Evidence and rights based

PLANNING & SUPPORT TOOL

for SRHR/HIV Prevention Interventions for Young People

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Developed by
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In cooperation with
STOP AIDS NOW!

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Save the Children Netherlands and the STOP AIDS NOW!
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PREFACE

In 2006, organisations in the Netherlands and the south identified a need to make more use of the evidence of effective SRHR education for young people. That was the start of the development of this tool. At an early stage in its development, organisations in South Africa and Pakistan began working with the tool and their feedback has been used to adapt it, making it more applicable and user-friendly. The current version of the tool translates academic, theoretical principles and topics into practical use.

All that could not have been possible without the help of many professionals. So we would like to thank the organisations in South Africa (Dance4Life, Targeted Aids Intervention, Catholic Institute of Education, South African Scouts Association, Stellenbosch University, God's Golden Acre), Pakistan (AAHUNG, IHDCS, AMAN Foundation, AAS, PAVNHA, PNAC, DANESH, WPF Pakistan) and the Netherlands (Save the Children Netherlands and the STOP AIDS NOW! partners Cordaid, Oxfam/Novib and ICCO). They provided useful and detailed feedback which has been integrated into this tool. Our thanks also go to our colleagues in the Netherlands: Professor Herman Schaalma (Maastricht University), Jo Reinders and Ellen Eiling from WPF, Maaike Stolte and Miriam Groenhof from STOP AIDS NOW!

A special word of thanks goes to Douglas Kirby for his valuable comments. The tool is to a large extent based on his work on school-based sexuality education for young people. Keeping a clear distinction between principles derived from a rights-based approach and facts derived from evidence was especially important during the development process.

Two other documents have been written to go with this tool. One is much more elaborate: the *Intervention Mapping Toolkit for Planning Sexuality Education Programmes*. 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 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.

WPF and STOP AIDS NOW! welcome all efforts to apply or distribute this document and appreciate any comments for improvement. We also provide training and support in both practical use of the tool and its underlying principles and approaches.

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ABBREVIATIONS

ARV	Anti-Retroviral Drug
CRC	Convention on the Rights of the Child
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IM	Intervention Mapping
LFA	Logical Framework Approach
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
SMART	Specific, Measurable, Aligned, Realistic/Relevant, and Time-bound
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UN	United Nations
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WPF	World Population Foundation

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1. INTRODUCTION

More than half of the global population consists of young people. Many of them face challenges such as HIV/AIDS, STIs, teenage pregnancies, gender inequality and discrimination, particularly in developing countries. Organisations worldwide have designed programmes to address problems like these that are related to young people's sexual and reproductive health and rights (SRHR). Some programmes aim to prevent SRHR problems, while others concentrate on caring for people facing these problems. Another programme objective could be to make positive changes to policies or legislation. In this tool, we focus on programmes that promote the sexual and reproductive health and rights of young people, also called SRHR education or sexuality education.

1.1 SRHR/sexuality education

Box 1 provides a definition of sexuality education by SIECUS,[1] the Sexuality Information and Education Council of the United States. Many programmes are part of SRHR/ sexuality education, for example life skills programmes, Information, Education and Communication (IEC) materials, HIV/AIDS prevention, pregnancy prevention, abstinence only 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 well-being. They also vary with regard to target groups and implementation.
Many organisations want to improve young people's quality of life and health, so they want to implement programmes that are good quality too. But developing effective programmes is not easy. Experience and evidence gained from work done all over the world shows what does contribute to quality and what doesn't. This tool provides the most important evidence, in a way that is useful for organisations who are working in the day-to-day practice of SRHR education for young people but have limited time and resources. It is a plan for organisations on how to best design and evaluate SRHR education programmes for young people.

Sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education addresses the biological, sociocultural, psychological, and spiritual dimensions of sexuality from the 1. cognitive domain, 2. affective domain, and 3. behavioural domain, including the skills to communicate effectively and make responsible decisions.

Box 1. Definition of sexuality education (SIECUS)

1.2 Aim and use of the tool

The tool has been developed for organisations who already implement SRHR education for young people and want to analyse their programme, as well as those who are planning to develop a new programme. It 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. In Pakistan and South Africa this has proved to be an effective way of learning from other organisations and sharing experiences.

The aim of the tool is to encourage people who develop SRHR education to reflect on why certain decisions in programme development and implementations were made/ about the reasons why their programme and its implementation are the way they are. For example, why does a programme only focus on increasing knowledge, while hardly paying any attention to the development of young people's values and attitudes? Or why is a programme conducted by youth peer educators and not by, teachers? The tool helps organisations to take well-informed decisions about the planning, development, implementation and evaluation of SRHR programmes in a step-by-step, chronological way.

The tool can be used to analyse or plan a variety of SRHR interventions: school and non-school-based interventions; large and small; with a focus on HIV, STIs, and/or pregnancy; targeting older or young people; for orphans and vulnerable children (OVC); children who are at work; and/or other young people.

Organisations can use the tool for the analysis of *existing interventions* to identify what is already going well and what needs improvement. No programme is perfect and effectiveness depends on a large number of factors, including available resources and barriers in the implementation setting. It may not be possible to address all the identified gaps at once. One option is to collaborate with other organisations that already have particular experience and are able to address gaps. For example, an analysis may show that young people don't have access to health services and counselling. As a result you could decide to collaborate with an organisation that has expertise in providing such services.

The tool can also be used for designing *new interventions*. It provides a framework for the design of SRHR projects. However, it should not oblige organisations to implement programmes completely according to the tool; the particular context, implementation setting or mandate of an organisation may require certain choices that are not in line with the tool.

Planning new interventions following a systematic, theory- and evidence-based approach usually requires a lot of time and therefore also funding. It's sometimes difficult for implementing organisations to find resources to plan interventions in such a way. Another difficulty can involve 'translating' the Intervention Mapping terminology into the format and requirements of donor agencies, as each of these has their own terminology and requirements. Some donors determine the agenda of the implementing agencies and aren't flexible to adopt new approaches.

Organisations in Pakistan used the tool for various purposes:

- Analysis of existing SRHR education programmes
- Design of new SRHR education programmes
- Framework to guide discussion with donor organisations
- Capacity building and improvement of their projects or programmes
- Documenting intervention planning afterwards
- Linking and learning between different organisations

Box 2. Examples of how the tool was used in Pakistan

1.3 Developing the tool

The idea for the planning and support tool was initiated by a number of organisations in the Netherlands who focus on orphans and vulnerable children (OVC). Together with their partner organisations in developing countries, they identified a need for information about what works and what doesn't work in SRHR education programmes for young people.

The first version of the tool was developed together with Maastricht University and primarily based on global evidence, including studies from developing countries, reviewed by Kirby and colleagues. They have published a number of documents on the Internet that can be useful for further reading:

1. a description of the characteristics of effectiveness[2]

and

2. a tool that is based on this review.[3]

The first version of the tool was tested in one high HIV-prevalence country (South Africa) and one low HIV-prevalence country (Pakistan) by organisations that implement SRHR interventions for young people (both school-based and outside school). The most relevant feedback has been used wherever possible to develop this version of the tool. The feedback also prompted us to develop a brief checklist (summary of the tool) for programme officers at donor agencies and to train the Dutch STOP AIDS NOW! partners (donors) to use the checklist.[4]

The introduction of the tool in South Africa taught us that this has to be done very carefully wherever it is introduced. It must always be made clear that the tool is not an external evaluation tool imposed by donors, but simply a self-assessment instrument for existing interventions and planning new ones.

