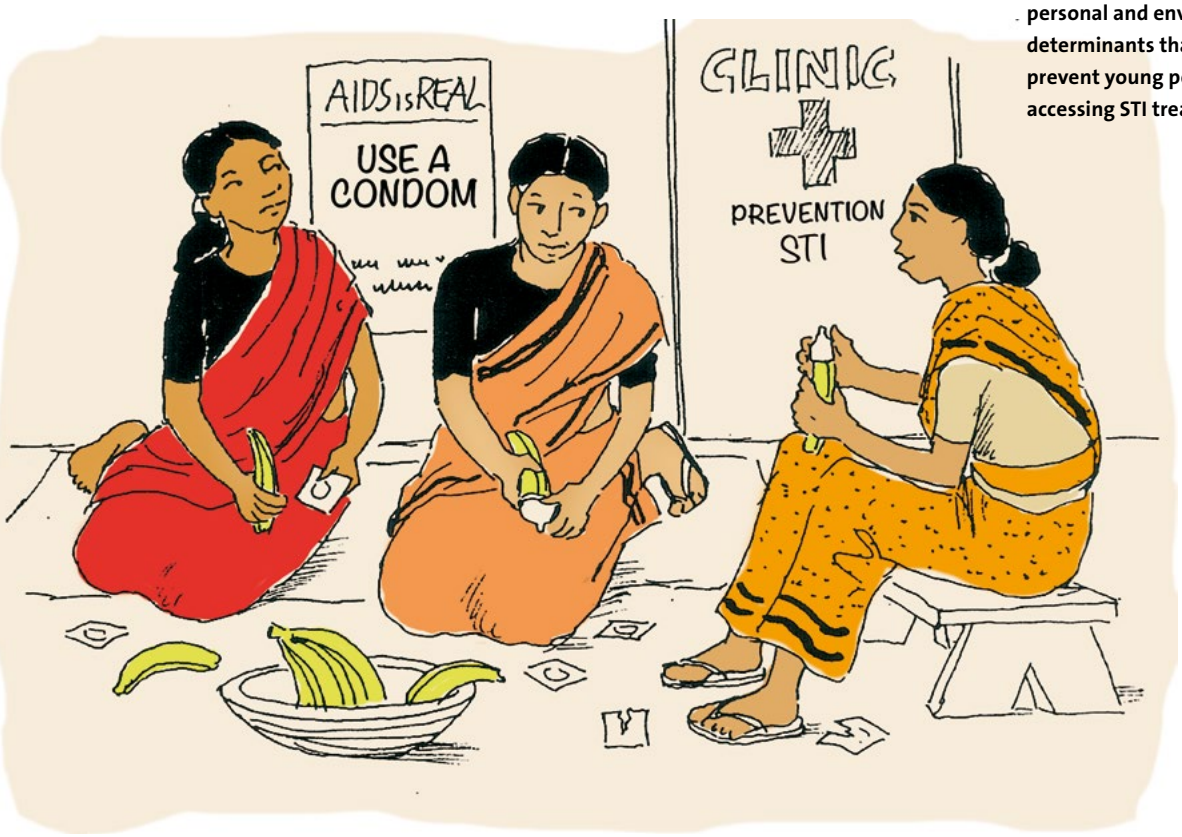
Social influence: what support, norms and influences encourage young people to seek medical treatment for STIs, and what discourages them? For example, a trusting relationship with a sympathetic relative or peer would be supportive, while a norm among peers to go to informal healers for STIs would be discouraging. Social influence comprises the actual influence (support or pressure shown by others, which is an environmental determinant) and the perceived influence (a personal determinant). For example, someone might fear a lot of stigma from peers for having an STI (perceived influence), but actually experience little pressure (actual influence).

Self-efficacy: do young people have enough self-belief to seek treatment? For example, being confident enough to travel to the service and to interact with adult staff members.

The above five personal determinants shape an intention to perform a health promoting behaviour (or not): for example, to visit a service next Tuesday. Note that the determinants are not necessarily equal in their influence: for example, some young people may have knowledge, understand the risks and have neutral attitudes, but if they are lacking self-confidence they may not develop or act on the intention to get treatment.

If someone has the intention to seek treatment there are two more categories of determinants that influence whether or not they do so:

We have to consider all the personal and environmental determinants that may prevent young people from accessing STI treatment



Skills: do they have the skills needed to access STI testing and treatment? For example, to find out where the service is and how to get there, and to get money for treatment. And skills to stand up for their right to non-judgmental and confidential services. Skills are closely related to self-efficacy and may also affect the forming of intention.

External factors: is there a service available offering STI testing and treatment? Is it physically accessible in terms of travel and opening hours? Does it offer non-judgemental services to unmarried young people without discrimination? Is it affordable? Does it have skilled staff who respect young people's rights? Is it functioning in terms of equipment, medicines and laboratory testing? External factors also influence the context: a community which has no access to medical treatment for STIs will not have norms of seeking medical treatment.

If we are to support young people's access to STI treatment we may need to consider health workers' determinants

Our example has focused on young people, but you can also use the model to analyse the behaviour of others in young people's environment. For example, in a school based programme we might explore the behaviour of teachers who implement sexuality education well, to learn about the determinants that might help other teachers to do so too. Or, if considering the behaviour of health care providers who are rude to young people seeking with STI testing and treatment we may ask:

*What is the **context** in terms of cultural, religious and social expectations with regard to the role of health workers with regard to young sexually active people?*

*Do they have **knowledge** about young people's right to non-judgmental, confidential, treatment? About government policy?*

*How do they **perceive the risk** of STIs to young people? And the risk to themselves of not giving them fair treatment? What are their beliefs and **attitudes?** Do they think that young people with STIs are equally deserving of treatment as older people? Do they feel different about young male and female clients with STIs, or married and unmarried clients? What **social influences** are there in the health service and their networks to encourage or discourage them from giving young people correct treatment? What about **self-efficacy?** How confident do they feel about handling young clients in an effective, confidential, non-judgmental and fair way? Do they have the **skills** to talk with them in a youth-friendly way? What **external factors** influence them, such as staffing and stock levels in their clinic?*

The personal determinants are our starting point for designing an SRHR programme: what has to change in terms of knowledge, risk perception, attitudes, self-efficacy and skills. For a holistic approach we must also analyse the environmental determinants, which may result in a specific programme targeting others in the young people's environment, such as training for health care providers, or lobbying for more staffing to reduce stress and improve quality of service. The work targeting others should ideally happen at the same time as the work with young people.

If your organisation does not have the skills or capacity to address key environmental factors you should collaborate with other organisations who can take action on those determinants. In **Appendix 1** we have listed the most and least effective methods and likely activities for each category of determinants.

To sum up, models help us to structure our thinking about complex realities, as achieving change in health promoting behaviours is a complex process with many determinants. Using models can help us to research and plan the issue carefully and to identify the most important determinants which can be changed. But they shouldn't be followed too strictly. They are simply a tool to assist our understanding.

2.3 Rights and evidence-based approaches

How are rights-based and evidence-based approaches related? In general, the two approaches support each other. For example, young people have the right to access youth-friendly health care, and evidence shows that they benefit from getting those services. Another example: young people have the right to accurate information and education about sexuality, including how to grow up in a balanced way, to develop a positive identity, gain self-esteem and prevent sexual health problems. Evidence shows that when this right is met, their health and wellbeing improves.

Sometimes it may be important to do something to stand up for people's rights, without being sure whether it will be effective. For example, according to the evidence-based approach, it's wise to concentrate on the most important determinants which are most open to change. However, from a rights-based perspective, we should sometimes address topics that are controversial and may be difficult to change but which require action if our organisation is to be rights-based. For example, if female genital cutting happens to girls in your target group you may decide to try to address the issue even if there is resistance from some stakeholders.

2.4 Including empowerment

One of the strengths of intervention mapping and the use of models is the focus that they bring, assisting us to analyse a situation systematically with the aim of learning and enabling choices for specific health promoting behaviours. However, by focussing on certain behaviours and their determinants the interventions may not respond to the diverse needs and rights of diverse young people. For example, the objective might be to enable young people to use condoms, but young people's SRH priorities might vary and include a reduction in gender based violence, a desire for more pleasurable sexual intimacy, and concerns about fertility or sexual orientation. The programme will be said to be successful if it increases condom use, but it might leave the other issues unaddressed, and may not attempt to measure other impacts.

One response to this problem is to make empowerment itself the goal of any intervention, without necessarily focussing on specific health goals but instead concentrating on wellbeing, positive identity development and self-esteem. That provides a broad scope which can embrace a wide range of issues and needs including sexual health issues. Evidence from developed countries shows that intensive **positive youth development** programmes which seek to foster positive social norms, spirituality and competence and confidence – but which don't necessarily include SRH goals - are associated with better SRH[16 p. 87, 32 p. 42, 33 p. 59, 34 p. 7], particularly if the work is with vulnerable young people[16 p. 75]. The SRH benefits sit alongside other benefits such as better school performance, decreased levels of violence and of substance abuse, and improved mental health. This is because positive youth development is a broad process of engaging youth in attempting to meet their needs to be safe, feel cared for, be valued, be useful, and be spiritually grounded, and to build skills and competencies that allow them to function and contribute in their daily lives. The broad approach means that the benefits can reach any part of life.

Besides heath-related behaviour we can include measures such as self-esteem for girls and boys

In this tool however we retain the use and focus of IM and models **for health promoting behaviours, but include empowerment.** An important consequence of using an empowering rights-based approach is that besides focussing on health-related behaviour such as use of condoms we can include measures concerning, for example: empathy, tolerance and respect of others; self-esteem and self-determination; communication skills; and attitudes towards gender equality[35 p. 34 , 52 p.5]. Table 1 gives an example for a school-based SRH project with students which also works with teachers and parents. Note, it is just an example, to illustrate how elements of empowerment can be included with health promotion.

	Youth	Parents and teachers
Overall goals	• Increased overall wellbeing • Improved ability to make informed choices regarding SRH rights • Reduced rate of unwanted pregnancies and STIs including HIV	• Improved ability to provide a supportive context to youth in home and school, where each person feels safe to talk about sexuality and where people treat each other with respect.
Objectives **(longer-term changes in behaviour resulting from the outcomes)**	• Positive identity development, improved self-esteem and greater confidence • Improved gender norms and behaviour based on equality by both sexes • Improved condom and contraceptive use • Increased use of HIV/STI testing among sexually active participants • Increased use of SRH services	• Seeing youth as actors of social change instead of recipients • Increased respect and motivation for meeting young people's rights • Improved provision of comprehensive sexuality education • Increased support to youth to access SRH services • Decreased use of punishment of youth and increased use of positive discipline
Outcomes **(short-term changes in determinants)**	• Improved knowledge e.g. about SRH rights, gender inequality, preventing pregnancy, STIs including HIV, and how to be more self-aware and confident • Better risk perception e.g. the risk of an unintended pregnancy, or of acquiring or transmitting STIs • Changed attitudes e.g. about delaying sex, consent, intimate partner violence, enjoyable sex and mutual pleasure, condom use, and masturbation • Improved skills and self-efficacy e.g. to be empathic and assertive, think critically, advocate for an enabling environment and act when rights are abused, talk openly about sex, get consent, negotiate condom use, and to delay sex • Improved social influence e.g. better understanding of perceived and actual norms and the effects of peer pressure; and changed norms e.g. attitudes among peers	• Improved knowledge e.g. about SRH rights and that CSE doesn't lead to more sex but to better sexual health • Changed attitudes e.g. towards respecting youth and supporting their rights especially in making well-informed decisions • Improved skills and self-efficacy e.g. to talk and listen to young people, involve them meaningfully and to support youth attain their SRH rights and gender equality • Improved social influence e.g. changing attitudes among community, school staff and peers towards supporting youth rather than controlling them

Table 1: Example of goals, objectives and outcomes for an empowering rights and evidence-based intervention

3. Planning and Support Tool

Summary: this section contains the self-assessment tool. It follows the 6 steps of intervention mapping, and asks you to assess your intervention through 28 questions and sub-questions relating to characteristics of effective SRHR projects. Section 4 contains more information and evidence for each characteristic.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

To do your self-assessment:

1. **Make a team:** Gather a small group of people with knowledge of the intervention. You need to trust and be honest with each other. The aim is to improve your work, get consensus and not to judge or blame each other.

