CHECKLIST FOR PROGRAMME OFFICERS

Improving the Quality of SRHR Education Programmes for Young People

INTRODUCTION

Comprehensive Sexual and Reproductive Health and Rights (SRHR) education for young people addresses adolescence, sexuality, gender, rights, and the prevention of health risks such as HIV/AIDS, other Sexually Transmitted Infections (STIs), unintended pregnancies and sexual abuse. The goal is to support young people in making own, informed decisions with a positive view on sexuality. SRHR programmes can only have impact on young people if they if they address their needs and are effectively developed and implemented.
To assist in the planning of effective SRHR programmes for young people the 'Evidence- and Rights-Based Planning & Support Tool for SRHR/ HIV-Prevention Interventions for Young People' (in short E-PAT)[1] was developed. This checklist is a summary of the E-PAT.

The structure of the E-PAT is based on the Intervention Mapping model, a framework that assists organisations in planning evidence-based programmes. The model consists of 6 steps: 1. Involvement; 2. Analysis; 3. Objectives; 4. Evidence-Based Intervention Design; 5. Implementation and 6. Monitoring & Evaluation[2]. The tool is based on a review of global evidence by Douglas Kirby[3] and provides more elaborate background information, explanation and evidence. The E-PAT was developed together with organisations in South Africa and Pakistan. This short checklist is revised using feedback of programme officers of organisations in the Netherlands.

Users and aim of the checklist

The ***users*** of the checklist are programme officers of donor organisations, who collaborate with partner organisations in developing countries that implement SRHR education for young people. Programme officers can use the tool to assess project proposals and for discussions with their partner organisations.
This checklist is based on international evidence, showing common characteristics of programmes that are effective in improving young people's SRH. Its main ***aim*** is to provoke thinking about why particular decisions are taken in programme planning and its contents. These decisions should rather be based on the needs of young people and on what works, than on own assumptions. For example, the checklist asks questions such as 'What kind of materials and activities will be developed?', 'Why these?', 'What are the messages?', and 'Why?' The checklist is a supplement to other tools that are used by donor organisations to assess project proposals. The aim is therefore not to be complete, but to provide key criteria related to effectiveness of SRHR programmes.

Rights-based approach and evidence-based approach

The checklist is based on two approaches, the rights-based approach and the evidence-based approach. The ***rights-based approach*** refers to the sexual and reproductive rights of young people to take their decisions and their right to be supported by other people, and by policies and organisations in their environment. These rights are formulated in a number of international conventions and conferences, signed by almost all countries in the world. The rights include the right to be yourself; the right to know; the right to protect oneself and be protected by others; the right to have access to health services; and the right to be involved[4]. Gender equality is one of the key elements in this approach.

The ***evidence-based approach*** refers to the use of evidence in all stages of programme planning: all information that either supports or contradicts the decisions that are taken. This information can be derived from the experiences in other projects, baseline research/needs assessments, from publications in scientific journals, reports, good practices inter-views with experts, and other documents.

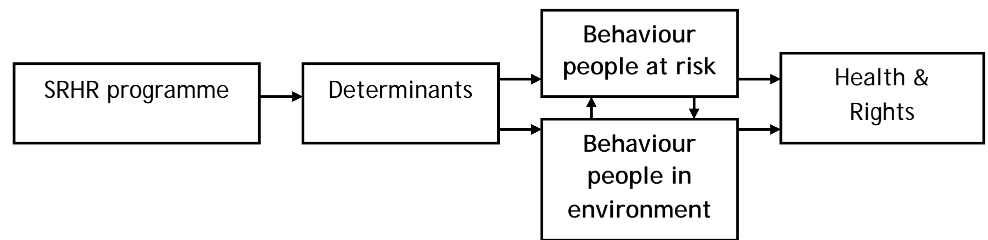
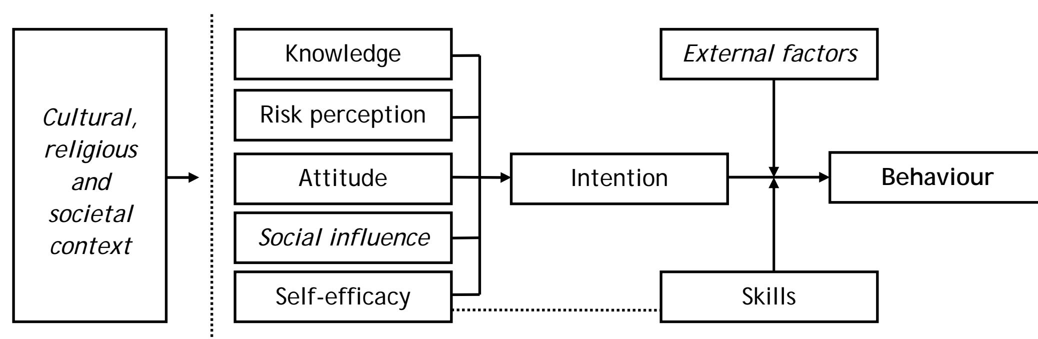