1.4 Intervention Mapping

This tool has been structured using the Intervention Mapping model[5], that helps planners to systematically design health programmes and encourages them to take evidence-based decisions. It is a model which is an useful approach in SRHR education for young people, looking at health and other problems from the perspective of behaviour (change). SRHR education for young people is more likely to work/have an impact if the problem is addressed systematically, based on evidence and theory.

Intervention Mapping is a health promotion model used all over the world, including Africa and Asia. It was developed by researchers from the USA and the Netherlands. The model emphasises the use of ***evidence***: information about the problems and needs of a target group (young people), available structures and resources to address these needs, and information about what works and what doesn't (effectiveness), in terms of approaches and methodology.

The Intervention Mapping model encourages programme developers to work in a ***systematic*** way. The model consists of 6 steps that are closely linked. After involving all those concerned (step 1), there is a comprehensive analysis of the problem (step 2). This analysis results in detailed objectives (step 3). Next, all the programme activities and materials are studied to see whether every objective has been met (step 4). To make sure the programme is adopted and implemented effectively, any barriers and possible structures and resources are analysed and addressed (step 5). And the end of the process is monitoring and evaluation (step 6).

One of the key features of the model is the ***behaviour change approach***. Health risks and other problems are translated into the behaviour of various people. For example, the problem of large numbers of young girls with unplanned pregnancies is caused by their own behaviour (unprotected sexual

intercourse) as well as by the behaviour of others (health care providers not providing young people with contraceptives; policy makers not making policies that state that young people should be provided with contraceptives). This behaviour change approach can be used to analyse why people behave in a certain way. Why don't health care providers give condoms to young people? There are several possibilities: lack of knowledge; the attitude that young people shouldn't have sex before marriage and therefore don't need condoms; lack of skills to approach young people in a non-judgemental way; and the influence of others or community norms. All these factors – knowledge, attitude and skills – can be addressed in an intervention targeting the health care providers.

The tool and the Logical Framework Approach (LFA)
As mentioned above, many organisations in development collaboration use the Logical Framework Approach (LFA) and other project management models for planning and monitoring their interventions. Sometimes there has been confusion about how this planning and support tool links with LFA and project management.

The tool does not replace the LFA – it's an add-on. LFA is a useful but very general approach. Unlike Intervention Mapping, LFA does not provide in-depth tools to specifically explore factors influencing health (i.e. SRH) problems or to develop programme activities and materials. IM can therefore be a useful addition to your Logical Framework, to better specify your expected outcomes and indicators for monitoring and evaluation.

There is a lot of overlap between the two approaches: both emphasise the involvement of stakeholders from the start, both emphasise SMART objectives and link monitoring and evaluation with the objectives. But this tool provides suggestions for the content of SRHR interventions as well as the steps to get to such an intervention in the most effective way.

1.5 How to use the tool

In Chapter 2, the two approaches used in this tool are further explored: the rights-based approach and the evidence-based approach. Chapter 3 is the 'core' of the tool and includes a table that can be used for checking the various characteristics of effectiveness. In Chapter 4, the background for each of the characteristics is provided, including references to documents and literature with more detailed background information.

All the way through the text, you'll see that we've inserted reference numbers, for example: [1]. And at the end of the document you'll find a numbered list of these reports, articles, books and websites with additional information.

The table in Chapter 3 consists of a number of columns. The column on the left shows all the characteristics of SRHR education interventions for young people that are effective. The middle columns give more detailed *indicators* for each of the characteristics – a. the 'what' indicator: what was done or included in the intervention and what wasn't? b. the 'how' indicator: what was its quality, or how was it included? Users of the tool can give their ratings for both 'what' and 'how' indicators with the following: *++ excellent; + fair; +/– needs improvement; –- is not done at all; and X not applicable*. Users can put additional information In the column on the right, plus any comments regarding the ratings and suggestions for improvement.

2. RIGHTS AND EVIDENCE

The tool uses two approaches – a rights-based approach and an evidence-based approach. Both are described below, and this section ends with a description of how the two are linked.

2.1 Rights-based approach
All young people around the world, regardless of their religion or culture, have sexual and reproductive rights. A rights-based approach serves the needs of young people by involving them, and that makes policies and programmes more effective and sustainable. This kind of approach provides the right framework for meeting the actual sexual and reproductive health needs of young people, and not just their needs as perceived by adults.[6]

A 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*, which states, among other things, that all people have a right to education, health care, protection, support and freedom of expression.[7] The idea of a rights-based approach is that you invest in young people's assets and in protective factors rather than moralising and giving warnings. The assumption is that young people's well-being can be achieved most effectively by empowering them and strengthening their capabilities, giving them more access to opportunities and services, and providing them with safe and supportive environments.[8] A rights-based approach allows young people to take control of their own sexual and reproductive life and to become self-reliant.

Reproductive Rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.[14]

Box 2. The definition of reproductive rights

'Young people's sexual and reproductive rights' has been a much-discussed topic, particularly at international conferences. This has led to various international conventions and the inclusion of SRHR in the Millennium Development Goals.[9] In 1989, the Convention on the Rights of the Child (CRC) introduced a rights-based approach to the sexual and reproductive health of young people. 191 governments worldwide have signed and approved the CRC. 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.[10;11]

UN conventions since then have reinforced and further elaborated on the rights of young people. All these conventions were the outcome of global meetings: the International Conferences on Population and Development (ICPD, 1994, 1999, 2004) and the UN's Conferences on Women in Beijing (1995, 2000, 2005). These conferences contributed to the fact that young people are now recognised internationally as sexual beings with a right to self-determination, education and information, youth-friendly services, protection and participation.[12]

By signing conventions, governments of almost all the countries in the world have committed themselves to expanding adolescents' access to reproductive health information and services as well as promoting young people's well-being and social equality.
At the heart of young people's rights is the right to take their own, well-informed decisions on having sex. Young people need to be told about the changes they go through during adolescence, the risks they face, and the rights their government has given them by signing international conventions. Whenever they have any problems or concerns, young people need to have access to affordable and confidential sexual and reproductive services. These services should be youth-friendly and provide both counselling and contraceptives – including condoms.
In addition, young people need to be able to protect themselves and their partner especially against sexual abuse. Finally, to ensure that policies, programmes and services meet the real needs and rights of young people, they themselves should take part in all levels of decision-making. This will empower them to become active members of society.[13]

A rights-based approach emphasises the fact that all people should be treated equally: both males and females whatever their sexual orientation, people who have or have had a sexual health problem, and people living with HIV/AIDS. It also encourages action if rights are violated (for example, in cases of sexual abuse or discrimination).

Putting the theory of rights into practice involves many different people working together. In this case, national governments, organisations that serve young people, and, of course, the young people themselves.[16] While making sure that young people are provided with all they are entitled to, other people's rights must be respected too. The right to make your own decisions should not have an adverse effect on your friends, partner, parents, family or community.
So decision-making also means taking responsibility, and taking the expectations of others into account where relevant.

A human rights-based approach to programming differs from a basic needs approach in that it recognises the existence of rights, and gives duty bearers (usually governments) more opportunities to respect, protect and guarantee these rights.