2. **Prepare:** Get a download of this section from **stopaidsnow.org/quality-youth-programmes** to print off and make copies for everyone to read and write on. Alternatively download the spreadsheet version of this tool from **stopaidsnow.org/quality-youth-programmes** and enter your answers there.

3. **Do the self-assessment:** Discuss each sub-question and agree a score as follows:
   3 is the top score, meaning you feel you have done that thing very well or rate it highly
   2 is the middle score, showing you think it has been done OK, or you rate it as OK
   1 is for things you have done but which need improvement to get to the standard of OK
   0 is for things you have not done
   X is for things are that do not apply to your intervention

4. **Analyse:** If you are doing the assessment using paper and pen, add up how many times you scored 1 or 0, and write the total in Table 2 on page 56. For example, if you scored 1 three times and 0 twice then your total would be five.

   If you are using the spreadsheet version then the total number of 1s and 0s will appear automatically, along with a bar chart to show the distribution of your scores.

5. **Formulate your next steps:** When you have answered all 28 questions, use the Next Steps part of this section to decide which areas most need attention, and the actions that you will take.

Please note, as this tool can be used for projects that are being planned and projects that exist, it is difficult to get the tense of the questions right for both situations, whether they are past or future events. You may need to alter the tense of the questions to make sense for your situation.

1. Are the right people in the project team?

Projects and interventions are more likely to be effective if they are planned by a team whose members have different backgrounds and, between them, a range of relevant skills and experience.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
To what extent do members of the planning team have expertise in:	
- project management?	
- research?	
- SRHR of young people?	
- behaviour change theories?	
- design of SRHR interventions for young people?	
- implementation of SRHR interventions for young people?	
- gender?	
- training facilitators?	
- educational methods?	
Does your team have a balance between male and female members?	

How	Score
Are the team members involved in all relevant planning stages?	
Are the values and attitudes of the planning team members supportive of an empowering rights and evidence based SRHR project for young people?	

Notes

2. Are young people involved?

Young people have the right to be meaningfully involved in interventions; involving them is also an effective way to shape interventions to fit young people's real needs. As it is difficult to involve large numbers of young people many organisations instead form a working group of different young people who represent their male and female peers.

What	Score
Has a working group been set up with representatives of the young people concerned?	
Have the working group members been trained in young people's rights and what empowerment, a rights- and evidence-based approach and gender-transformative working means?	
Are young males and females involved in Steps 2, 3 and 4 (research and design)?	
Are young males and females involved in Steps 5 and 6 (implementation and M&E)?	

How	Score
Do the young people in the working group represent the diversity of the young people you want to influence?	
How high is the quality of the young people's involvement?	

Notes

3. Are facilitators involved?

We are using the word 'facilitators' to describe the people who implement the intervention, such as teachers and youth workers. As with the young people, projects benefit by involving facilitators in planning and design, and a common approach is to have a working group of facilitators who represent their peers. Some organisations form a single working group of both young people and facilitators, which is often very beneficial.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Has a working group been set up with representatives of the facilitators?	
Have the working group members been trained in young people's rights and needs and what empowerment, a rights- and evidence-based approach and gender-transformative working means?	
Are male and female facilitators involved in Steps 2, 3 and 4 (research and design)?	
Are male and female facilitators involved in Steps 5 and 6 (implementation and M&E)?	

How	Score
Do the facilitators in the working group represent the diversity of the facilitators?	
How high is the quality of the facilitators' involvement?	

Notes

4. Are relevant decision-makers involved?

Involving decision-makers can help them to develop ownership of the project or intervention, to facilitate it and to help sustain it. However, involving too many decision-makers or decision-makers who not support young people's rights can slow things down, so it's important to be strategic about who you involve and how.

What	Score
Have you obtained at least minimal support from the Ministries of Education, Health and/or Youth?	
Have you obtained the support you need to implement the intervention from relevant local people:	
- parents +/or community members?	
- community +/or religious leaders?	
- in schools: board, school administration, governing bodies, staff, non-teaching staff?	
Have you involved specialists in SRHR of young people and education and any other relevant organisations:	
- family planning organisations?	
- AIDS commission?	
- funding agencies?	
- university, research or expert centres?	
- relevant NGOs & faith based organisations?	
- health service providers?	
- youth based organisations?	
- community organisations?	

How	Score
How do you rate the support you have received or expect to receive from:	
Government authorities?	
Relevant local people?	
Specialists and other relevant organisations?	

Notes

5. Is the intervention based on a needs assessment?

Effective interventions respond to the needs of young people and other relevant people such as facilitators, within the context of their community. Your needs assessment should make use of any relevant data which already exists , and undertake objective research for other elements.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Did you collect or access information:	
- from males and females, and actively look for relevant gender issues?	
- from diverse relevant young people?	
- about young people's overall quality of life?	
- about young people's sense of self-efficacy and ability to influence their own lives?	
- about the prevalence of SRHR problems?	
Did you collect or access data about young people's sexual needs and behaviour (whether sexually active or not):	
- types of sexual acts (e.g. oral, anal, and vaginal sex, and masturbation)?	
- use of condoms and contraceptives?	
- experiences related to consent and gender based violence?	
- number & characteristics of sexual partners?	
- whether using health seeking/problem solving behaviours?	
Did you collect or access information about the personal determinants of young people's sexual behaviour including their:	
- knowledge and misconceptions?	
- perceptions of risk?	
- attitudes, values and beliefs?	
- self-efficacy and skills?	
- perceptions of social influence?	
Did you collect information about the environmental determinants of young people's sexual behaviour:	
- social influences including community norms and (harmful) cultural practices?	
- laws and policies?	
- accessibility, affordability, acceptability and quality of health services?	
- other external factors e.g. poverty?	
Did you collect or access information from relevant adults e.g. parents, teachers or health workers?	

How	Score
How do you rate the reliability and quality of the data? Were sensitive issues discussed openly?	
How do you rate the quality of your needs assessment?	
How do you rate your data collection methodology?	
How well did you manage to include the different types of young people within your target group in your research?	
Was the data collected by trained people?	
To what extent is the data applicable to your target group and context?	
How do you rate the extent to which you analysed and presented the data objectively?	

Notes

6. Is the intervention based on a situation analysis?

Projects are more effective when they assess and use available structures, capacities and resources. Your situation analysis might involve literature reviews, meetings and group discussions to learn about laws, norms, the setting, and other relevant SRHR programmes.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Did you research relevant laws, regulations and policies (on youth, SRHR, HIV & AIDS, gender and education), and find out if they are implemented?	
Did you assess relevant norms and values in the community regarding:	
- gender roles & the position of girls and boys?	
- sexuality, abstinence, premarital sex, masturbation?	
- sexual harassment and abuse, sexual orientation, HIV & AIDS, stigma & discrimination?	
- communication with young people about sexuality?	
- condoms, contraceptives & abortion?	
- pregnancy and marriage?	
- harmful cultural practices such as child marriage and female genital cutting?	
- the ability and right of young people to make their own well-informed decisions?	
Did you analyse the available resources in the community:	
- networks of education and care?	
- youth-friendly SRH services?	
- access to condoms & other contraceptives?	
- organisations supporting youth e.g. vocational training or micro credit?	
- organisations to collaborate with/refer to?	
Did you analyse barriers and opportunities in the implementation setting:	
- personal determinants (knowledge, attitudes, self-efficacy, skills and social influence) of relevant adults e.g. facilitators and school managers?	
- environmental determinants of relevant adults e.g. facilitators and school managers?	
- existence of sexual harassment and abuse, and mechanisms for reporting and addressing it?	
- comfort and safety of (school) atmosphere and facilities?	
- availability of inputs e.g. stationery, computer and video equipment?	
- capacity and skills of facilitators (youth-friendliness, experience, facilitation style)?	
Did you research and analyse the materials and lessons learned from relevant existing SRHR education and related interventions?	

How	Score
How do you rate the quality of your situation analysis?	
How do you rate your data collection methodology?	
Was the data collected by trained people?	
How well did you manage to include young people and relevant adults in your research?	
Were sensitive issues discussed openly?	
How do you rate the reliability and quality of the data?	
To what extent is the data applicable to your target group and context?	
How do you rate the extent to which you analysed and presented the data objectively?	

Notes

Involve different actors when conducting an assessment

7. Are the goals and objectives of the intervention clearly stated?

Effective projects and interventions need to have clear goals and objectives. The goals may be specifically about aspects of health such as reducing teenage pregnancy, STIs or unsafe abortion, but can also concern empowerment such as improving self-esteem or body pride, increasing the quality of relationships, reducing gender based violence, or creating greater gender equity. In this tool the objectives are the health promoting behaviours which should lead to achieving the goals or impacts of the intervention.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Are the goals clearly stated? E.g. increased self-esteem, or more safe and consenting sexual behaviour, or decreased incidence of unintended pregnancies or STIs.	
Are the objectives clearly stated, and likely to contribute to the goals? E.g. increased assertiveness and presenting oneself with confidence, increased use of condoms and other contraceptives, greater ability to resist pressure to have sex, to stand up for own rights.	
Do the intervention activities relate to the goals and objectives?	
Do the goals and objectives reflect that the intervention is using an empowering, rights-based and gender transformative approach?	
Does the intervention address both personal and environmental determinants?	

How	Score
Are the goals and objectives SMART? (Specific, Measurable, Attainable, Relevant, and Time-bound)?	
Are you able to measure changes in health promoting behaviours, sense of wellbeing and in an enabling environment, in order to assess the intervention's objectives?	
Are the goals and objectives based on evidence?	
What is the quality of the evidence?	

Notes

8. Are the behavioural messages clear and consistent?

Effective interventions to promote healthy behaviours give young people easy to understand and focused behavioural messages that are relevant to their needs and rights, link to their values, and relate to the project objectives.

What	Score
Does the intervention focus on specific behaviours that promote SRHR, empower youth and link to your objectives:	
- stand up for your own rights and respect others' rights	
- think critically, reflect on your own values, and use your power to improve your SRHR	
- take the perspective of the other gender into account and act accordingly	
- abstain from or delay sexual intercourse	
- ensure that any sexual activity is consensual	
- try to make sexual activity pleasurable and safe for both partners	
- use contraceptives when having vaginal sex to prevent unintended pregnancy	
- use a condom when having vaginal or anal sex to prevent STI (including HIV) transmission, and unintended pregnancy	
- go in time for counselling, pregnancy tests, HIV and STI testing and treatment	
- reduce risks by having fewer sexual partners, and partners who have had fewer partners	
Are the messages appropriate for the age, gender, and sexual experience of the target group, and its values and culture?	

How	Score
Are the behavioural messages comprehensive, presenting complete information and giving a range of options to choose from?	
Are the messages clearly communicated, so that you are confident that the target group will know what behaviour is being encouraged?	
Are the messages consistent throughout the intervention?	
Have you taken steps to improve the likelihood that the messages are conveyed correctly e.g. not diluted or altered by facilitators?	

Notes

9. Does the intervention address all relevant and changeable personal determinants of behaviour?

No programme can address all the determinants which affect behaviour. Effective programmes focus on determinants which are both relevant to the intervention's objectives and goals and possible to change with the time and resources available.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Does the intervention address different personal determinants of behaviour that emerged from Step 2's research:	
- knowledge?	
- risk perception?	
- attitudes?	
- self-efficacy and skills?	
- social influence?	
Is the focus on determinants that are both relevant and changeable?	
Is it likely that the intervention will result in intentions to practice health promoting behaviours and a more enabling environment?	

How	Score
Are the outcomes in relation to the personal determinants based on evidence?	
What is the quality of the evidence?	

Notes

10. Does the intervention address key environmental determinants and collaborate with others if needed?

Effective interventions address not only personal determinants but environmental ones too. As it is not possible to address all environmental determinants it's important to focus on some key determinants that can be changed, and to consider collaboration with other organisations to achieve change.

What	Score
Does the intervention, or the work of collaborating partners, address the key environmental determinants that emerged from Step 2's research?	
Are efforts to address environmental determinants being implemented at the same time as the work to address personal determinants?	
Do the interventions, including those of collaborating partners:	
- raise awareness about and support for CSE, rights and gender among relevant adults (e.g. parents, teachers, community)?	
- encourage community dialogue and reflection about relevant norms?	
- facilitate access to youth-friendly SR health services and supplies?	
- involve relevant lobbying or advocacy?	
- encourage economic empowerment?	
For school-based CSE, are there actions to:	
- make the school environment safe and healthy?	
- make school regulations clear and fair?	
- integrate CSE lessons in the school's budget, staffing and resource planning?	