Figure 1. Health Promotion Model

Evidence shows that SRHR programmes for young people that are based on ***behaviour change models*** are more likely to be effective. These models state that all (*health and rights*) problems are 'translated' into behaviours of various actors. For example, if a large number of young people have untreated Sexually Transmitted Infections (STIs), there can be a number of reasons. One of the reasons is that young people who are infected do not seek treatment (*behaviour of the people at risk*). But this can also be caused by *behaviour of people in their environment*: health care providers do not provide STI testing and treatment for young people, or policy makers do not include provision of these services in their policies[5].

The terminology of 'behaviour change' implies that the model can only be applied to change of behaviour. However, the model can also be used to understand how to sustain behaviours that contribute to health and rights. For example, to understand why young people do go for testing and treatment and help them to sustain their health promoting behaviour.

After identification of behaviours of people that contribute to or inhibit health and rights, the next step is to analyse why people do what they do: why do young people with STIs not seek treatment? And why do health care providers not provide STI testing and treatment? Behaviour change models distinguish a number of factors that can influence behaviour (also referred to as *determinants*). Figure 2 provides a model with various determinants influencing behaviour (Theory of Planned Behaviour[6]). We use the example of young people who do not seek treatment as an illustration.



1. Knowledge; young people do not have information or have misconceptions about STIs, or they lack information about services where they can get tested and get treatment
2. Risk perception; they do not see it as their personal risk, or are not aware of the risks of untreated STIs
3. Attitude (advantages and disadvantages); they have a negative attitude towards STI services and towards visiting the service. Attitudes are amongst others influenced by people's personal values.

4. Social influence (support, norms, pressure by others); the norm among young people that it is not 'cool' to go to STI services or that an STI is similar to promiscuous behaviour
5. Skills & self-efficacy are closely linked; a relevant skill in this example is the skill to resist pressure of peers. Self-efficacy is the confidence of someone to actually perform these skills, even in difficult situations. E.g., being confident to actually go to the service, even if friends would laugh about it.
6. Intention to perform a behaviour or not; e.g., intention to visit a service within the next week or month. Intention is shaped by the abovementioned factors. If someone has the knowledge, but has a negative attitude or is strongly influenced by others, he or she is not likely to go. And even if someone has the intention to go, lack of skills or external factors (no service available) may prevent him/her to go.
7. External factors; someone has the intention to go to a clinic, but if there is no clinic close by, or if the clinic does not provide (friendly) services to unmarried young people, he/she may not go. External factors relate to legislation, affordability, availability and accessibility.
8. The cultural, religious and societal context influences all the above mentioned determinants: what people know, value, what they are used to and their norms are all influenced by the context they live in.

Behaviour change models can also be used to analyse the behaviours of people in the environment of young people, e.g., why health care providers do not provide STI testing and treatment to young people. Do they lack knowledge? What is their attitude towards young people's rights? Are they influenced by others not to provide these services to young people? Or do they lack skills to approach them in a youth-friendly way?
When the causal relations between 1) a health problem (untreated STIs) or lack of rights, 2) the behaviours and 3) the determinants are clear, planners can expect that by changing these factors, this will ultimately result in behaviour change and in promotion of health and rights.