Sexual Rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:[15]
- the highest attainable standard of sexual health, including access to sexual and reproductive health care services
- seek, receive and impart information related to sexuality
- sexuality education
- respect for bodily integrity
- choose their partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not, and when, to have children
- pursue a satisfying, safe and pleasurable sexual life

Box 3. The definition of sexual rights

2.2 Theory- and evidence-based approach

A theory- and evidence-based approach applies evidence and theory to every stage in programme planning. It refers 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.[17] An important source for this tool was the review of effective interventions worldwide by Kirby and his colleagues, as mentioned in the previous chapter.[18]

Information can also be obtained from ***theories***. Some theories explain behaviour and the factors that influence health problems, while others give principles for effectively changing behaviour or the causes of certain behaviour. If planners apply these principles, their interventions are more likely to actually change behaviour.[19] A useful guide that can be downloaded from the Internet gives a clear explanation of some of these health promotion theories and how they can be put into practice.[20]

Sometimes you'll find contradicting evidence. It may then be tempting to use the evidence that supports your organisation's practice or approach, but this does not always mean that the result will be increased effectiveness. Another point to remember is that evidence that applies to one setting does not necessarily apply to other settings. So although it is wise to use evidence, you must check whether it is applicable in a particular situation. For example, evidence from Africa cannot automatically be used in Asian contexts, but evidence from a similar country to your own may well be applicable.

Behaviour

Evidence shows that SRHR programmes for young people that are based on ***behaviour change models*** are more likely to be effective. These models[21] state that all *(health and rights)* problems are 'translated' into behaviour. For example, there may be several reasons why a large number of young people have untreated sexually transmitted infections (STIs). One of these could be that young people who are infected don't seek treatment *(behaviour of the people at risk)*. But this, in turn, could be caused by the *behaviour of people in their environment*: health care providers don't provide STI testing and treatment for young people, or policy makers don't include the provision of these services in their policies[21].

The advantage of using behaviour change models is that planners are then more likely to take into account all the relevant factors for explaining and changing a health problem. The model can help to identify factors on different levels, and also show how these factors are related. When planners start to have a clear idea about 'the problem' and the factors that determine the problem, they can address these in the intervention, and are more likely to create change.

The term 'behaviour change' seems to imply that the model can only be applied if behaviour needs to be changed. But it can also be used to gain an understanding of how to sustain behaviour that contributes to the promotion of health and rights. To understand why some young people do go for testing and treatment, for example, and to help them maintain this behaviour.

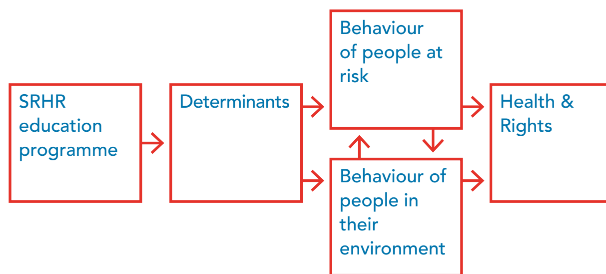

Figure 1. Health promotion model

Determinants

After identifying behaviour that contributes to or inhibits health and rights, the next step is to analyse why people do what they do: why do young people with STIs not seek treatment? And why do health care providers not provide STI testing and treatment? Behaviour change models distinguish a number of factors that can influence behaviour (also referred to as *determinants*). Figure 2 shows a model with various determinants that influence behaviour (Theory of Planned Behaviour [22]). Below we use the example of young people who do not seek treatment to explain the model.

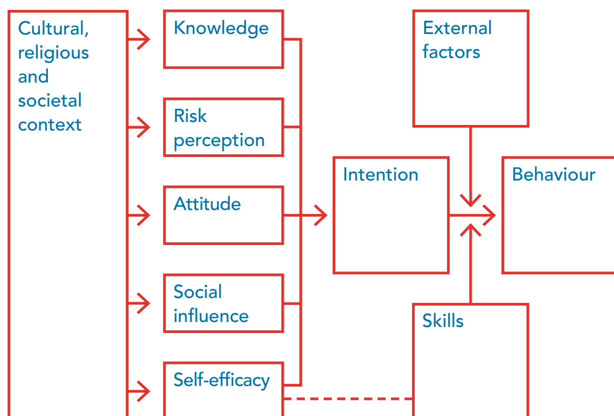

Figure 2. Theory of Planned Behaviour

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

Behaviour change models can also be used to analyse the behaviour of others in young people's environment.
For example, why health care providers don't provide them with STI testing and treatment. Do they lack the knowledge? What is their attitude to young people's rights? Are they influenced by others and is that why they don't provide these services for young people? Or do they lack the skills to approach them in a youth-friendly way?
If a programme planner succeeds in identifying the link between the health problem (untreated STIs), behaviour and determinants, then changing the determinants will ultimately result in behaviour change and improved health.

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

Behaviour change is a complex process in which many determinants play a part. The behaviour change model is an attempt to structure this and create categories of the most important determinants which can be changed. It shouldn't be followed too strictly. It is simply a tool for understanding and changing behaviour where possible. In some contexts, or for specific problems, certain determinants may be more important than others.

SRHR education programme

If planners are aware of the main determinants that influence behaviour and the environment, they can identify the most important ones which can be changed and use this as a framework for developing activities and materials. For example, they can develop skills training to improve communication skills. Or organise group discussions to make young people aware of their own values and how they are influenced by others. If the link between determinants, behaviour and environment becomes apparent, changing the determinants may ultimately result in a change in behaviour and the environment.

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 when young people get these services, they live a healthier life. Another example: young people have the right to get information and education about sexuality, growing up, and how to prevent sexual health problems. Evidence shows that when young people get this information and education, they are more likely to live a healthier life.

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 can be changed. However, from a rights-based perspective, programmes should sometimes address topics that are controversial and may be difficult to change. Where necessary, the tool explains these conflicts.

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3. PLANNING AND SUPPORT TOOL

A. Involvement (step 1)

1. Are the right people in the project team?

Indicators: What	**++ + +/– -- x**	**Indicators: How**	**++ + +/– -- x**	**Comments and suggestions for improvement**
Is the following expertise represented in the planning team		Are they involved in all		______
- Project management	______	relevant planning stages?	______	______
- Research	______			______
- SRHR of young people	______	Are the values and attitudes		______
- Behaviour change theories	______	of the planning team		______
- Design of SRHR interventions for young people	______	members supportive for a		______
- Implementation of SRHR interventions for young people	______	rights- and evidence-based		______
- Training implementers	______	SRHR project for young		______
- Educational methods	______	people?	______	______

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

2. Are young people involved in intervention planning?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Has a working group been set up with representatives of the young people concerned?		Are the right young people part of the working group?		
Are they involved in all relevant planning stages:		What is the quality of their involvement?		
- Design of the project plan/proposal				
- The needs assessment/situation analysis (as respondents)				
- Interpretation of the conclusions of the needs assessment/ situation analysis and decisions about the objectives				
- Intervention design (including selection of activities/ materials and pre-testing)				
- Implementation, as peer educators				

3. Are facilitators involved in intervention planning?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Has a working group been set up with representatives of the facilitators concerned?		Are the right people part of the facilitator working group?		
Are they involved in all relevant planning stages:		What is the quality of their involvement?		
- Design of the project plan/proposal				
- The needs assessment/situation analysis (as respondents)				
- Interpretation of conclusions of the needs assessment/ situation analysis and decisions about the objectives				
- Intervention design (including selection of activities/ materials and pre-testing)				
- Implementation and expansion of the programme, as trainers of other teachers				

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

4. Are relevant decision-makers involved in intervention planning?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Have you obtained at least minimal support from relevant authorities? - Ministry of Education - Ministry of Health - Ministry of Youth		How do you rate the actual support you expect to receive or have received?		
Have you obtained the support of relevant community organisations and leaders that is needed to fully implement the intervention? - Parents/community - Community/religious leaders - In schools: board, school administration, governing bodies, school staff		How do you rate the actual support you expect to receive or have obtained?		
Have you involved specialists in SRHR education and any other relevant people? - AIDS commission - Family planning association - Funding agencies - Relevant NGOs (specialised in sexual abuse, teenage pregnancy, advocacy) - Health service providers - Youth-based organisations - Community organisations		How do you rate the actual support you expect to receive or have obtained?		