How	Score
Are the outcomes in relation to the environmental determinants based on evidence?	
What is the quality of the evidence?	
How do you rate the quality of the collaboration?	
How do you rate the likely impact of the collaborating interventions?	

Notes

11. Is the intervention explicit about gender and power?

Gender is linked to all aspects of SRHR, but interventions that explicitly use a gender transformative approach and include critical thinking and reflection about gender and power are more likely to be effective.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

Note, to assist with designing activities, Appendix 1 lists each type of determinant, the main effective and ineffective methods, and likely activities.

What	Score
Does the intervention:	
- state and reinforce the message of equal rights for all?	
- encourage critical thinking about how gender norms and power operate in relationships?	
- enable participants to explore how gender norms are not fixed, and can be transformed?	
- foster personal reflection including how gender norms influence our own self-esteem and identity?	
- encourage participants to value themselves, and to recognise their own power?	
Are the facilitators trained and supported to reflect on their own attitudes and behaviours concerning gender and to work in an empowering way with males and females?	

How	Score
How do you rate how well the intervention is explicit about gender and power?	
To what extent is a gender transformative approach used?	
To what extent have you trained and supported facilitators to be able to work effectively with regard to gender and power?	

Notes

12. Is the intervention explicit and positive about sexuality?

Effective interventions do not shy away from using explicit communication, such as naming the genitals and talking about sexual practices, as appropriate for the target group.

What	Score
Is the intervention explicit about sexuality? (E.g. talking about: genitals, sexual pleasure, contraceptives, condoms, sexual acts, consent and negotiating safe sex).	
Are young people approached as sexual beings who are able to make their own, well-informed decisions?	
Is sexuality approached in a positive way?	
Are diversities in sexuality addressed? (Such as differences in gender identity and sexual orientation, the right to choose our own sexual partner).	
Are facilitators encouraged and trained to communicate about sexuality with young people explicitly, positively and without judgement?	

How	Score
How do you rate how well it is explicit about sexuality?	
To what extent have you trained and supported facilitators to be able to communicate openly, explicitly and positively about sexuality, and to address diversities in sexuality?	

Notes

13. Do schools and facilitators create a positive and safe environment in which young people can learn effectively?

Effective interventions use strategies that build on existing knowledge, enable young people to participate, and use participatory methods that allow them to have their own learning process, facilitated by an educator. They also create a safe environment more generally in which young people can learn and develop.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Do learning sessions:	
- start by setting group ground rules?	
- use active learning and participatory methods (e.g. small group work, discussions, role plays)?	
- when appropriate, divide participants by gender e.g. when discussing topics such as menstruation and wet dreams?	
- provide opportunities for all participants to take part in the learning process?	
- include activities that help participants to apply the information in their own lives?	
Are facilitators encouraged to be open about themselves and use positive reinforcement e.g. praise for desired behaviours?	
Are actions being taken to make the school environment more positive and safe, such as:	
- providing clean toilets which give full privacy?	
- supporting staff members to use positive discipline to support students rather than verbal or physical abuse to punish them?	
- addressing bullying, violence and abuse within school, and encouraging positive communication?	
- a participatory review of school regulations to make them fair and transparent?	
- other actions in response to issues identified during Step 2 research?	

How	Score
To what extent have you supported facilitators to be able to create a positive and safe environment for effective learning?	
How do you rate the extent to which facilitators create a safe setting?	

Notes

14. Does the intervention provide correct and complete information?

Effective interventions provide young people and others with accurate and factual information about all aspects of sexuality, and provide opportunities to explore and correct myths and misconceptions.

What	Score
Is the information medically correct?	
Are there opportunities to discuss and correct myths and misconceptions?	
Do you use factual information (facts and figures) to develop or correct value-based opinions and ideas?	
Is the information up to date and complete (not withholding information and including sensitive topics, such as masturbation, sexual diversity and how to access safe abortion)?	
Is the information tailored to the target group (age, literacy, gender, ethnic background)?	

How	Score
How do you rate the reliability of your sources of information?	
How do you rate the extent to which the information is correct and complete?	

Notes

15. Does the intervention address risk perception?

Effective interventions enable young people to assess their own risks and reflect on the consequences of SRHR problems. They also increase their self-efficacy to protect themselves through information and support to develop protective skills.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Does the intervention address risk perception, so that young people reflect on their own situation and are motivated to protect their SRHR, by:	
- giving information about their risks?	
- using active learning methods through which they obtain information about risks?	
- providing support to reflect, and to assess their personal risks?	
- enabling opportunities to reflect on the likely personal consequences of these risks, in relation to the future that they desire?	
- giving information about related prevention options?	
- providing support to develop skills and increase self-efficacy to use prevention options?	

How	Score
How do you rate the extent to which the intervention motivates young people to protect their SRHR through addressing their perception of risks?	

Notes

16. Does the intervention help people understand and develop their own attitudes, values and awareness of social influence?

Attitudes and values are important determinants which can be hard to change. Effective interventions enable people to refresh their attitudes by thinking critically, hearing persuasive arguments based on evidence, understanding the effect of social influence, and exploring misconceptions in their perception of social influence.

What	Score
Does the intervention:	
- encourage young people to actively look for information and to relate it to their rights?	
- help them develop their ability to think critically, to question and form their own attitudes and values?	
- provide information and opportunities to reflect on beliefs and misinformation that lead to stigma and discrimination (e.g. with regard to masturbation, abortion, being HIV positive, or having same-sex attraction)?	
- include persuasive arguments in favour of health promoting behaviours including gender equality, positive relationships, enjoyment of sexuality, consent, and safer sexual behaviour?	
- create awareness about the positive and negative effects of social influence including peer pressure?	
- provide information and opportunities to correct misconceptions about social influences and norms (e.g. everyone has sex before they are 16)?	
Does the intervention link with and support relevant adults to understand and develop their values, norms and attitudes related to young people's SRHR (e.g. facilitators, parents, health workers)?	

How	Score
How do you rate the extent to which the intervention helps people understand their own attitudes and values?	
How do you rate the extent to which the intervention helps people develop their awareness of social influence?	

Notes

17. Does the intervention build the skills of young people and relevant adults?

It is important to enable people to develop relevant skills if they are to adopt health promoting behaviours; effective interventions equip participants with new skills by providing advice and instruction, the example of role models, and opportunities for practice and feedback.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Are young people trained in the following skills:	
- taking the perspective of others, and acting accordingly?	
- explicitly talking and negotiating about e.g. SRH rights, gender equality, consent, contraception and correct condom use?	
- assertive attitudes and behaviour to communicate well and attain rights?	
- avoiding and refusing unwanted, unintended or unprotected sex?	
- obtaining condoms or other forms of contraception and using them correctly?	
- going in-time for SRH services such as counselling, pregnancy tests, STI/HIV testing and treatment?	
- avoiding and managing negative social influences?	
- seeking, asking for and creating positive social influences and support?	
- coping with negative emotions, self-stigma, and avoiding the use of violence?	
- self-defence and escaping from situations of abuse?	
- reporting abuse and seeking help?	

How	Score
What is the quality of the skills training:	
- do the participants practice the skills themselves e.g. through role-play?	
- do they receive constructive feedback about their performance?	
- does the training start with easier situations and progress to more difficult ones?	
- does it use role models to demonstrate how to cope with negative social influences?	

Notes

18. Do young people have access to individual support?

Not all issues can be dealt within a group setting, so it is important that young people have access to individual support. Interventions which do not provide that support need to share information about where it is available, and refer young people to youth-friendly services.

What	Score
Is individual support and counselling accessible as part of the intervention, or locally?	
Does the intervention share up to date information about how individuals can access support and where?	
Is there an effective system in place to refer young people to counselling and youth-friendly health care providers?	
Does your organisation have policies and procedures regarding the safety, health, wellbeing and protection of young people?	
Do other organisations involved in the intervention have policies and procedures regarding the safety, health, wellbeing and protection of young people?	

How	Score
How do you rate the quality of the support and counselling?	
How well is the information shared?	
How do you rate how well the referral system works?	
How do you rate the quality of the health care services?	
Are your organisation's policies comprehensive?	
Are your organisation's procedures effective?	

Notes

19. Does the intervention promote communication with parents or other relevant adults?

Parents and other adults influence young people's behaviour and their quality of life; effective interventions encourage young people to influence those adults positively by sharing what they learn, and also provide key adults with information about the intervention.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Does the intervention:	
- encourage young people to talk about topics to their parents, or other relevant adults they trust (e.g. using activities such as homework assignments)?	
- provide parents or other relevant adults with information about the programme, sexuality education and SRHR of young people?	
- provide training and support to parents and other relevant adults?	

How	Score
How do you rate how well the intervention promotes communication between young people and their parents or other adults?	

Notes

20. Are the topics covered in a logical sequence?

Effective programmes present activities and materials in an order which makes sense. They often move in steps: from building self-esteem and developing one's own attitudes; to creating motivation to enhance one's SRH and avoid SRH problems; to giving clear messages about health promoting behaviours which contribute to the quality of life and enjoyment of sexuality and reduce risk; followed by activities to enhance the knowledge, attitudes and skills needed to adopt those behaviours.

What	Score
Is the intervention structured in a logical way?	
Are the following topics addressed:	
- building self-esteem, develop a positive identity?	
- adolescent development (physical, emotional and psychosocial changes such as relationships with parents and peers)?	
- culture, harmful practices (child marriage, female genital cutting), social norms related to SRHR of young people, citizenship?	
- rights, power, gender, and gender transformation?	
- sexuality, sexual practices, masturbation, intimacy, love, sexual diversity, relationships and wellbeing?	
- susceptibility to and consequences of sexual health problems (e.g. unintended pregnancy, STIs, HIV & AIDS, abortion, sexual harassment and abuse, stigma and discrimination)?	
- safe, pleasurable and consensual sexuality?	
- behaviours to reduce or prevent SRHR risks and seeking help in-time?	
- knowledge, values, attitudes and barriers related to reducing risks and seeking help?	
- skills needed to reduce risk and seek help?	
- where to get support for sexual health, including counselling and youth-friendly health services?	
- forming intentions and future plans, how to achieve dreams?	
- standing up for own rights, citizenship and advocating for an enabling environment?	
- sharing lessons learned with peers, relevant adults and community?	

How	Score
Are the topics covered in this, or another, logical sequence, e.g. starting with neutral, issues before going to more sensitive and complex issues?	
Are the sessions spaced enough to practice new skills but frequent enough to remember and reinforce learning?	
Will facilitators be able to cover all the topics in the time available to them?	

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

Notes

21. Does the intervention appeal to the target group?

Interventions are more likely to be effective if the content, approach, language and tone of activities and materials are attractive and tailored to the target group; they also need to be appealing to, and user-friendly for facilitators, and be feasible for implementation in the setting.

What	Score
Are the activities and materials tailored to the target group (i.e. consistent with developmental age, language, lifestyle and communication skills, literacy levels)?	
Are the activities and materials attractive to young people (e.g. fun and thought-provoking activities, clear and vivid images, colours and graphs)?	
Are the activities and materials appealing to the facilitators, being user-friendly, functional and with comprehensive instructions?	
Is the content consistent with an empowering and rights-based approach and sensitive to the target group's, facilitators' and setting's values and culture?	
Does the intervention address obstacles to young people's participation by:	
- ensuring, safety and confidentiality?	
- providing incentives for attendance e.g. food?	
- running sessions at a convenient time and in an appealing, safe and acceptable place?	

How	Score
How do young people rate how well the activities and materials fit their needs and interests?	
How do young people rate the quality of the content, approach, language and tone of the activities and materials, in terms of how appealing they are?	
How do facilitators rate the quality of the activities and materials, in terms of how appealing and user-friendly they are?	
How well does the intervention address obstacles to young people's participation?	