Two categories of factors (determinants) can be distinguished: ***personal determinants*** (within a person) and ***environmental determinants*** (outside one's own control). The environmental determinants include social influence and external factors, as well as the cultural, religious and societal context. The others are personal determinants and are the starting point of designing the SRHR programme: what has to change in terms of knowledge, risk awareness, attitudes, skills and self-efficacy. The environmental determinants are translated into behaviours of people who are responsible, again analysed in terms of determinants and may result in a specific action or programme for people in the environment (e.g., a training for health care providers) or may remain unchanged as organisations cannot do everything.

Behaviour change is a complex process with many factors playing a role. The behaviour change model is an attempt to structure this and bring it back to categories of the most important (and changeable) factors. The model should therefore not be used in a rigid way but as a tool to understand and change behaviours. In some contexts or for specific problems some determinants are more important than in others.

Finally, a remark about how the rights-based and evidence-based approaches are 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 when young people get these services, they live a healthier life. Another example: young people have the right to take decisions about their own sexual behaviour, and evidence shows that own decision-making is more likely to result in sustainable behaviour change, than prescribed behaviour by parents or others.
However, sometimes it may be important to do something according people's rights, without being sure whether this is effective or not. For example, from the evidence-based approach the ... is to focus on the most important and most changeable factors. However, from a rights-based perspective, programmes should sometimes address topics that are controversial and sometimes difficult to change. The checklist is explicit about these sometimes conflicting approaches.

CHECKLIST

When programme officers communicate with partner organisations or look at project proposals, they can use the 12 topics below to assess the quality of the ***planning process*** (A), and the ***content*** (B) of SRHR programmes for young people. The checklist is based on an 'ideal' situation, which generally is not the case. It can differ per context which criteria can be met or not.

A. Planning SRHR programmes for young people

Planning SRHR programmes for young people includes various tasks. It starts with the involvement of relevant stakeholders. After the analysis of problems and solutions, objectives are stated and the programme materials and activities are developed. Finally, the programme is implemented and monitored and evaluated. The criteria in this section relate to this planning process.

1. Are young people and implementers *actively* involved in planning?

Many programmes are developed by planners in their offices, without the involvement of the beneficiaries and the implementers of the programme. The quality of programmes however improves if representatives of young people and implementers (such as teachers) are involved from the start by providing feedback and suggestions on needs, messages, and activities and materials. This results in a programme that addresses actual needs of youth and ensures that implementers feel comfortable to implement the activities. Many programmes involve young people as peer educators in programme implementation. However, there is little evidence that shows that peer-delivered SRHR education is effective, and evidence shows that it is only effective when specific conditions are met.

2. Are relevant decision makers *actively* involved in planning?

Involving relevant decision makers from the start is essential for approval for and collaboration in (sustainable) implementation. Not involving them may result in lack of linkage to existing programmes and policies, and in the long term lack of ownership and sustainability. Decision makers can be involved by establishing an advisory board with representatives of the most important stakeholders, who provide feedback and advice. For example, ***policy makers*** (e.g., Ministry of Education/ Health/ Youth); ***community*** organisations or individuals (e.g., parents, religious leaders, school board, health service providers, youth based organisations); and ***specialists*** in education and SRHR (e.g., teacher union, curriculum advisors, national AIDS commission, Family Planning Association, relevant NGOs). Involvement of parents may in some contexts contribute to effectiveness, but can also be a barrier for implementation and therefore for effectiveness.

3. Does the programme start with a relevant analysis?

Many projects start with a baseline analysis, which is often very general and only restricted to health figures. However, to be able to design programmes aiming at behaviour change, behaviours and determinants should be included in the analysis. If this analysis is not conducted, the programme may not address the actual needs and may not fit with the policy and community context. This is referred to as ***needs assessment***: assessing the capacities and needs of beneficiaries (young people). This can start with a literature review about SRHR of young people in the specific context (HIV/AIDS, STIs, pregnancy, rights, etc.). Most relevant to explore are sexual behaviours (e.g., abstinence, condom use, age onset sexual intercourse, sexual abuse) of young people (e.g., using a short questionnaire) and its determinants (knowledge, attitude, skills, self-efficacy, environmental factors) using group discussions and/or individual interviews. This assessment should take into account the differences between sub-groups among young people (e.g., age, boy/girl, rural/urban).