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

B. Needs assessment/situation analysis (step 2)

5. Is the intervention based on a needs assessment?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Were all important aspects studied?		How do you rate the quality of the assessment?		
Did you collect information about the overall quality of life of young people? - What concerns them most in life?		What is the reliability and quality of the data?		
Did you collect data related to the size of the SRHR problems of young people? For example HIV/STI rates, teenage pregnancy, abortion, sexual abuse, stigma and discrimination?		To what extent are data applicable to your target group, setting and context?		
Did you collect information about the sexual behaviour of young people? - Sexual behaviour/abstinence - Sexual acts (masturbation, oral/anal sex, etc.) - Condom/contraceptive use - Consensual sex - Number/characteristics of their sexual partners - Health problem solving/health seeking behaviour		Were data collected among representatives of the target group?		
		Were data collected among adults who are involved with young people?		
Did you collect information about the personal determinants of young people's sexual behaviour, including knowledge/misconceptions, attitude/values/beliefs, risk perception, skills/self-esteem/self-confidence and their perceptions of social influence and peer pressure?		Were the data collected by trained researchers/assistants?		
		Were problems encountered in avoiding/negotiating sex and using condoms or contraceptives discussed openly?		

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Did you collect information about the environmental determinants of young people's sexual behaviour? - Social influence/community norms - Laws - Availability/affordability of health services, counselling and supplies - Other external barriers		Was the data collection methodology good quality? Was the data analysis done objectively? Was the reporting of the results done objectively?		

6. Is the intervention based on a situation analysis?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Were all important aspects studied? Did you collect and analyse relevant laws, regulations and policies (on youth, SRHR, HIV/AIDS, gender and education), and find out to what extent these are implemented? Did you assess relevant norms and values in the community? - Sexuality, abstinence, marriage, masturbation - Position of girls and boys - HIV/AIDS, pregnancy, abuse, stigma - Communication with young people about sexuality - Condoms and other contraceptives - Sexual orientation, abortion - Right of young people to make their own decisions and be protected		How do you rate the quality of the analysis? What is the reliability and quality of the data? To what extent are data applicable to your target group? Were data collected among representatives of the target group? Were data collected among adults who are involved with young people?		

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Did you analyse the available resources in the community? - Networks of care - Youth-friendly health care, services, counselling, VCT - Commodities (condoms and other contraceptives) - Possibilities for collaboration/referral to other organisations		Were the data collected bytrained researchers/ assistants?		
Did you analyse barriers and opportunities in the implementation setting? - In schools: school administration and others - knowledge, misconceptions, attitudes and social influence - Safe and comfortable facilities for implementation - Supplies (e.g. video equipment, pencils) - Trained and available facilitators		Were problems encountered in avoiding/negotiating sex and using condoms or contra-ceptives discussed openly?		
		Was the data collection methodology of good quality?		
		Was the data analysis done objectively?		
Did you assess the needs of facilitators? - Behaviour - Personal determinants (knowledge, attitude, skills) - Environmental determinants (materials, time, social support) - What motivates them to do this?		Was the reporting of the results done objectively?		
Did you collect and analyse existing SRHR education interventions? - Materials - Lessons learned				

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

C. Objectives (step 3)

7. Are the health goals of the intervention clearly outlined?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Are the health goals clearly outlined?		Are the health goals based on evidence?		
		What is the quality of the evidence?		
Does the intervention reflect these goals?		Are the health goals sufficiently and correctly addressed?		

8. Are the behavioural messages for young people clear and consistent?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention clearly focus on one or more specific behaviours that directly affect pregnancy, STIs/HIV or consensual sex?		Are the behavioural messages based on evidence?		
- Abstain (from all sexual activities)		What is the quality of the evidence?		
- Have consensual sex				
- Delay sexual intercourse (and practise other sexual activities)				
- Use contraceptives		Are the behavioural messages explicitly communicated in the intervention?		
- Use a condom each time you have sexual intercourse				
- Avoid having several partners, or sex with people who have several partners				
- Go for HIV and STI testing and treatment				

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Is the intervention clear about what is meant by the behavioural messages? - Condom use (buying, carrying, negotiating, etc.) - Abstinence (from what, up to when)		Are the behavioural messages consistent throughout the intervention?		
Are the messages appropriate to the age, sexual experience, family/community values and culture of the young people for whom the intervention is intended?		Does the intervention pay sufficient attention to the behavioural messages?		
Does the intervention link the behavioural messages with other important values of young people?				

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention address many different determinants of behaviour? - Knowledge - Risk perception - Attitudes - Social influence - Self-efficacy and skills - Intentions - Social influence		Are the objectives for determinants based on evidence?		
		What is the quality of the evidence?		
		Does the intervention primarily focus on determinants that are relevant and can be changed?		
Are these objectives directly linked to the intervention activities and materials, and are they addressed in these?		Are the different determinants sufficiently addressed?		

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

10. Will enough be done to promote a supportive environment?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention address the environmental barriers identified in the needs assessment/situation analysis? This includes community awareness, services, counselling, supplies and advocacy.	______	Are the objectives related to 'supportive environment' based on evidence?	______	______
Does the intervention attempt to raise awareness in the community (among parents) where sexuality education is to be implemented?	______	What is the quality of the evidence?	______	______
Does the intervention provide access to health services, supplies (such as ARVs, condoms and other contraceptives) and counselling.	______			______
Does the intervention include advocacy and lobbying for sexuality education in general and the programme in particular.	______			______

11. Is the intervention based on a holistic approach?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention use a rights-based approach?	______	How do you rate the extent to which this was done?	______	______
Are both females and males involved in intervention design?	______	Are they both equally involved?	______	______
Does the intervention address the equal rights of males and females?	______	Is this well included?	______	______

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Is HIV/AIDS prevention integrated into the broader scope of SRHR education?		How do you rate the extent to which this was done?		
Does the intervention provide information about all relevant preventive sexual behaviour of young people (including delaying sexual intercourse, abstinence from sex, and condom use)?		Is the information complete, and sufficiently explicit?		
Does the intervention include activities that promote an enabling environment for young people and for sexuality education?		How do you rate the extent to which this was done?		
- Supportive legislation/ policies				
- Access to health services/counselling				
- Access to supplies such as condoms, contraceptives				
- Community support				

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

D. Evidence-Based intervention design (step 4)

12. Is the intervention explicit about sexuality?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Is the intervention explicit about sexuality, genitals, contraceptives, condoms, sexual acts and negotiating safe sex?		How do you rate the extent to which this was done?		
How do you rate the extent to which this was done?				
Are young people approached as sexual beings who are able to make their own decisions?				
Is sexuality approached in a positive way?				
Are facilitators encouraged and trained to openly communicate with young people about sexuality and gender in a safe and confidential environment?				

13. Do facilitators create a safe setting for young people to participate?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention start by setting group ground rules?		How do you rate the extent to which this was done?		
Does the intervention use icebreakers or other activities to ease students into discussion/involvement?				
Does the intervention encourage facilitators to provide positive reinforcement when appropriate?				
Does the intervention provide tips or recommendations for classroom management?				