Notes

22. Has the intervention been tested?

Pre-testing and pilot testing are effective ways to improve activities and materials, and so improve the implementation and impact of the intervention, before running it at full scale. Pre-testing is usually done by trying out materials and activities with a small but representative group of young people. Pilot testing involves running the whole intervention properly, but on a small scale.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Did you pre-test:	
- whether male and female young people and facilitators liked the activities and materials and found them attractive, comprehensive, relevant and convincing?	
- how easily activities and materials were used and implemented?	
- how the activities and materials could be improved?	
Did you make modifications and improvements following the pre-testing, approved by young people?	
Did you pilot test the intervention with trained facilitators (i.e. do full implementation but on a small scale)?	
Did you make modifications and improvements after the pilot test, approved by facilitators?	

How	Score
How do you rate the quality of the pre-testing?	
How do you rate the effect of the pre-test and subsequent modifications on the intervention?	
How do you rate the quality of the pilot testing?	
How do you rate the effect of the pilot test and subsequent modifications on the intervention?	

Notes

23. Have you taken steps to increase adoption of the intervention?

One obstacle to effective work is if interventions are not adopted by key people involved in implementation. This is less likely to happen if facilitators and others have a sense of ownership about the intervention, seeing it as being needed and helpful in improving their work and community.

What	Score
Do you have a comprehensive implementation plan, related to class, school, community and policy makers?	
Does your plan consider how to sustain the activities?	
Did you organise activities to make the intervention more understood and welcome among:	
- managers and staff in relevant organisations e.g. school management, school governing bodies, and school board?	
- facilitators and new facilitators?	
- parents?	
- community members in general?	

How	Score
How do you rate the quality of your plan?	
How do you rate the quality of these activities to increase adoption of the intervention?	

Notes

24. Is the intervention implemented by appropriate and skilled facilitators?

The motivation, skills, sense of ownership and comfort of facilitators are all important factors in how well they deliver sexuality education. The goal is for them to deliver in a complete way and according to the instructions or guidelines, in terms of both how they work and what content they deliver.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
Do the facilitators have the following characteristics:	
- seeing the intervention as needed and helpful in improving their work and setting?	
- positive about and willing to support young people's SRHR?	
- some experience with HIV prevention or SRHR education, open-minded and (motivated to become) comfortable talking openly about sexuality with young people?	
- able to see young people as agents of change rather than passive recipients of traditional teaching?	
- motivated to put time and energy in the intervention?	
- able to facilitate, to use participatory methods, be open-minded and non-judgemental, and not impose own norms and values, or motivated to learn those skills?	
- willing and able to create a safe atmosphere and maintain confidentiality?	
- not being gender-biased?	
- motivated to help create an enabling environment in school and community?	

How	Score
How do you rate the quality of the facilitators?	
To what extent did you actively select as facilitators people who are most likely to implement the intervention well?	

Notes

25. Do the facilitators get training and support to implement the intervention properly?

For facilitators to implement interventions fully as intended they need training and on-going support. Facilitation by those with less training, and by those who use it not as intended (e.g. not fully by skipping sessions or sensitive issues, not using participatory methods, or using in a different setting) is associated with less impact.

What	Score
Are the facilitators trained in the following ways to enable them to implement well:	
- seeing young people as agents of change and knowing their SRHR?	
- gaining familiarity with and expertise on the content and how to use it?	
- facilitating in an interactive way without imposing own norms and values?	
- creating safety, keeping confidentiality and using positive and non-judgmental communication?	
- building skills and confidence by practising activities, including the more difficult ones?	
- understanding why all the activities need to be implemented fully and as planned?	
- supporting young people with problems and referring them to services?	
- contributing to an enabling environment for young people In school and community?	
Is there on-going support to them such as:	
- stationery and equipment needed?	
- dedicated time for them to run activities?	
- refresher courses and/or coaching?	
- review/feedback and linking and learning meetings with trainers or other facilitators?	
- supervision and monitoring?	
- on-the-job support and feedback?	
- support from managers and colleagues?	

How	Score
How do you rate the quality of this training?	
Have all the facilitators been trained?	
How well do you address the challenge of trained facilitators leaving and the need to train new facilitators to replace them?	
How do you rate the quality of this on-going support?	

Notes

26. Is the implementation sustainable?

Guaranteeing sustainability of SRHR work with young people usually involves mainstreaming the intervention in the on-going work of the relevant organisations (schools, youth centres, health services), or, on a bigger scale, within government policy and systems.

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

What	Score
How sustainable is the intervention:	
- is there ownership and commitment of all involved in the implementation setting of the intervention?	
- are you able to motivate facilitators and peer educators and to keep them involved?	
- are there incentives for facilitators and peer educators e.g. gadgets, certificates, recognition and social status?	
- do you have enough funding and support to sustain activities, or ways to access funding and support in the future?	
- are activities mainstreamed in the usual programme and policies of the relevant organisations such as schools, youth centres and health services?	
Did you get support from relevant decision-makers?	
Does the intervention fit into national guidelines or policies?	
Is the intervention integrated in government policy/system, or are you linking with educational and health officers in order to do this?	
Is the training for facilitators accredited?	
Has your organisation or collaborating partners engaged in relevant advocacy?	

How	Score
Overall, how do you rate the likelihood of the intervention being sustainable?	
How do you rate the impact of this advocacy?	

Notes

27. Have you monitored and evaluated the process of the intervention's design, implementation and sustainability?

Monitoring the process of implementation is important for tracking implementation and making changes as necessary. Evaluating the process of design, implementation and sustainability enables learning to better understand impact results and improve future implementation.

What	Score
Did you gather feedback from young people about the intervention and their suggestions to improve it?	
Did you gather feedback from facilitators and other relevant adults about their training, the intervention, and their suggestions to improve it?	
Did you research the process of implementing sexuality education?	
Did you assess if:	
- the design has the characteristics of effective sexuality education interventions?	
- the content, activities and materials have the characteristics of effective sexuality education interventions?	
- all the activities were implemented, including those on contraceptives, condom use and other sensitive issues?	
- it was implemented according to plan?	
- all the educational methods were used (e.g. group work, class discussions and role plays)?	
- it was implemented in the setting for which it was designed?	
Did you find out why certain content and activities were not implemented, and/or why certain educational methods were not used?	
Did you find out whether not implementing all the activities and/or using all the educational methods affected the impact?	
Did you research the process of trying to change environmental determinants in the class, school, on parents, community and health services?	
Did you assess:	
- the quality of training for facilitators?	
- the attendance and completion rates of male and female participants?	

How	Score
How do you rate the quality of your monitoring and evaluation of the intervention's process:	
- tools and data collection?	
- reliability?	
- mix of methods and quantitative and qualitative data?	

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

Notes

28. Have you evaluated the effects of the intervention?

Measuring impact in health promoting behaviours can be difficult, particularly without a control (non-intervention) group to compare. Biological outcomes such as incidence of pregnancy and STIs are good indicators, but such data can be difficult and expensive to gather. However, we can use a baseline and follow-up survey to gather data from young people with regard to their determinants and intentions, and supplement that with qualitative data to learn about their experiences and reported changes. We can also gather information from other sources such as facilitators, teachers and parents.

What	Score
Have you measured change in personal determinants of health promoting behaviours and wellbeing:	
- knowledge?	
- risk perception?	
- attitudes?	
- self-efficacy and skills?	
- social influence?	
Have you measured change in intentions?	
Have you measured change related to empowerment and ability to take action?	
Have you measured the impact of sexuality education on interactions in the classroom and within the school?	
Have you measured the change in environmental determinants in school, on parents, community and health services?	
Have you assessed the extent to which the intervention has met its objectives?	
Have you attempted to assess the extent to which the intervention has met its goals?	

How	Score
How do you rate the quality of your monitoring and evaluation of the intervention's outcomes and objectives:	
- tools and data collection?	
- reliability?	
- mix of methods and quantitative and qualitative data?	

Notes

Score options:
3 = Very well
2 = OK
1 = Needs improvement
0 = Not done
X = Not applicable

Next Steps

Now you have completed the self-assessment it is time to consider what you have learned and what to do next. You can use this process:

If you doing the assessment using paper and pen:

1. Enter your total (number of 0s and 1s) for each characteristic in Table 2.
2. Which characteristics have higher scores, suggesting they are in most need of improvement?
3. Turn back to revisit each of those characteristics. Are there things you could act on now, to improve? Are there things which should form part of a longer term plan? If so, what are the first steps to take towards addressing those points in the long term? Enter your plans in Table 3.
4. You could also revisit the characteristics with slightly lower scores in the same way, looking for short term and longer term actions.

If you are doing the assessment using the spreadsheet:
Go to the tab called 'Summary' and use the charts to help you identify which characteristics are most in need of improvement. Make plans by following points 3 and 4 above.

Table 2

Characteristics	Total 0s + 1s
1. Are the right people in the project team?	
2. Are young people involved?	
3. Are facilitators involved?	
4. Are relevant decision-makers involved?	
5. Is the intervention based on a needs assessment?	
6. Is the intervention based on a situation analysis?	
7. Are the goals and objectives of the intervention clearly stated?	
8. Are the behavioural messages clear and consistent?	
9. Does the intervention address all relevant and changeable personal determinants of behaviour?	
10. Does the intervention address key environmental determinants and collaborate with others as needed?	
11. Is the intervention explicit about gender and power?	
12. Is the intervention explicit and positive about sexuality?	
13. Do schools and facilitators create a positive and safe environment in which young people can learn effectively?	
14. Does the intervention provide correct and complete information?	
15. Does the intervention address risk perception?	
16. Does the intervention help people understand and develop their own attitudes, values and awareness of social influence?	
17. Does the intervention build the skills of young people and relevant adults?	
18. Do young people have access to individual support?	
19. Does the intervention promote communication with parents and other relevant adults?	
20. Are the topics covered in a logical sequence?	
21. Does the intervention appeal to the target group?	
22. Has the intervention been tested?	
23. Have you taken steps to increase adoption of the intervention?	
24. Is the intervention implemented by appropriate and skilled facilitators?	
25. Do the facilitators get training and support to implement the intervention properly?	
26. Is the implementation sustainable?	
27. Have you monitored and evaluated the process of the intervention's design, implementation and sustainability?	
28. Have you evaluated the effects of the intervention?	

Table 3

Characteristics	Short term actions	Longer term plans and first steps to take

4. Background information for the 28 characteristics

Summary: this section provides background information for each of the 28 characteristics in Section 3. Most of it is based on evidence but sometimes we've included information that has little or no proof that it works, but is relevant to mention in terms of young people attaining their rights.

Step 1: Involve relevant people and organisations

1. Are the right people in the project team?

Interventions that are planned by a team of people with specific expertise in SRHR education for young people are more likely to be effective[9 p. 31]. The team involved in intervention planning, including curriculum development and implementation, should consist of people with different backgrounds. Exactly who should be in the team depends on the scope, content and target group of the intervention and how and where it will be implemented. However, interventions are ideally planned by a team of specialists collaborating from start to finish, including people with expertise in:

- Project management
- Research (conducting needs assessment/situation analysis; pre-testing; monitoring & evaluation)
- SRHR of young people (SRHR issues, youth culture)
- Health promoting behaviour theories (determinants, behavioural choices, environmental change)
- Rights-based approach, empowerment
- Design of SRHR interventions for young people (intervention development; educational methods; materials and activities; elements of effective intervention design; familiarity with culture and values)
- Implementation of SRHR interventions for young people (communicating about sexuality with young people and the community in general, training of facilitators, school and community involvement)
- Gender and gender transformative approaches

Sometimes one person may have expertise in more than one area. In many projects, individuals are called in to do certain tasks. For example, a researcher may do research but not be involved in other stages of intervention design. However, involving these specialists in all planning stages increases the chance that they give appropriate input as they fully understand the whole process, and this should raise the quality of both the intervention development and its implementation.

2. Are young people involved?

The meaningful involvement of young people in all stages of intervention planning is one of young people's rights. Their contributions enhance the fit between interventions and the contextual realities and needs of the target groups and can be key in creating an enabling environment for other young people. However, there is only limited research on the impact of such efforts, and none which compares the effectiveness of programmes which do and do not involve young people. Most of the research concerns the effectiveness of peer education. Recent reviews[36, p. 335] find that peer educators may be good at sharing information and raising awareness, but their efforts have limited effects on the behaviour of their peers. They can also be good at mobilising and referring others to health services. However, benefits tend to mainly go to the peer educators themselves, who are trained and supervised, rather than the intended beneficiaries.