In the ***situation analysis***, existing structures, capacities and resources in the community are explored, that can be used to address the problem. Generally this is a review of reports and literature, including: 1. Relevant legislation, laws, *policies* and regulations related to young people and SRHR; 2. Values and *social norms in the community*; 3. *Available resources* and facilities such as health care, services, contraceptives, and collaboration with other organisations; 4. Opportunities and barriers in the *implementation setting* (e.g., school, staff time, resources); 5. Needs of the *implementers* (e.g., skills of teachers) to be able to implement the programme; 6. *Existing SRHR education programmes* (including materials).

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

Planning programmes in a 'logic' way increases the quality of programmes. This means that there should be a direct link between 1. Needs assessment/ situation analysis (e.g., which may show that only few young people use condoms, because they don't have the skills to use them correctly), 2. Objectives (e.g., increase skills to use condom), and 3. Activities & materials (e.g., exercise with broom to learn how to put on condom).
Often, a baseline analysis is conducted, but the findings are not reflected in the objectives, content, activities, materials, messages and implementation. And activities and materials are selected because they 'look nice', 'are innovative, or 'feel good', but not because they address the actual needs. Documentation of the linkage between analysis, objectives and activities & materials can assist planners not to forget important topics.

5. Is the programme pre-tested and piloted among beneficiaries and implementers?

Testing programmes on a relatively small scale adds highly to the effectiveness, but is rarely done. Planners (and donor agencies) tend to start with large scale implementation after production of the programme materials. We distinguish between 1. *Pre-test*: evaluating some complex, sensitive or questionable activities and materials on a small scale, e.g., with 10-20 young people and some implementers; and 2. *Pilot*: implementing the complete programme among a relatively small audience (e.g., three pilot schools). If needed, the activities and materials are adapted, based on the findings of the pre-test or pilot. For example, the pre-test or pilot may show that implementers cannot implement skills building exercises on condom use because this is too difficult for them. The exercises may need to be replaced by easier exercises, or the training of implementers may need adaptation.

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

A well-developed programme is generally not sufficient for creating change. Equally important is the selection, training and support of implementers, so that they can communicate all key messages in a way as intended by the planners. Such training and support of implementers should at least include information sharing; training of interactive teaching skills and participatory didactical techniques; skills in discussing sexuality with young people in a non-judgemental and open way; attitude and value clarification towards rights of young people, sexuality and SRHR related topics; and increasing confidence that they can actually implement the programme. This can be done through training sessions before and/or during implementation; review/ feedback meetings; (individual) supervision and monitoring, and on the job support and feedback.

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

In monitoring and evaluation, most planners do not measure the impact of the programme in terms of behaviour change. Measuring behaviour change is often not possible on a short term. It requires time to see change; e.g., some young people may only get sexually active after some years and only

then apply what they have learnt about condom use. However, it is possible to measure a change in *determinants of behaviour* by asking for changes in knowledge, risk perception, attitudes and skills, and intention for future sexual behaviour. This can be done with a questionnaire for young people before and after implementation; or using qualitative methods such as Focus Group Discussions (FGDs), In depth Interviews (IDIs) and/or (class) observations. In addition this impact evaluation, planners should closely monitor the implementation on different levels: beneficiaries (young people), implementers (e.g., teachers), and the implementing organisation (e.g., CBO, NGO, government).

B. Content of SRHR programmes for young people

The second category of topics relates to the content and shape of the programme: how and by whom it is implemented, messages, activities and materials. This may be difficult to assess in a project proposal but can be discussed with partner organisations.

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

Many programmes for young people on SRHR address factors that cannot easily be changed (e.g., social norms), do not address the most relevant behaviours (e.g., condom use for sexually active youth) or address factors that have little impact on behaviour (e.g., knowledge-only programmes). Effective programmes address factors that were found in the needs assessment to be important behavioural determinants. Many programmes can already be largely improved if they do not only focus on a transfer of information (e.g., in leaflets, posters or billboards), but also address personal risk awareness, attitude change, and skills building.
According the rights-based approach (the right to complete and correct information), it is sometimes also necessary to address topics that are difficult to change, but are young people's right to know. For example, attitudes related to sensitive topics such as abortion or homosexuality may be difficult to change, but important to address.