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
If needed and appropriate, does the intervention divide students by gender so that they are more comfortable discussing some topics?		How do you rate the extent to which this was done?		
Does the intervention provide adequate opportunities for all young people to participate?				

14. Does the intervention provide correct and complete information?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Is the information provided in the intervention correct? - Medically correct - Myths and misconceptions are corrected		How do you rate the extent to which this was done?		
Is the information factual (not value-based)? - Are facts and figures provided? - Did you use reliable sources of information?				
Is the information complete (not withholding information) and up to date?				
Is the information tailored to the target group (age,literacygender ethnic background)?				
Is the information provided through active learning/ participatory methods (e.g. small group work)?				
Do the activities help participants to apply the information in their own lives?				

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

15. Does the intervention address risk perception?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention inform young people about their individual risk of STIs, HIV/AIDS, pregnancy, sexual harassment and abuse?	___	How do you rate the extent to which this was done?	___	
Does the intervention clearly inform young people about the negative consequences associated with STIs, HIV/AIDS, pregnancy, sexual harassment and abuse?	___			
Does the intervention include activities that motivate young people to prevent STIs, HIV/AIDS, pregnancy, sexual harassment and abuse?				
- Information on how to prevent it	___			
- Skills building to increase the confidence that they can do something about it	___			
Do the activities encourage young people to actively obtain the risk information? For example, quizzes or small group work	___			
Do the activities help participants to apply risk information to their own lives, by assessing their personal risk and becoming aware of the consequences?	___			

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

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention include activities to help young people understand and develop their own values and attitudes?	___	How do you rate the extent to which this was done?	___	___
Do the intervention activities and materials include persuasive arguments in favour of safe sexual behaviour?	___			___
Does the intervention encourage young people to actively look for information?	___			___
Does the intervention provide information to correct misconceptions about social influences and norms?	___			___
Does the intervention create awareness on negative and social influences, including peer pressure?	___			___
Does the intervention help young people to handle negative social influences, teaching coping skills and assertiveness?	___			___
Are they encouraged to get positive social support?	___			___
Are other target groups also encouraged to understand and develop their values, norms and attitudes? For example facilitators, schools, parents, the community	___			___
Does the intervention use role models to teach the target group how to cope with social influence?	___			___

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

17. Does the intervention include interactive skills training?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Are young people trained in the following skills ?		What is the quality of the skills training?		
- Saying NO: refusing unwanted, unintended or unprotected sex		- Do the participants practise the skills themselves in, for instance, role-play?		
- Insisting on using condoms or contraception		- Is feedback given to participants about their performance?		
- Using condoms correctly		- Does the training start with easier situations and move to more difficult ones?		
- General assertiveness skills (coping with social pressure/norms)				
- Obtaining condoms or contraception; visits with fellow students either to drugstores to locate and price condoms, or to clinics to get information about using reproductive health services				
- Going for STI/HIV testing and treatment				
- Negotiation skills				
- Self-defence and escaping situations of sexual abuse				
Does training for facilitators include skills training?		What is the quality of the skills training?		
- Open communication with young people about sexuality		- Do the participants practise the skills themselves in, for instance, role-play?		
- An interactive approach in teaching, including roleplay		- Is feedback given to participants about their performance?		
		- Does the training start with easier situations and move to more difficult ones?		

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

18. Do young people have access to individual support?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the organisation provide individual support and counselling if necessary? - Is staff trained to provide this support in the area of SRHR?		Is the support and counsel-ling of good quality?		
Is there a good system in place to refer young people to youth-friendly health care providers?		Is it a good-quality system and does it work?		
Does the organisation (or school) have a policy that includes regulations and facilities related to the safety, health and protection of young people?		Has the policy been implemented?		
		Is the policy comprehensive?		

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Does the intervention encourage students to talk about relevant topics to their parents, or other adults they trust, using activities such as homework assignments?		How do you rate its quality?		
Does the intervention provide parents or other adults with information about the programme and relevant topics related to sexuality education and SRHR?				

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

20. Are the topics in the intervention covered in a logical sequence?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Is the intervention structured in a logical way?		How do you rate its quality?		
Are the following topics addressed?		Are they carried out in this (or another) logical sequence?		
1. Self-esteem				
2. Adolescent development				
3. Rights, gender				
4. Sexuality, intimacy, love and relationships				
5. Sexual health problems (STIs, HIV/AIDS, unplanned pregnancy, sexual abuse)				
6. Safe and consensual sexuality				
7. Behaviour to reduce vulnerability, prevention of health risks				
8. Knowledge, values, attitudes and barriers related to this behaviour				
9. Skills needed to perform this behaviour				
10. Support in sexual health problems				
11. Future plans				
12. Sharing lessons learned				

21. Does the intervention appeal to the target group?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Is the intervention (activities and materials) tailored to the specific target group (i.e. consistent with developmental age, language and communication skills, literacy levels)?		How do you rate its quality?		
Is the intervention's form and packaging attractive to young people (clear and vivid pictures, colours and graphs; font & readability of lettering appropriate for the target group?				

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Did you motivate young people to participate in the intervention, by ensuring safety and confidentiality, providing incentives for attendance, and planning a convenient time and place?		How do you rate its quality?		
Is the intervention (activities and materials) attractive and functional for the facilitators (manageable size and weight; resistant and durable; reasonable cost; logic description of all lessons/topics including objectives, lesson outline, how to organise activities, tips and background information)?				

22. Has the intervention been tested?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Was the intervention pre-tested on the following topics? - Whether the young people and implementers liked the activities and found them relevant - How they interpreted these activities - How the activities could be improved		Was it pre-tested with young people and facilitators? How do you rate the quality?		
Were modifications and improvements made after the pre-testing?		To what extent is it possible that the modifications will decrease the impact of the intervention?		
Was the intervention piloted (full implementation on a small scale)?		Was it piloted with young people and facilitators?		
Were modifications and improvements made after the pilot?		How do you rate the quality?		
		To what extent is it possible that the modifications will decrease the impact of the intervention?		

E. Adoption and implementation (step 5)

23. Have you done anything to increase adoption of the intervention?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Did you organise adoption/acceptance activities for the following people?		How do you rate the quality?	______	______
				______
- New facilitators	______			______
- Parents and wider community	______			______
- Management of organisation/school	______			______

24. Is the intervention implemented by appropriate facilitators?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Do the selected facilitators have the following characteristics:		How do you rate the quality?	______	______
- Able to relate to young people and youth-friendly	______			______
- Some experience with SRHR education and comfortable				______
talking about sexuality with young people	______			______
- Motivated to work on the SRHR of young people	______			______
- Able to facilitate and not impose their own norms and values	______			______
- Able to maintain confidentiality	______			______
- Not gender-biased	______			______

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

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Are the facilitators trained to implement the intervention, on topics including young people's SRH, interactive teaching skills, participatory educational techniques, attitude and value understanding and development, content of the intervention, counselling skills		How do you rate its quality?		
Are there support procedures in place?				
- Refresher courses and/or coaching				
- Review/feedback meetings				
- Supervision and monitoring				
- On-the-job support and feedback				

26. Is implementation sustainable?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Did you achieve or are you aiming at sustainability on an implementation level (in a school, in an organisation)?		How do you rate its quality?		
- Are you able to motivate volunteers and keep them involved?				
- Do you plan to obtain sufficient funding and support?				
- Are incentives for the implementers guaranteed (e.g. certificates)?				
Did you integrate or are you aiming to integrate the intervention into governmental policy?				
- Did you get support from the government for your intervention?				
- Is training for facilitators (e.g. teachers) accredited?				
- Was the intervention developed in such a way that it fits into national guidelines/policies?				