An effective involvement method is to set up a working group of approximately 10 young people, which is gender-balanced and representative of the target population. They can be involved in several ways: in the design of the project plan/proposal; giving input to the research tools regarding the needs assessment and situation analysis; as respondents to those pieces of research; during the process of interpreting the conclusions of the analysis and deciding about the objectives; in intervention design (including content, educational methods,

pre-testing and piloting); in facilitator training and during implementation as assistants to facilitators, peer educators and youth advocates; and in monitoring and evaluation, including the interpretation of the conclusions.

The ideal situation is one trained working group made up of both young people and facilitators. Their training should ideally include how to work in youth-adult partnership. The young people can personally make their needs clear to the facilitators, and the facilitators can then help the young people contribute in the best way possible. Readers who want to know more about how to meaningfully involve youth in SRH work may wish to download a detailed guide[37] or read pages 21-25 of Rutger's Essential Packages Manual[3].

3. Are facilitators involved?

Interventions that are developed together with the people who will be implementing them (e.g. teachers, youth workers, experts, peer educators, health providers) are more likely to be implemented fully and as planned, resulting in more impact on young people and their environment.

Involving facilitators is important. It strengthens their commitment and helps to create an intervention that is attractive to them and feasible to implement. It also helps the content, activities and instructions to be user-friendly.

One way of involving facilitators is to set up a gender-balanced, representative working group of approximately 10 selected facilitators. They should be trained and involved from the start, providing feedback and input at relevant planning stages. This includes: the design of the project plan/proposal; giving input to research tools for the needs assessment/situation analysis; as respondents to those pieces of research; and during interpretation of the conclusions of the analysis and deciding about the objectives. Their involvement is particularly important during intervention design (including content, educational methods, pre-testing and piloting), when implementation begins, in giving input on tools for monitoring and evaluation, including the interpretation of the conclusions and, if the programme is expanded, as trainers of new facilitators.

As stated under characteristic 2, the ideal situation is one trained working group made up of both facilitators and young people.

4. Are relevant decision-makers involved?

The global review by Kirby and colleagues found that one of the characteristics of effective SRH interventions is that project staff obtained at least minimal support for implementation from appropriate authorities such as Ministries of Health and Education, school districts or community organisations. Their support may have been needed in order to progress, and provided official approval to educators to cover controversial content.

If relevant decision-makers are involved from the start, they are more likely to be committed to the project, take ownership and thus feel it is also 'their' project, which may prevent obstacles and solve resistance during implementation.

A possible method of involvement is to set up an advisory board with representatives of the most important decision-makers. Their task is to provide the project team with feedback and advice at relevant planning stages. This may help the material to become part of recommended national resources and the intervention to become a part of national/regional policies, such as educational standards or health strategies.

There are three categories of relevant decision-makers:

- To guarantee implementation of the intervention over a longer period and to aim for sustainability, it is often necessary to obtain at least minimal support from appropriate **authorities**, such as the Ministry of Education (when implementing in schools), Ministry of Health, and the Ministry of Youth (or a ministry responsible for youth policies and programmes).
- The cooperation of **community organisations and leaders** is also needed to fully implement the intervention. These include parents and the wider community, community/religious leaders, and (if schools are involved) the school administration, school board and school staff including non-teaching staff.
- A third group of decision-makers is especially important for collaboration during development and implementation: **specialists in SRHR education**, and possible (future) funding agencies. These could include the national AIDS commission, the national family planning association, universities, donor organisations, relevant NGOs who specialise in areas such as sexual abuse, teenage pregnancy or advocacy, health service providers, youth-based organisations, legal advisers and other community organisations.

However! Involving too many decision-makers, or those with a traditional mind-set, each with their own agendas, could slow down the whole process. So think carefully about who you bring on board and what you expect them to do.

Step 2: Undertake research and analysis

5. Is the intervention based on a needs assessment?

Interventions that are based on an assessment of the needs and assets of young people are more likely to be effective[9, p. 31]. The aim of the assessment is to understand these needs: what is important to diverse young people; on what, how and by whom would they prefer to be educated about sexuality.

A better understanding of young people's real needs and assets (rather than those assumed by adults) can guide programme developers in creating the most effective programmes that best fit these needs.

A needs assessment can be conducted very academically and thoroughly, but not all organisations have the time, expertise or resources to do so. It is advisable to make collecting existing epidemiological data on SRHR a priority, and also to get a good idea of the communication channels for getting information on sexuality, lifestyles and sexual behaviour of young people and the determinants that influence that behaviour (see Section 2).

Information (evidence) can be found in existing literature and publications or on the Internet and you can gather new information through focus group discussions, interviews, expert meetings or surveys. It is difficult and costly to do research with every type of young person, but it's also important to remember that 'young people' are not all the same. As a minimum you should actively explore differences between males and females. Ideally you should also learn about the needs of marginalised young people such as those who are poor, school drop-outs, living with HIV or are sexually attracted to the same sex, whose needs are very likely to be ignored otherwise. Equally important as the content of the assessment is the way in which you collect and analyse data. You need to do this objectively, to begin with an open mind and to try find out what is happening, rather than setting out to find evidence of something you would like to be happening or believe to be happening. Only selecting the information that is consistent with your own perceptions and values, for example, would not be objective. You also need to gather the data well, using suitably trained staff and using different methods to confirm findings or to check any unexpected findings.

6. Is the intervention based on a situation analysis?

Evidence indicates that interventions are more effective when existing structures, capacities and resources in the community are assessed and used for implementation[9 p. 32].

The aim of the situation analysis is to get an overview of the community where the intervention is to be implemented and link this to the broader (national) context of policies and other interventions that exist for young people.

In the situation analysis, you collect and analyse relevant **laws, policies and regulations** related to young people, and particularly related to their sexual and reproductive health and rights. For example, the age of consent, rules regarding access to STI and HIV testing, laws about sexual activity, sexual diversity and sexual harassment and abuse, legal age of marriage, and access to abortion. Of course, you also need to look at the extent to the laws, policies and regulations are implemented.

A second category of information relates to the **values and norms in the community** where the target population (young people) is living. This includes values related to sexuality of young people, the position of girls and boys, gender roles, abstinence, marriage, teenage pregnancy, (unsafe) abortion, HIV/AIDS, stigma, communication with young people about sexuality, condoms and other contraceptives, sexual orientation, sexual abuse, harmful cultural practices , and the right of young people to make their own decisions.

In addition to the values and norms, you should collect information about **available resources** in the community. You can map the networks of education and care, including police units, social workers, and the availability of (youth-friendly) health care, services, commodities (condoms and other contraceptives), and counselling. You can also assess to what extent it is possible to collaborate with these organisations, or refer young people to them, if they are youth-friendly, during implementation.

Fourthly, you can research the **implementation setting** to gain a good idea about the opportunities and barriers in adoption and implementation. If the intervention is to be implemented in a school setting, assess the willingness of various people in the school (such as the school administration and others) to adopt and take ownership of the intervention, and look at their knowledge, misconceptions and attitudes. Other factors to look at include how safe students feel in school, levels of harassment and bullying, what support mechanisms exist for students, and more specifically the things needed to implement the intervention such as a class room, supplies (such as video equipment, photocopying, markers, flipchart paper, snacks for the young people) and trained staff who have enough time.

In addition to general information about the implementation setting, you can conduct an analysis of the intended **facilitators of SRHR education:** what do they need to be able to implement the intervention? Look at both their behaviour and the determinants: what are the reasons why they can or cannot implement sexuality education? What motivates them to do this? Does it depend on personal determinants (knowledge, attitude, skills) or on environmental determinants (materials, time, social support)? Will they get support from management and colleagues?

Finally, you can collect and analyse **existing SRHR education and HIV prevention interventions,** including materials, curricula or specific programmes, training given by other organisations for this particular target group and lessons learned from their implementation.

The information in the situation analysis can be obtained from literature reviews, interviews, expert meetings and focus group discussions with various people in the community, including

facilitators and other organisations working on young people's SRHR. As for the needs assessment, the data needs to be gathered and analysed objectively and with appropriate skills to be of good quality.

Step 3: Define the goals and objectives

7. Are the goals and objectives of the intervention clearly stated?

SRHR education differs from HIV prevention or pregnancy prevention because it links wellbeing, quality of life and all the health problems related to sexuality and reproduction that young people may face, rather than focusing on certain issues.

What do you think the intervention should contribute in terms of empowerment and improved health and wellbeing? For most organisations it's technically difficult to measure change in health goals such as the prevalence of HIV, STIs, pregnancy, unsafe abortions, stigma and sexual violence as a result of their SRHR education; it may also be unrealistic to expect large changes in these measures (rather than the objectives of health promoting behaviours) as a result of sexuality education alone. However, clear health goals can give direction and a framework for the intervention, and are a feature of effective sexuality education programmes[9 p. 32].

Generally, SRHR education aims are to increase young people's self-esteem, confidence and decision-making skills to empower them and to promote their health, wellbeing and rights and reduce their vulnerability. Looking at the health and wellbeing goals, these can be different for each particular target group and context. Some examples of empowerment, wellbeing and health goals for SRHR education are:

- Increase of self-esteem, confidence and decision-making skills
- Increase in gender transformative attitudes and skills
- Increase in age when starting having sex
- Increase the proportion of safer sex and sex with consent
- Decrease unintended pregnancy
- Decrease (unsafe) abortions
- Decrease new HIV and/or STIs infections
- Prevent the development of AIDS among people living with HIV
- Decrease the prevalence of gender-based violence, sexual harassment and abuse
- Decrease discrimination and stigma related to HIV, sexual orientation, gender
- Increase health-seeking behaviour, STI & HIV testing, use of counselling and health services
- Increase responsible citizenship, advocating for own rights and an enabling environment

Sexuality education can contribute to those goals, but when the environment is not supportive (e.g. little access to commodities and health services, negative social norms about SRH for young people) effects may be limited to personal determinants and intentions.

8. Are the behavioural messages clear and consistent?

Providing clear, unambiguous, easy to understand, focused messages about how young people can improve their wellbeing and health by adopting health promoting behaviours is one of the most important characteristics of effective sexuality education programmes[9 p. 32-33]. Young people should receive sufficient, correct, up-to-date, evidence-based and consistent information about the options of empowering and preventive health promoting behaviours,

so they are able to make their own decisions related to their sexual behaviour and acting with confidence. These include messages relating to rights, equality, acceptance and tolerance.

It's important to note that programmes that only address the message of abstinence (or delay) among young people don't seem to have any long-lasting effect on protective behaviour[7, 38, 39]. In contrast, comprehensive sexuality education programmes that address a range of options including delay, consent and condom use have proved to be effective in delaying sexual debut and sexual intercourse, increasing contraceptive and condom use, and reducing the number of sexual partners[7, 38, 40].

Behavioural messages are stronger when they make use of information gained from a needs assessment, tailoring messages to local realities. The messages need to fit the age, sexual experience, family and community values, social circumstances and culture of the young people targeted by the intervention. Linking behavioural messages with other important youth values has proved to contribute to effectiveness. For example, emphasising that avoiding sex or always using a condom is a 'responsible' thing to do, or stating that young people should only have consensual sex and 'respect themselves and their partner'.

Research also indicates that making the behavioural messages more specific contributes to a better understanding of the link between risk behaviour and behavioural messages[10]. In intervention mapping we define performance objectives, specific actions that together form behaviour. For example, the performance objectives for condom use by young people include:

1. Act with confidence
2. Decide to use condoms each time you have sexual intercourse
3. Obtain/buy condoms
4. Always take condoms with you
5. Negotiate condom use with sexual partner
6. Use condoms every time you have sexual intercourse
7. Use condoms correctly
8. Keep on using condoms

Of course, very clear messages will be less effective if they are not delivered correctly. So it is important that facilitators are trained, motivated and supported to deliver the messages fully and as intended.

9. Does the intervention address all relevant and changeable personal determinants of behaviour?

Evidence[9 p. 34, 30] shows that interventions are more likely to be effective when they address the determinants that are both relevant (having a distinct impact on self-esteem and behaviour) and changeable (can be noticeably changed by feasible interventions). No programme can address all the determinants that influence self-esteem and sexual behaviour, so we need to be strategic and focus on those that are most significant and amenable to change.

In each context and culture the determinants may be different, but a report by WHO gives a useful overview of risk and protective factors derived from 158 studies in developing countries[41].