9. Does the programme encourage active learning by young people?

Many programmes are delivered by implementers using a one-way, frontal approach; through radio or TV announcements; or in written materials such as brochures, posters and billboards. All these approaches give young people facts and information and tell them what to do and how to do that. However, this hardly encourages them to actively process the information. Effective programmes encourage people to learn in an active way by looking for or reflecting on information (e.g., in quizzes), discussing this with others (e.g., in small groups), and by practicing skills (e.g., in role plays or homework assignments).

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

Often, programme materials and activities are not based on thorough thinking, pedagogical principles nor on evidence about what works or not for a particular target group, but is based on 'what we have always done' or 'what others also do'. This hinders effectiveness of programmes. Therefore, some principles should be taken into account. Programme planners can select activities and materials that:

1. match with the beneficiaries and context and take gender into account (e.g., lay out, language, tone, examples of own context)
2. address the most important and changeable determinants (e.g., not only providing information, but also skills building and attitude change)
3. provide factual information that is based on evidence and not on values (e.g., about condoms, masturbation, rights, sexuality)

4. are effective in changing risk awareness; not with fear-based information, but by giving people insight in personal health risks combined with giving confidence that he/she can do something about it
5. are effective in changing attitudes; e.g., in guided group discussions and providing persuasive arguments
6. are effective in changing skills; e.g., through role plays, individual practicing and giving positive feedback

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

One of the most difficult aspects of SRHR programmes (for young people) is to explicitly communicate about sexuality and related topics. It means that the programme materials and implementers openly address issues such as masturbation, abortion, condom use, pleasure, abuse, sex before marriage, and taboos. It also means that this is done in a positive, non-judgmental way.
This requires a safe and confidential atmosphere (created by implementers such as teachers in a classroom). It is important not to pose own norms on young people, but to give them sufficient information and guidance so that they can take their own decisions related to sexuality. Evidence provided by many evaluation studies worldwide shows that open communication about condom use and sexual behaviour does NOT result in more sexual activity among young people. On the contrary, evidence shows that it helps in delaying sexual debut and for sexually active young people to practice safe sex. However, there is hardly any evidence that shows that abstinence-only programmes do increase safe sexual behaviour of young people.

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

SRHR education programmes can raise individual questions, worries and needs (e.g., for condoms, contraceptives) or result in recognition of individual challenges or health problems, such as STIs, HIV/AIDS, unintended pregnancy, sexual orientation, and sexual abuse. It is therefore necessary and ethical to provide young people with facilities or other opportunities where they can find support for their individual needs and questions. If the implementing organisation cannot provide this support, a solid referral system can be established through which young people can be referred to other (health) service providers (e.g., HIV testing facilities), adequate counsellors or for instance a helpline or magazine to ask all questions that may bother them. Creating such a safe and supportive environment should assist young people to translate what they have learned in the programme to their day to day life.

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Further reading

[1] Leerlooijer, J.N., Reinders, J. & Schaalma, H. (July 2008). *Evidence- and Rights-Based Planning & Support Tool for SRHR/ HIV-Prevention Interventions For Young People.* World Population Foundation, STOP AIDS NOW! and Maastricht University, the Netherlands. See www.stopaidsnow.org or www.wpf.org for a digital copy.
[2] Bartholomew, L.K., Parcel, G.S., Kok, G. & Gottlieb, N.H. (2006). *Planning Health Promotion Programs; an Intervention Mapping approach (2nd ed.)*. San Francisco, CA: Jossey-Bass.
[3] Kirby, D., Laris, B.A., & Rolleri, L. (2006). *The Impact of Sex and HIV Education Programs in Schools and Communities on Sexual Behaviors Among Young Adults.* Research Triangle Park, NC: Family Health International. See www.fhi.org for a digital copy.
[4] See IPPF website for more information about 'Young People's Sexual and Reproductive Rights': www.ippf.org
[5] Green, L.W. & Kreuter, M.W. (1999). *Health promotion planning: An educational and ecological approach, 3rd ed.* Mountain View, Mayfield.
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