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

F. Monitoring & evaluation (step 6)

27. Have you evaluated the change in behavioural determinants (outcome evaluation)?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
Did you measure the change in behavioural determinants? (knowledge, attitudes, risk perception, social influence, self-efficacy, intention)	___	How do you rate the quality of the evaluation?		___
		- Tools, data collection	___	___
		- Reliability	___	___
Did you measure the change in young people's sexual behaviour (short and long term)?	___	- Qualitative/quantitative	___	___

28. Have you monitored the intervention's design and implementation (process evaluation)?

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
To what extent did you measure whether intervention design has the characteristics of effective sexuality education interventions?	___	How do you rate the quality of the evaluation?		___
		- Tools, data collection	___	___
		- Reliability	___	___
To what extent did you measure whether the content, activities and materials has the characteristics of effective sexuality education interventions?	___	- Qualitative/quantitative	___	___

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

Indicators: What	++ + +/– -- x	Indicators: How	++ + +/– -- x	Comments and suggestions for improvement
To what extent did you assess whether the intervention was implemented according to plan?		How do you rate the quality?		
- Was the intervention implemented in the setting for which it was designed?				
- Were all the activities implemented?				
- Were the activities to increase condom use included?				
- Were the activities on sensitive issues (e.g. masturbation and sexual orientation) and all educational methods (such as roleplay) included?				
- Did you find out whether NOT implementing all the activities and educational methods reduces the intervention's effectiveness?				
Did you measure the change in the behaviour (and determinants) of facilitators?				

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

4. BACKGROUND TO THE CHARACTERISTICS

This section provides background information for each of the 28 characteristics in the tool. Most of it is based on evidence – to a large extent derived from reviews by Kirby and his colleagues. Sometimes we've included information that has little or no proof that it works, but is relevant to mention from the perspective of young people's rights.

A. Involvement (step 1)

Interventions that are developed at planners' desks are less likely to be effective than programmes developed by a team of planners in close collaboration with young people, the people who work with them and others who will benefit from the programme and its effects.

1. Are the right people in the project team?
Interventions planned by a team of people with specific expertise in SRHR education for young people are more likely to be effective.[23] Evidence shows that the team involved in intervention planning should consist of people with different backgrounds. 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,

Interventions are preferably 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* (statistics, youth culture)
- *Behaviour change theories* (determinants, behaviour change)

- *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 sexuality with young people and the community in general)

Sometimes one person may have expertise in more than one area, but often several people are involved. In many projects, consultants are called in to do certain tasks. For example, a researcher only does research but is not involved in other stages of intervention design. Or an intervention designer is only involved at the material production stage. This could result in a scattered planning of stand-alone activities. But involving these specialists in all planning stages increases the chance that they fully understand the whole process. And this will raise the quality of the intervention and its implementation.

2. Are young people involved in intervention planning?
Programmes in the HIV/AIDS and SRHR field can involve young people in various ways. Partnerships at a local level could include youth involvement in planning and developing programmes, peer education projects, youth-led clubs and sports teams, and youth-run newspapers. Involvement in advocacy, policy development, governance and evaluation is also seen more and more. The meaningful involvement of young people in all stages of intervention planning is one of young people's rights.[24] There is only limited research on the impact of such efforts, and most of it covers the effectiveness of peer education. More information on this is provided in the background for characteristic 24.

There are a number of examples of studies (in Nigeria, Ghana and Zambia) that show that involving young people in the development of sexuality education (material development and design) has an impact on the sexual behaviour of the target group.[25;26] General evidence shows that involving beneficiaries at all planning stages increases the effectiveness of interventions.[27]

An effective involvement method is to set up a working group of approximately 10 young people (gender-balanced and representative of the target population). They can be involved in the design of the project plan/proposal; as respondents in the needs assessment/situation analysis; during the interpretation of the conclusions of the analysis and in deciding about the objectives; in intervention design (including content, educational methods and pre-testing); and in implementation as peer educators.

The ideal situation is one working group made up of both young people and facilitators. 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.

The 'Youth Participation Guide: Assessment, Planning, and Implementation' by Family Health International provides a lot of useful documents on the subject.[28]

3. Are facilitators involved in intervention planning?
Interventions that are developed together with the people implementing them (e.g. teachers, youth workers, experts, peer educators) are more likely to be implemented according to plan, resulting in more impact on young people.

Involving these facilitators is important. It strengthens their commitment and helps to create an intervention that is attractive to them. It will also ensure that the content, activities and instructions are user-friendly.

One way of involving them is to set up a (preferably) gender-balanced, representative working group of approximately 10 facilitators. They are involved from the start, providing feedback and input at relevant planning stages. This includes the design of the project plan/proposal, as respondents in the needs assessment/situation analysis, during interpretation of the conclusions of the analysis and in deciding about the objectives. Their involvement is particularly important during intervention design (including content, educational methods, and pre-testing), when implementation begins and if the programme is expanded – as trainers of other teachers.

The ideal situation is one working group made up of both facilitators and young people. The facilitators can help the young people contribute in the best way possible once the young people have personally made their needs clear to the facilitators.

4. Are the relevant decision-makers involved in intervention planning?

The global review by Kirby and colleagues showed that a characteristic of effective SRH interventions was that the project staff obtained at least minimal support from appropriate authorities such as Ministries of Health, school districts or community organisations.[29] This support is essential, especially for the long-term success of the intervention. If relevant decision-makers are involved from the start, they are more likely to be committed to the project and feel it is also ‘their’ project, which may prevent obstacles and 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. One of the advantages is that the intervention can then 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, 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).

Another category of decision-makers consists of *community organisations* and leaders who are 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.

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 a national AIDS commission, family planning association, donor organisations, relevant non-governmental organisations (specialised in areas such as sexual abuse, teenage pregnancy or advocacy), health service providers, youth-based organisations, legal advisers and other community organisations.

Involving too many decision-makers, each with their own agendas, could slow down the whole process. So think carefully about who you bring on board.

B. Needs assessment/situation analysis (step 2)

The second step is a needs assessment/situation analysis. In a *needs assessment*, planners assess the needs and assets of the young people themselves. In the *situation analysis*, the values, resources and capacities of their community are analysed. These factors could either help in meeting the needs of young people or be obstacles that need to be overcome.

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.[30] The aim of the assessment is to understand these needs: what is the most important to the young people; on what, how and by whom would they prefer to be educated about sexuality. A better understanding of young people's needs and assets 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 sexual behaviour of young people and the determinants that influence that behaviour. In Chapter 2 we explain a model of behaviour and determinants.

Information (evidence) can be collected from different sources. You'll find it in existing literature and publications or on the Internet. New information can be obtained from focus group discussions, interviews, expert meetings or surveys.