In 2005 Kirby and his colleagues made an overview of the personal and environmental determinants that are generally changeable and important in the context of the USA[42]. The risks (-) and protective (+) factors they considered most changeable by organisations who run SRH programmes in the USA were personal determinants: mostly about attitudes towards condom use, and peers' attitudes and behaviours, but also factors such as parent-child communication about sex and condoms, and the perception of male responsibility for preventing pregnancy.

10. Does the intervention address key environmental determinants and collaborate with others if needed?

Kirby and colleagues' review of sexuality education programmes[9 p. 36] indicates that creating a safe and supportive environment for youth participation is a characteristic of effective programmes (see characteristic 13). However, addressing wider environmental factors beyond the education session can be challenging. Your Step 2 research should provide an overview of the most important environmental barriers and opportunities for addressing young people's SRHR. You will probably not be able to address them all, so you need to focus on a small number of interventions and/or collaborate with others who are better placed to address certain environmental factors.

You may opt to undertake sensitisation and **awareness raising** in the community and/or among parents. This may result in more support for young people's SRHR and their sexuality education. In practice, it may lead to better acceptance of young people's needs, rights and capabilities and more support and help for them. For example, they may be given help in accessing health services and obtaining contraceptives, or in reporting sexual or other forms of abuse to the police. Another aim of awareness raising and further support can be to equip parents with information and skills to help them communicate with their children about positive identity development and sexuality and related topics. This may be particularly important if parents are not accepting young people's rights, providing misinformation (e.g. that masturbation is harmful or condoms do not protect against STIs and HIV) or unhelpful support (e.g. to punish them or get STIs treated by local healers).

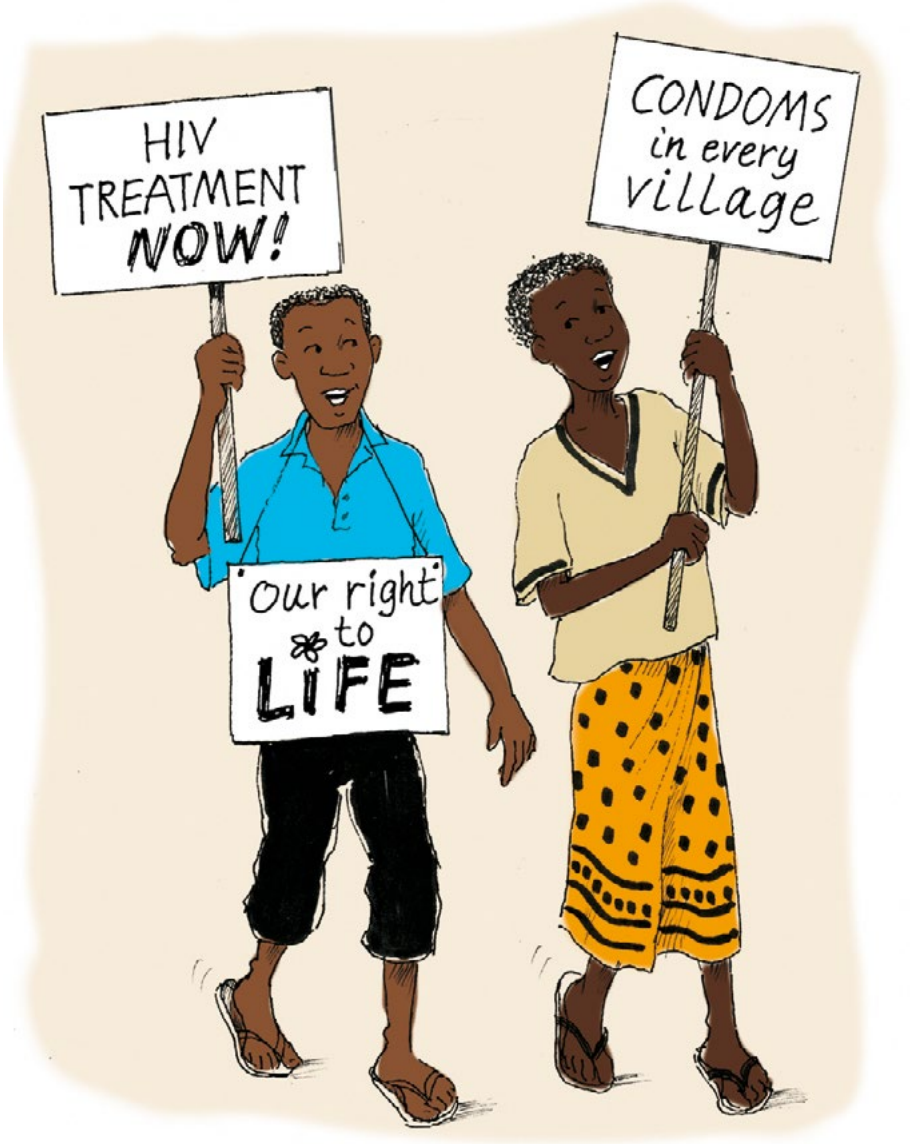
Work with community members and parents can also extend to **exploring community norms and creating new norms.** For example around gender transformative thinking, masculinity and expectations of male responsibility with regard to preventing pregnancy.

You may be able to collaborate with others to improve young people's access to **health services, supplies** (such as ARVs, condoms and other contraceptives) and **counselling**. For example, to fund or support changes to make existing local services more youth-friendly, or to create a system for referring young people to VCT centres, health clinics, and youth centres and even provide buddies (supporters) to accompany them.

Depending on your needs assessment it can also be important to collaborate with organisations that aim to promote economic empowerment, through for instance vocational training, micro finance, or cash transfers[43].

Your organisations might work with young participants on **lobbying or advocacy**[3 p. 65-75]. This could be to campaign for changes in community norms, facilities, relevant policies and laws that are barriers to young people's rights, wellbeing and health, but it could also be about a specific local issue. For example, challenging instances of discrimination and bullying, changing a school policy, getting a safer environment in schools[4], or using positive messaging to promote rights.

When you develop interventions to address barriers and opportunities in the environment of young people, be sure to define behavioural performance objectives for the relevant, responsible people. For example, if your aim is to improve how health services serve young people then you need to look at the determinants of health workers' behaviour; the knowledge, attitudes and skills they need to be able to provide youth-friendly services. In effect you may need to run a parallel health promoting behaviour programme with the managers of the health service.



Step 4: Design the intervention

11. Is the intervention explicit about gender and power?

An important component of a rights-based, empowering approach is equality of males and females. Haberland's research shows us that programmes are more effective if the issues of gender and power are made explicit and a gender transformative approach is used[20 p. 31].

A lot of evidence shows us that gender norms, power in relationships, and intimate partner violence are all linked to SRH behaviour and outcomes. Harmful norms correlate with adverse outcomes: for example, people who hold harmful gender attitudes are much less likely to use condoms or contraceptives, compared to those with who do not. Those who report low power in their relationship are more likely to have negative SRH outcomes such as higher rates of STIs and HIV. And females who experience intimate partner violence are more likely to have adverse outcomes regarding condom use, pregnancy and STIs and HIV compared to those who do not[20 p. 32]. This means that gender transformative programming is crucial for the realisation of the sexual and reproductive health, rights and wellbeing of people of all genders. Download our manual: http://www.rutgers.international/what-we-do/positive-masculinities.

In terms of **process** your intervention needs to target both males and females, involve them all in planning and implementation, and guarantee that males and females can contribute equally and are taken seriously.

In terms of content, you need to take the position and status of females and males into account. Messages should emphasise that girls are capable, powerful and 'can be in control', both generally and more specifically by resisting unwanted or unprotected sex and insisting on condom use, safety and own comfort. Work with boys includes empathy and skills to 'put themselves in the girl's position' and teach them to have self-control, act responsibly and be respectful to themselves and girls.

When using a gender transformative approach it is important to include boys too. Teach them to have self-control and be respectful.

Haberland found the following common features of how effective SRHR programmes address gender and power[20 p. 36]:

- **Explicit attention to gender or power in relationships:** Providing facilitators with specific content, activities and vocabulary to explore gender stereotypes and power inequalities in intimate relationships. Some interventions also provide explicit instructions for handling subtle, and not so subtle, sexual or homophobic harassment.
- **Fostering critical thinking about how gender norms or power manifest and operate:** Depending on the local context, this element may include critically examining and analysing images of how females and males are portrayed in visual media and music, harmful practices such as early marriage, power disparities in relationships caused by economic or age differences, or how some of the differences in the ways males and females express their sexuality are the result of gender stereotypes.
- **Fostering personal reflection:** Participants are given opportunities to reflect on how the contextual factors of gender and power relate to their own life, sexual relationships or health. For example, to explore how power operates in relationships and why it makes it difficult to protect one's health. The ways programmes foster such reflection varies. Some use personal writing exercises, another asks participants to think about their own current and past relationships while playing a game about relationship types and situations, and others provide short case studies and facilitate discussions about how power inequality and gendered sexual scripts influence condom use. Many programmmes also address sexual coercion and intimate partner violence. In contrast, one programme which did not decrease STIs or pregnancy has a single session on gender which focuses on the equal abilities of males and females, rather than taking the next step to help participants reflect on how gender norms and stereotypes affect relationships, power, sexual and reproductive health, or HIV.
- **Valuing oneself and recognising one's own power:** Acknowledging one's power to effect change in one's own life, relationship or community is another consistently recurring theme in the successful gender and power programmes. For example, engaging participants in community service, having a fundamental belief in participants' "pure potential", and fostering gender pride. Many emphasise young women's power, strength, self-respect and agency.

12. Is the intervention explicit and positive about sexuality?

Effective SRHR interventions are based on explicit communication about sexuality[9, p. 33]. Many people think that talking to young people about sexuality and condoms will encourage them to have sex. However, there is a lot of evidence that shows that explicit communication does not increase sexual activity among young people; to the contrary it helps to delay sexual debut and increase safe sexual behaviour[9 p. 45, 44].

By **explicit communication** we mean that the materials and the people working with the young people name the genitals and explain what is meant by sex, sexuality, sexual intercourse, contraceptives, condoms, and so on. The topics may vary for each setting and should be age-and context-appropriate for the target group. For example, what is relevant for primary school children might not be relevant for secondary school students and what is relevant for young sex workers might not be relevant for students.

The way **young people are approached** in the intervention will determine its success. According to an empowering, rights-based approach, sexuality should be discussed in a positive way, acknowledging the power of sexuality, intimacy, pleasure. It should be something that can be enjoyed by young people, part of their wellbeing, not something to be feared or feel guilty about.

Young people should be accepted as sexual beings from birth, whether they are currently sexually active or not. They should also be regarded as being able to make their own decisions. The intervention should give them correct evidence-based information so that they can make their own choices, rather than ideologically based advice. And no young person is the same, so they should be approached as a diverse group of unique individuals and given various relevant options. This includes non-judgmental information for all young people, also for those who are sexually active, HIV-positive or attracted to the same sex as themselves.

Facilitators of sexuality education, such as youth workers, peer educators or teachers, may find it difficult to have open, explicit and non-judgmental discussions about sexuality. Proper training and support for facilitators is therefore essential.

13. Do schools and facilitators create a positive and safe environment in which young people can learn effectively?

One of the characteristics of effective interventions in Kirby's review is that they create a safe setting for the young people when they are participating in sexuality education[9 p. 36].

By **setting ground rules** for group involvement, facilitators help provide a safe atmosphere. These rules can be developed with the young people. Some ground rules include:

- Not making someone look foolish
- Not asking judgmental questions
- Confidentiality
- Full participation
- Respecting the right to refrain from answering questions
- Recognising that all questions are legitimate questions
- Not interrupting others
- Respecting the opinions of others

Creating a positive learning environment also involves making it easier for participants to contribute to discussions and other activities, for example, by using ice-breakers (doing something that helps people to get in the mood, laugh, relax and get to know each other so that they immediately start to work well as a group) and working with same-sex groups for certain topics or the entire intervention. However, sharing important views or experiences between groups can support young people to develop empathy, see the other's perspective, and so support gender transformative thinking.

Another characteristic of effective SRHR programmes is the use of sound participatory teaching methods that actively involve the participants, and help them to personalise the information and practise skills[9 p. 40]. This is because active involvement in obtaining information is more effective than passive listening. The materials and activities should encourage participants to apply the information to their own lives. Examples of interactive teaching methods include class discussions, small group work, video presentations, storytelling, role-play, competitive games, worksheets, testimonies of guests such as young people living with HIV or young people with a same sex attraction, homework assignments (e.g. talking to parents or friends, advocating for own rights, activities to create a more enabling environment), drugstore visits, clinic visits, question boxes, hotlines, condom demonstrations and quizzes.