Topics that can be assessed:
- Overall quality of life of young people: what they like most in life; what concerns them most, their major challenges; and the youth culture they live in
- Size of the SRHR problems among young people: HIV/STI rates, teenage pregnancy, abortion, sexual abuse/harassment, stigma and discrimination
- Sexual behaviour of young people: sexual behaviour/abstinence, condom use, number/characteristics of sexual partners, consensual sex, health problem solving/health seeking behaviour
- Personal determinants of behaviour: knowledge/misconceptions, attitude/values/beliefs, risk perception, skills/self-esteem/self-confidence, their perceptions of social influence, peer pressure
- Environmental determinants of behaviour: social norms, laws, availability/affordability of counselling, services and supplies, other external barriers

Equally important as the content of the assessment is the way the data are collected and analysed. This should be done in an 'objective' way: planners should try to find out what is actually happening, not what they would like to see happening. Only selecting the information that is consistent with their own perceptions and values, for example, would not be objective. Some indicators for the quality of the needs assessment are:
- What is the reliability and quality of data?
- To what extent are data applicable to your target group, setting and context?
- Were data collected among representatives of the target group?
- Were data collected among adults who are involved with young people?
- Were the data collected by trained researchers/assistants?
- Were problems encountered in avoiding/negotiating sex and using condoms or contraceptives discussed openly?
- What was the quality of the data collection ?
- Was the data analysis done objectively?
- Was the reporting of the results done objectively?

6. Is the intervention based on a situation analysis?
Evidence[31;32] indicates that interventions are more effective when existing structures, capacities and resources in the community are assessed and used for implementation. The aim of the situation analysis is to get an overview of the community where the intervention is implemented and link this to the broader (national) context of policies and other interventions that exist for young people.

In the situation analysis, planners collect and analyse relevant *laws, policies and regulations* related to young people/adolescents, and particularly related to their sexual and reproductive health and rights (age of consent, gender, HIV/AIDS, sexual abuse, legal age of marriage, abortion, etc.). In the analysis, planners also look at the extent to which this is actually 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, the position of girls and boys, abstinence, marriage, HIV/AIDS, stigma, communication with young people about sexuality, condoms and other contraceptives, sexual orientation, sexual abuse, abortion, pregnancy, and the right of young people to make their own decisions.

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

Fourthly, planners can analyse the *implementation setting* to have a good idea about the opportunities and barriers in adoption and implementation. If the intervention is to be implemented in a school setting, planners can assess the willingness of various people in the school (such as the school administration and others) to adopt the intervention, and look at their knowledge, misconceptions and attitudes. Other factors to look at include the availability of safe and comfortable facilities for implementing the intervention (like a class room), supplies (video equipment, photocopying, markers, flipchart paper, snacks for the young people, pencils, etc.) and trained staff who have enough time.

In addition to general information about the implementation setting, planners can conduct an analysis of the intended *facilitators of SRHR education*: what do they need to be able to implement the intervention? Planners can 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)?

Finally, planners can collect and analyse existing SRHR education interventions (including materials, curricula or specific programmes, IEC materials, training given by other organisations for this particular target group and lessons learned from 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. The quality of information depends on a number of factors, as outlined in the previous characteristic (needs assessment).

C. Objectives (step 3)

Step 3 encourages planners to decide about the objectives of the intervention. They can base their decisions on information gained from the needs assessment/situation analysis (step 2).

7. Are the health goals of the intervention clearly outlined?

What do planners think the intervention should contribute in terms of improved health? For most organisations it's difficult to measure an actual change in the prevalence of HIV/AIDS, STIs, pregnancy, unsafe abortions, stigma and sexual violence as a result of their SRHR education. However, clear health goals can give direction and a framework for the intervention.[33]

Generally, the aim of SRHR education is to reduce young people's vulnerability, and to empower them and promote their health and rights. Looking at the health goals, these can be different for each particular target group and context. Some examples of health goals for SRHR education are:

- Decrease new HIV infections
- Prevent the development of AIDS among people living with HIV
- Increase gender equity
- Decrease the prevalence of gender-based violence, sexual harassment and abuse
- Decrease new STI infections
- Decrease unintended pregnancy
- Decrease the prevalence of unsafe abortions
- Decrease discrimination and stigma related to HIV, sexual orientation, gender
- Increase testing, visits to VCT and health services

SRHR education differs from HIV/AIDS prevention or pregnancy prevention because it links all the health problems related to sexuality and reproduction that young people could face, rather than focusing on isolated issues.

8. Are the behavioural messages for young people clear and consistent?

Providing clear, unambiguous, easy to understand, focused messages about how young people can behave sexually is one of the most important characteristics of effective SRHR/sexuality education programmes.[34] Young people should receive sufficient, correct, up-to-date and consistent information about the options of preventive behaviour, so they are able to make their own decisions related to their sexual behaviour. In Intervention Mapping, these behavioural messages are referred to as health-promoting behaviour.[5]

Clear messages for young people include:

1. Abstain from all sexual activities
2. Have consensual and safe sex
3. Delay your first sexual intercourse by practising other sexual activities
4. Use contraceptives
5. Use a condom each time you have sexual intercourse
6. Avoid having several partners or having sex with people who have several other partners
7. Go for HIV and STI testing and treatment

Programmes that only address the message of abstinence (or delay) among young people don't seem to have any effect on behaviour change. They only have an effect on the attitude to abstinence (or delay).[35;36;37] Comprehensive sexuality education programmes that address both delay and condom use have proved to be effective in delaying sexual intercourse and increasing contraceptive and condom use.[35;38;39]

Behavioural messages are stronger when they make use of information gained from a needs assessment. Putting the right emphasis, for example, on delaying the first time someone has sex, reducing the number of sexual partners or increasing the use of condoms or other contraceptives. The message chosen also depends on 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. This could mean 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'.

Research also indicates that making the behavioural message more specific contributes to a better understanding of the link between risk behaviour and behavioural messages.[5]
In Intervention Mapping, this is referred to as performance objectives, specific actions that together form behaviour. For example, the performance objectives for condom use by young people include 1. Decide to use condoms each time you have sexual intercourse 2. Obtain/buy condoms 3. Always take condoms with you 4. Negotiate condom use with sexual partner 5. Use condoms every time you have sexual intercourse 6. Use condoms correctly 7. Keep on using condoms.[40]

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

Evidence[22;18;41] shows that interventions are more likely to be effective when they address the determinants that are both ***relevant*** (having a distinct impact on behaviour) ***and changeable*** (can be noticeably changed by feasible interventions). No programme can address all the determinants that influence sexual behaviour.

In each context and culture the determinants may be different, but useful examples and overviews of possible determinants[42] of condom use[43;44] and abstinence are given in a number of publications.[45;38]

In Chapter 2 we saw that behaviour is not only determined by a lack of knowledge, but also by many other determinants, such as risk perception, attitudes, social influence, skills and self-efficacy, intention, external factors and the cultural, religious and societal context. So planners should look carefully at their needs assessment and decide which determinants are important and changeable enough to be included in the intervention.

Kirby and his colleagues reviewed many publications and made an overview of the personal and environmental determinants that are generally changeable and important.[46]

10. Will enough be done to promote a supportive environment?

Studies found[21] indicates that creating a safe and supportive environment is a vital part of improving young people's SRHR. The needs assessment/situation analysis provides an overview of the most important environmental barriers and opportunities for addressing young people's SRHR. However, planners are limited in what they can do and may have to decide to focus on a small number of interventions while leaving other people or organisations to address the environmental barriers. Some opportunities for creating a supportive environment for young people are described below.

1. One method is *awareness raising* in the community and among parents. This may result in more support for young people's SRHR and their SRHR/sexuality education. In practice, it may lead to better acceptance of the young people themselves and more help for them. For example, they may be given help in obtaining contraceptives, or in reporting sexual or other forms of abuse to the police. Another aim of awareness raising can be to equip parents with information and skills to help them communicate with their children about sexuality and related topics.