Using participatory learning in a school setting is usually more difficult than outside school. Teachers may lack time, and find it difficult to use interactive methods if they are not used to or trained in teaching that way. If they can be trained to use such methods then they may

apply the methods to teaching other subjects, to the benefit of the students' learning and the teacher-pupil relationship[52 p. 6]. However, if they will not implement activities requiring, for example, role plays then it is better to use a methodology that facilitators will use such as instruction and modelling using a video of a role model[9 p. 32].

Other strategies for creating a positive and safe learning environment will depend on the issues that emerged during the Step 2 research. They might include:

- Giving recognition and positive reinforcement
- Reducing violence within schools between students, and by reducing negative punishments given by teachers, supporting them to use positive discipline instead
- Making toilet facilities acceptable to students in terms of cleanliness and privacy
- Supporting girls to attend school when menstruating through provision of washable sanitary pads, and tackling stigma around menstruation
- Holding the intervention in a convenient facility or room and at convenient times for young people
- Implementing a school health policy regarding a safe atmosphere and supportive facilities, rules of conduct, and protection related to bullying, harassment, abuse and discrimination
- Reviewing school regulations to make them fair and transparent

For detailed information about using the whole school approach please read the We All Benefit! manual[28].

14. Does the intervention provide correct and complete information?

Providing correct and complete information is not only ethical, but also essential: effective programmes have multiple activities to address the many different determinants[9 p. 36-40]. This applies to the information shared with young people and other groups such as facilitators, schools, parents, health workers and the community.

Correct information is factually robust and objective, rather than value-based:

- Give facts and figures and explain your sources of information.
- If practical refer participants to reliable further sources of information, for those who want to learn more.
- You can also encourage participants to assess the reliability of sources of information; for example, whether to trust what peers may say, and the difference between reliable internet sites and places where myths are reinforced or opinions are presented as facts.
- It's also useful to explore any misconceptions that are revealed, before sharing correct information, rather than to tell someone they are wrong.
- Encourage facilitators to say that they don't know the answer to a question if they don't; it is better that they or the students research the answer than to make up a wrong response.

Giving **complete information** involves sharing all the relevant information, but tailored to the target group according to context, age, literacy level and gender. In other words, not missing out topics which may seem embarrassing or controversial. Facilitators need to understand that by sharing information they are not endorsing certain behaviours; for example, they should still explain about safe abortions (if available) even if they are personally opposed to abortion.

15. Does the intervention address risk perception?

Effective health interventions address people's perception of personal risks, both their own susceptibility to the health problem and how serious the problem could be[9 p. 37]. Risk information coupled with advice about how to reduce risk can have a large impact. In a randomised trial in Kenya one group of schools had a HIV prevention curriculum which included information about the different rates of HIV infection among males and females of different ages, and the use of condoms to reduce risk. The control group had the standard national HIV prevention curriculum, with a focus on abstinence and general statistics about HIV. Compared with the control group, there was a 28% decrease in child bearing among the female students who received relative risk information and strategies. It seems this was achieved by them shifting from sex with older men to protected sex with their peers; it may be that they were more adverse to becoming pregnant with their resource-poor peers, compared to wealthier older men, and that they were more able to negotiate condom use with their peers[45 p. 23-26].

Interventions are more likely to increase an awareness of risk if young people **actively obtain** the information and **apply it to themselves**. This can be done by providing interactive activities (e.g. small group work, scenarios, quizzes) through which participants assess their personal risk and how, for example, unintended pregnancy, STIs or HIV would affect them.

Effective interventions inform young people about their **chances (risks)** of becoming pregnant or getting STIs or HIV as a result of unsafe sexual behaviour. This can be done by telling them how often this happens to other young people, and by stressing that risk is not about who you are, but about what you do or what is done to you.

Effective SRHR interventions also enable young people to reflect on the **personal negative consequences** associated with challenges such as unintended pregnancy, STIs and HIV. Young people are more likely to relate to short-term consequences, but can also consider long-term implications if supported to 'dream' about their future. You can enable them to explore their anticipated regrets through small group activities, or via testimonies from young people who have faced such challenges and who explain the impact on their lives.

Note: fear-only-based programmes do not work and may even have a harmful effect. By creating fear, people may conclude there is nothing they can do to avoid risks, resulting in resignation rather than intention to act. In addition to information about risk, it's very important to motivate young people to prevent STIs, HIV/AIDS and unintended pregnancy[46]. They need to be aware of what they can do to prevent or reduce the risk of SRH problems (e.g. consent, using condoms, not having sexual intercourse) and they need to feel confident that they can take the necessary actions. This is why activities to improve risk perception need to be linked to increasing self-esteem, skills-building and self-efficacy activities.

16. Does the intervention help people understand and develop their own attitudes, values and awareness of social influence?

Another characteristic of effective interventions is that they help people – whether youth, facilitators or other targeted groups – to understand and develop their own values and attitudes, and give information about the influence and norms of others[9 p. 33-41]. Attitudes and norms are important behavioural determinants, but they are also difficult to change. It's a long process, as people's values and norms are often very much a part of the norms in their social environment. It is difficult for people to stick to new values if they differ from those of the people around them. Evidence and theories provide suggestions for effective ways to help them understand and develop their own attitudes and perceptions.

You can encourage **understanding and development** of critical thinking and personal values and attitudes through a variety of activities, for example:

- Self-assessment of own positive characteristics and issues to improve, with feedback from trusted peers
- Quizzes to learn about own values and those of others in the group
- Positive feedback and rewarding positive attitudes
- Group discussions about the advantages and disadvantages of, for instance, using violence to assert yourself, having sexual intercourse, drinking alcohol, or using a condom
- Information about rights and the change in people's lives when rights are met
- Debates in which participants defend opposing views
- Interactive theatre, with the audience having roles in a play
- Learning about true-life stories of role models who are similar to the target group

Attitudes can be changed by providing or asking groups to develop **persuasive arguments**. For example, the benefits to males and females of more equitable relationships. In general talking about the short-term consequences and benefits is more likely to have an impact than talking about long-term effects. For example, young people may relate more to the prospect of becoming pregnant after having unprotected sexual intercourse than the long term consequences of acquiring HIV and getting AIDS.

Arguments are also more likely to be persuasive if they reflect all the views and values of the target group. For example, their perceptions about the disadvantages of using a condom, gender-based violence, or of using alcohol. By allowing people to weigh up all the arguments you avoid alienating them by just telling them one side while ignoring other attitudes and values which they may hold. Facilitators need to ensure that all the correct information is covered if it does not emerge from the participants.

The intervention is more likely to develop, change or reinforce attitudes if people **actively obtain** the information and **apply it to themselves.** This can be done by providing interactive activities (e.g. group discussions, quizzes) through which participants assess their own values, norms and perceptions and may discover why they should change these.

In terms of addressing **social influence**, interventions need to address both its actual components and the way it is perceived by the target group. They should obtain information about actual social influence (community norms, social pressure), while also correcting misperceptions and giving people assertiveness skills to deal with negative pressure or norms. For example, young people may think that all other young people have had sexual intercourse by the time they're 16, but statistics may show that this isn't true. The statistics can be used to correct the misperceptions and to illustrate the gap between reality and what they may perceive to be true. This can be supported by critical thinking about the positive and negative effects of social influence, especially peer pressure, and greater understanding of why what peers say may not reflect reality.

Another effective way of addressing social norms and influence is getting young people to map their own social environment and to identify who they can get support from. In addition, the use of positive role models can be very effective – examples that people can identify with, and who 'model' ways of coping with social norms and social pressure.

17. Does the intervention build the skills of young people and relevant adults?

Effective interventions include skills training[9 p. 39] in skills that are relevant to self-esteem and the behavioural outcomes and objectives.

There are different ways to train skills. A common and effective method is through role-play following these steps:

1. Describe components of the skills, the steps to take.
2. Model the skills in role-play (created by the facilitator or from a video or modelling story in printed materials), starting with easy situations and progressing to increasingly difficult situations.
3. Give everyone the chance for individual practice through role-play in groups of two or four in which two can act as observers and can give feedback later on, for example, practicing avoiding unwanted sex, challenging violence, or insisting on using condoms.
4. Get feedback from the facilitator and/or peers.
5. Practise in real-life situations (e.g. buying a condom, or being assertive).

Facilitators (especially teachers) sometimes find it difficult to implement role-play activities with young people. An alternative is to use modelling whereby someone whom young people can identify with uses the steps and so demonstrates the skills, whether through video, hostteachers, host health workers, invited relevant young people, or a written account. However, this approach is less effective as it does not give the young people the opportunity to practise the skill themselves.

Skills building should also be one of the most important activities in training for facilitators. Important skills for them include open, positive and non-judgmental communication with young people about sexuality and young people's rights, and how to use an interactive, empowering approach in teaching.

18. Do young people have access to individual support?

To address the needs of all the young people participating in an intervention (and to be really effective), the intervention should include possibilities for individual support.

When young people are provided with SRHR education, it may lead to earlier recognition of individual problems (e.g. related to adolescent development, low self-esteem or to HIV, STIs, pregnancy, sexual harassment and abuse and harassment, or stigma) and more awareness of the need to seek help in-time. Implementing organisations or schools should therefore be prepared to provide individual support, for example counselling, either through having trained staff or by referring the young person to support outside school such as to health services. For referral facilitators need to know the names of people who can give support, where and how young people can find them, and empower them to access those, possibly with the support of a buddy.

The organisation's support services and referral system can be part of a wider youth centre or school health policy. This policy should also include regulations and facilities within the organisation or school regarding the safety and protection of young people's SRHR. There should be rules on not tolerating bullying, stigma, harassment, abuse or discrimination with regard to gender, ethnic background, religion, disability, HIV status or sexual orientation .

19. Does the intervention promote communication with parents or other relevant adults?

Effective interventions often encourage communication between young people and their parents or significant others[9 p. 36]. Interventions may involve adults in ways that range from meetings, discussions, training and events to less intense methods such as sensitisation, receiving information in leaflets or letters. Sometimes communication may be necessary to gain consent from the parents before young people may participate in sexuality education lessons.

One way of increasing communication is giving homework assignments which encourage young people to talk to their parents and other adults they trust, about the SRHR programme or specific topics. Homework assignments might also encourage them to share lessons learned with peers and to advocate for their rights in the community.

20. Are the topics covered in a logical sequence?

Effective programmes present activities and materials in a logical order[9 p. 34]. Typically they: 1. enhance self-esteem through empowerment; 2. enhance motivation to improve own wellbeing and avoid SRH problems by giving information, explaining their susceptibility and capabilities and how serious the matter is; 3. Give a clear message about the behaviours needed to increase confidence and wellbeing and quality of life and reduce the risks; and 4. address the knowledge, attitudes and skills, needed to adopt those behaviours and act upon them.

The sequence may vary in different contexts and depends on the content of the intervention. Beginning with self-esteem, values and norms, rights, decision-making skills and gender is preferred above starting with sexual health and SRH problems. Some SRHR interventions include relevant topics such as stress management, use of alcohol and drugs, use of pornography, or decision making about money issues and income-generating activities.

Usually it is more difficult in settings outside schools to implement a very structured intervention, as young people may drop in and out.

21. Does the intervention appeal to the target group?

Interventions that are tailored to specific groups and their context are more likely to be attractive, useable and, as a result, more effective. This means that materials and activities need to be attractive, easy to identify with and functional for young people and facilitators, such as teachers, peer educators and youth workers. Key elements are:

- The teaching strategies should be tailored and consistent with the developmental age and academic skills of the young people who participate. This includes their literacy levels and their ability to communicate and understand concepts.
- The intervention should also approach young people as a diverse group of unique individuals.

- The **form and packaging** of the education should be appealing:
  - Attractive presentation of materials (clear, vivid, pictures, graphs)
  - Font and readability appropriate to the target group
- The **content** needs to be:
  - Relevant to the target group and their context
  - Avoiding racist, sexist, homophobic, coercive or judgmental associations; gender-sensitive and gender-transformative; and sensitive to the values and culture of the target group
  - Gender-sensitive and gender-transformative
  - Sensitive to the values and culture of the target group
  - Featuring situations and role models that the target group can identify with

Effective programmes also have to avoid or **overcome obstacles to young people's attendance**[9 p. 42]. This includes recruiting participants and retaining them. For example, to get consent from parents so that young people can participate, perhaps provide transportation, implement activities at convenient times, offer incentives such as a little food or a drink, and ensure confidentiality and safety. Although this characteristic may be obvious, there are many reported examples in which a high turnover happens or too few young people chose to participate in voluntary programmes; and if they don't turn up the interventions cannot be effective!

Whether the intervention is **attractive to facilitators** depends on a number of factors in addition to those already mentioned:

- Facilitators are comfortable to use the methods in the materials, and to deliver the content[9 p. 32]
- The size and weight of materials are reasonable (to transport and keep at home); printed/printable space is used efficiently
- The materials are resistant and durable
- Cost is reasonable
- The activities are well described for each lesson or topic, have clear objectives, explain the methods to use, a logical sequence of activities, and time and materials needed for each activity, and giving tips and background information

22. Has the intervention been tested?

SRHR interventions for young people (both the activities and the supporting materials) are more likely to be effective if they are tested in practice before being approved for use[9 p. 32]. There are two types of testing that can be conducted: pre-testing and piloting.

Pre-testing means informally using and evaluating some (perhaps the most difficult) or all of the materials and activities. This can be done on a very small scale with young people (about 10-20, representative of the target group, and gender-balanced) and a few facilitators in one group or in separate groups. They provide feedback about what works and what doesn't and whether they think it is effective, convincing, easy to identify with and whether they like it. The pre-test results are used to adapt the intervention, if necessary, before producing the definite intervention materials. The need for pre-testing is the most critical when little is known about the target group or when the content of the intervention is controversial or sensitive.

Piloting means that the whole intervention is implemented by trained facilitators on a small-scale for a certain period of time. For instance, all the lessons and sessions of a SRHR curriculum are given in pilot schools in one district during one school year. Piloting is fully testing the intervention with sound monitoring and process evaluation, and making any

necessary changes, before beginning full-scale implementation, assuming that the pilot results warrant scaling up. The pilot-facilitators might become the trainers for new facilitators.

Piloting can also be used to compare methods on a small scale. For example, implementing the SRHR curriculum in some pilot schools and the whole school approach in other schools.

Step 5: Implement the intervention

23. Have you taken steps to increase adoption of the intervention?

When SRHR education interventions are developed, it does not automatically mean that they will be adopted by the organisations and people who are supposed to implement them. One characteristic of effective programmes is that they have taken steps to overcome barriers to adoption and local organisations are willing to take ownership[9 p. 41]. (The need to recruit and retain the intervention's participants was covered under characteristic 21.)

For adoption the most important group to approach are the facilitators and their managers. Listen to their needs, hear their views, and look for ways in which the programme may assist with the problems they see in their school. Try to put forward persuasive arguments about why it's important that they own and deliver the programme. For example, the likely benefits to the school and the young people, and to their relationship with the young people. If they still have concerns try to find ways of addressing those concerns. For example, if facilitators refuse to deliver part of the content – e.g. a topic which is culturally controversial – try to find a compromise to suit all parties, such as inviting a health worker to do the condom demonstration.

You may also need to consider how to make the programme acceptable to parents and other adults in the community, such as religious and community leaders. For example, by using the results of the needs assessment as a basis for how the intervention can meet identified needs and problems and discussing what can be done to address the issues. Other strategies are, providing information through printed materials and creating opportunities for dialogue in meetings.

24. Is the intervention implemented by appropriate and skilled facilitators?

Effective programmes typically select facilitators with desired characteristics[9 p. 42] such as those that have:

- Ability to relate to young people and be youth friendly
- Open minds and preferably some experience with HIV prevention and/or SRHR education and comfortable talking about sexuality with young people
- Motivation to work on the SRHR of young people
- Willingness to promote the rights of young people
- Ability to facilitate, to use participatory methods, to be non-judgmental, to not be gender-biased, and to not impose their own norms and values

In many settings however, it's difficult to find facilitators that have these desirable characteristics. Motivating them, and providing training and support for facilitators then becomes particularly important. Without sufficient training and on-going support they may, for example, teach abstinence, use fear-based messages, and reinforce gender norms, because that approach fits with contextual norms and so is easier to do[52 p. 8].

Limited evidence suggests that matching the young people's race and gender with that of the educators does not have a significant impact on outcomes[47, 48] and that the age of the facilitators (adult or peer) has no influence on the effectiveness of the intervention[48]. With regard to having peer educators as teacher-assistants or facilitators, research has found that peer educators can sensitise and mobilise young people and increase the number who are reached. They also are effective in referring people to health care, being buddies and youth advocates[3 p. 50]. However, peer education interventions tend to influence the behaviour of only small numbers of peer educators, but not necessarily that of the target groups[36 p. 335]. We should therefore consider if peer education is cost-effective enough to justify implementation on a large scale. It works best under certain conditions, such as in youth-adult partnership and with extensive support, training and follow-up.

25. Do the facilitators get training and support to implement the intervention properly?

One of the key characteristics of effective SRHR education interventions is training and support for the facilitators who implement the intervention, to increase the chance that they will deliver the programme fully and as intended[9 p. 43, 49 p. 9 , 52 p. 7].

Not implementing all the activities, or implementing the intervention in a different way or in a different type of setting (e.g. during school instead of after school) may reduce effectiveness. Interventions are less likely to be effective if they are shortened considerably, and when activities that focus on protective behaviours such as increasing condom and contraceptive use are left out[9 p. 43, 49 p 9 , 52 p. 7].

Training takes time, particularly if the facilitators need to learn both about the content of the intervention and how to use its methodologies. One week's training usually isn't enough, especially for facilitators who are doing it for the first time. Involving young people in the training may help convince facilitators of the importance of including sensitive issues.

In addition to training, facilitators benefit from other forms of support such as refresher courses, review/feedback meetings (sharing experiences and solving common challenges with other facilitators), individual supervision and monitoring, and on-the-job support and feedback.

26. Is the implementation sustainable?

Planners have to make implementation of the intervention sustainable as it should be a long-term process, reaching many young people every year and so increasing the cost-effectiveness of the initial investment in developing the curriculum. Sustainability can have different meanings and be achieved in different ways, depending on the kind of intervention, implementing organisation and context. Sustainable implementation means that implementation of the intervention can be guaranteed for a longer period of time, either with the same target group and in the same implementation setting, or by expanding the implementation to cover more or other settings and target groups.

Some planners aim to sustain implementation in a limited number of settings (e.g. schools or youth centres). This can be done by integrating the intervention into the curriculum or main programme and policy of the organisation, with support, time for training and coaching, incentives for the facilitators (e.g. certificates), CSE in the timetable, and funds in the budget that are allocated to implementation.

In the whole school approach sustainability is sought by thinking of the school as a community and getting stakeholders to take ownership right from the start. Schools and youth centres adopt the intervention with participation from a wide range of people including all staff, their board, governing bodies, parents, the responsible district policy makers and community leaders; all take part because they see it is needed and will help improve the school and community as well as the SRHR of students who then perform better. An important component is to put CSE into the timetable and budget.

Implementing an intervention on a wider scale by involving new schools or settings often means a certain loss of control and, possibly, effectiveness if guidance is not given as intensively as previously. This is evident when the results of pilot projects are not replicated to the same degree when the intervention is scaled up. A buddy system can help where schools or youth centres support each other.

Another way of making an SRHR intervention sustainable is by making it part of a general national, regional or organisational programme. The support and involvement of relevant decision-makers is then important. There are two reasons for this. First, the intervention's scope and content will need to be adapted to fit the requirements and guidelines of the organisation or government. This might mean losing quality as the comprehensiveness might not be acceptable for policy makers. Secondly, lobbying may be needed to get subsequently the intervention included in the school curriculum and mainstream policies and programmes.

Step 6: Monitor and evaluate

27. Have you monitored and evaluated the process of the intervention's design, implementation and sustainability?

On-going monitoring during implementation can be used for tracking progress and making any changes that may be required. For example, if in feedback sessions with facilitators you learn that most are not implementing certain sessions you could explore why and consider what to do. Or if you found that girls are dropping out at a much higher rate than boys you could investigate and consider ways to retain them. Monitoring data can also be used to inform the end of project evaluation, as it provides a record over time of what happened and when.

The aim of **process evaluation** is to assess whether the intervention was completely and adequately implemented according to plan, and what users and the target group thought of the intervention. For example, whether stakeholders stayed involved, and whether efforts to improve the school environment matched those to deliver the CSE. A process evaluation can provide valuable information that can be used to improve implementation (e.g. training for facilitators and support, support for managers to get a safer climate in school), which may result in increased effectiveness in future uses of the programme.

Methods of data collection in the process evaluation can include class observations, lesson evaluation forms, focus group discussions with young people, facilitators and other relevant people, a questionnaire to measure the impact of training and support for facilitators, and discussions with school managers.

28. Have you evaluated the effects of the intervention?

In SRHR education, one of the challenges is to measure the changes that are created as a result of the intervention. We may not always be able to accurately measure whether the intervention has improved health and wellbeing goals such as fewer teenage pregnancies or STI infections. If particular health problems are found to be decreasing, it's difficult to identify the exact contribution of the intervention to the outcome unless you have a control population which has the same influences but lacks the intervention. So that kind of evaluation is usually done as part of more extensive research.

Your organisation should however be able to measure changes in the intervention's determinants, intentions and behavioural objectives, using young people's reports. This can be done by comparing baseline data with a post-test measurement using a questionnaire. The quality of such a study increases if large numbers of students participate (approximately 1,000) and a comparison group that didn't participate in the intervention is included in the study (another 1,000 students). It is recommended to get more insight through qualitative research such as conducting focus group discussions with young people. You may also conduct research with other stakeholders such as facilitators, managers and parents to get a different perspective on the same topics.

For both the survey and qualitative research you can use indicators about personal determinants including aspects of self-esteem and confidence, feelings of safety, ability to take action and empowerment. The indicators you use will depend on your intervention's objectives.

You can also look for unintended outcomes through open questions during monitoring and evaluation, asking young participants and other stakeholders what significant changes they have noticed, both positive and negative. Those changes might be at the level of the class room, the school, within families, among peers, at the health centre or more generally in the community. This form of research may reveal changes that you were not expecting, or unexpected links between different aspects of change.

You may find it useful to involve research institutions or local universities to help you undertake quality research which can then be published and shared.

Appendix 1

Overview of determinants, methods and activities for promoting health promoting behaviours

	Most effective methods	Least effective methods	Likely activities
Changing knowledge	• Active processing of information • Obtain knowledge through discussions & interactions • Correct misconceptions & myths	One way transfer of information e.g. a lecture with no participation	• Provide information through: leaflets, web pages, phone apps & helplines, films, quizzes (with results and the right answers explained)
Changing risk perception	• Provide realistic information about risks and ways to reduce risk • Support personal reflection • ALWAYS ensure people have the feeling they can do something, by providing skills building and increasing their confidence	Create fear	• Quiz to self-assess risk • Relevant scenarios and modelling stories (film or written) of other young people's experiences
Changing attitudes	• Use convincing arguments, highlighting short-term consequences • Allow exploration and critical thinking • Communicate rights-based values	Tell people what they should think	• Group discussions and brainstorms • Encourage anticipated regret and creating motivation for change • Debates
Developing self-efficacy and skills	• Step-by-step skills training which gives people practice and positive experiences • Give praise when skills are used • Give support to set realistic goals	Only tell people about skills, without the chance to practise them	• Positive relevant role model stories • Practising skills in sessions through role plays and getting feedback • Practising skills in real life and give feedback
Changing social influence	• Correct misconceptions about norms that hinder health promoting behaviours • Seeking support from trusted peers, parents, etc	Ridicule perceived norms that are not accurate	• Explore misconceptions • Explore how to seek support • Testimonies of positive role models
Changing external factors	• Explore community norms with e.g. parents • Run parallel programme with e.g. health workers • Use whole school approach • Collaborate with other relevant organisations • Support advocacy and community mobilisation	Put all responsibility on young people to change while ignoring the effects of external factors	• All of the above • Advocacy training, lobbying & meetings • Media messaging • Forming advocacy and support groups • Community action

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