2. One of the environmental barriers for young people relates to *health services, supplies* (such as ARVs, condoms and other contraceptives) and *counselling*. These are either unavailable, too expensive or not youth-friendly.47 If planners are unable to set up an additional intervention to provide or improve services, they may decide to put a system in place to refer young people to service organisations (VCT centres, health clinics, youth centres).

3. Efforts can be made to *stand up for* the rights and health of young people, and to campaign for changes in relevant policies and laws that are barriers to young people's rights and health. Some websites provide more elaborate information on this.[48]

When planners decide to develop interventions to address barriers and opportunities in the environment of young people, they can define behavioural objectives and performance objectives for the people responsible. They can also look at the determinants of these people's behaviour, such as the knowledge, attitudes and skills they need to be able to provide services, change policies or support young people.

11. Is the intervention based on a holistic approach?

Interventions that are based on a holistic approach to young people's sexual and reproductive health and rights are more likely to address the actual needs and problems young people face, and as a result contribute to the effectiveness of sexuality education.

Holistic SRHR interventions consider a number of things at the same time, all of which are described in more detail below: the sexual and reproductive rights of young people, gender, integrating HIV-prevention in the broader scope of SRHR and adolescent development, addressing all the behavioural options for young people, and creating an enabling environment.

1. Holistic interventions use a ***rights-based approach***,[49] meaning that – according to declarations signed by countries all over the world – young people have the right to be who and what they are; to acquire knowledge; to protect themselves and be protected by others; to have access to health services; and to participate in society. An important component of a rights-based approach is the equality of males and females.[50;51;52]

2. Addressing ***gender*** means that where needed and possible, planners approach males and females in an equal way, both in the content and planning of the intervention. They 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.

The intervention *content* can address gender by taking the position and status of girls into account. Education for girls should emphasise that they are capable, powerful and 'can be in control', both generally and more specifically by resisting unwanted or unprotected sex and insisting on condom use. Education for boys should include empathy and skills to 'put themselves in the girl's position' and teach them to 'have self-control', act responsibly and be respectful of girls.

3. The disadvantage of HIV/AIDS-only interventions is that they tend to focus on the risks of unprotected sexual intercourse and are primarily fear-based. When young people only hear about sexuality related to AIDS (something negative), they may get a negative view of sexuality in general. By ***integrating HIV/AIDS education*** into the broader context of SRHR, the intervention is more likely to have a positive approach to sexuality. But there is little evidence showing whether this is more effective than HIV/AIDS education only. And the risk of this kind of approach is that it may be too broad, limiting the intervention's effectiveness.

4. Programmes that only address the *behavioural message* (health-promoting behaviour) of abstinence among young people (including delaying the first sexual intercourse) don't seem to have any effect on behaviour change. They only have an effect on the attitude to abstinence (or delay).[35;36;37] Programmes that address both delay and condom use (comprehensive programmes) have proved to be effective in the promotion of contraceptive and condom use.[35;38;39]

From a rights-based perspective, interventions should encourage young people to make their own decisions with regard to sexuality, providing correct, complete and non-moralistic information about behavioural options.

Evidence from the USA shows that effective programmes state very clearly that young people should not engage in unprotected sex and often present evidence in a biased manner to support that. In a rights-based approach, the behavioural message is that young people should always have 'safe sex' (meaning that they should protect themselves against HIV/AIDS, STIs and unplanned pregnancy), only have consensual sex, and only have sex when they are ready to do so. Evidence shows that programmes that simply give the pros and cons and then let young people decide for themselves are not effective in changing behaviour.

5. In a holistic approach, planners also address external factors, creating an *enabling environment* for implementation and the needs of young people. It may be necessary for planners to address legislation and policy-making, health services and counselling, as well as the availability of supplies such as condoms. In some settings, it is more important to tackle the environmental factors than to provide sexuality education for young people. For example, in one of India's provinces, the government had banned sexuality education. Planners first campaigned for the need for this education, contributing to the removal of the ban, before they could start implementing interventions in schools.

D. Evidence-based intervention design (step 4)

Step 4 incorporates relevant theories and evidence on effective methods and activities plus other ways of increasing the effectiveness of interventions. Interventions may consist of a number of different activities, some of which are provided by other people and organisations.

12. Is the intervention explicit about sexuality?

Effective SRHR interventions are based on explicit communication about sexuality.[2;35;53;54;55;56] Many people think that if you start talking to young people about sexuality and condoms, it 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. It sometimes even leads to a delay in having sexual intercourse (if it is emphasised that not having sex is the best and safest option).

With *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, etc. The topics may vary for each target group. For example, what is relevant for primary school children is not relevant for secondary school students.

The way *young people are approached* in the intervention will determine its success. According to a rights-based approach, sexuality should be discussed in a positive way. It should be something that can be enjoyed by young people and something that is nice.

Young people should be accepted as sexual beings, 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 the right information so that they can make their own choices. And no young person is the same, so they should be approached as a diverse group of unique individuals nd given various relevant options.

When sexuality education is implemented by *facilitators* (youth workers, peer educators or teachers), they may find it difficult to have open, explicit and non-judgemental discussions about sexuality. Proper training and support for facilitators, such as skills training, is therefore essential.

13. Do facilitators create a safe setting for young people to participate?

One of the characteristics of effective interventions in Kirby's review is that they create a safe setting for the young people participating in sexuality education.[57]

By setting *ground rules* for group involvement, facilitators help provide a safe atmosphere. They could decide to develop these rules together with the young people. Some ground rules include
- not making someone look a fool
- not asking judgemental questions
- confidentiality
- respecting the right to refrain from answering questions
- recognising that all questions are legitimate questions
- not interrupting others
- respecting the opinions of others
- views expressed in the group are not talked about outside the group[58]

More ways of making it easier for the students to contribute to discussions and other activities are:
- introducing ice-breakers (doing something that helps people get to know each other so that they immediately start to work well as a group)
- working with same-sex groups for certain topics or the entire intervention
- providing recognition and positive reinforcement
- holding the intervention in a convenient facility or room and at convenient times for young people
- implementing a school health policy with facilities, rules of conduct, and protection related to harassment, abuse and discrimination
- drawing up regulations for interaction between teachers and students and (referral to) friendly youth services and counselling

14. Does the intervention provide correct and complete information?

Providing correct information is not only ethical, but also essential for effectiveness.[59] Some factors that contribute to effective provision of information are given below.

Correct and complete information should be provided, and myths and misconceptions related to sensitive topics such as condoms, masturbation and sexual diversity should be corrected. The information should be *factual* and not value-based: facts and figures should be given, indicating the sources of information. All the information should be *tailored* to the target group, taking into account age, literacy level, ethnic background and gender.

The information should be provided through *active learning* and participation, working in small groups is an excellent way to do that. Theories[60;61] indicate that 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 short lectures, class discussions, small group work, video presentations, stories, role-play, competitive games, worksheets, homework assignments (e.g. talking to parents or friends), drugstore visits, clinic visits, question boxes, hotlines, condom demonstrations, quizzes, etc.

Using participation in a school setting is usually more difficult than outside school. There's often the problem of limited time, and teachers find it difficult to handle their students in interactive/fun approaches, as they're not used to or trained for teaching that way.

Providing correct and complete information doesn't only apply to the interventions targeting young people. It obviously also applies to everyone who is provided with information, such as facilitators, schools, parents, the community and all others participating in intervention activities.

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 (e.g. HIV/AIDS, other STIs, pregnancy, sexual harassment and sexual abuse).[59;62;63] But communicating risk is only effective when it meets certain conditions. Fear-only-based programmes do not work and may even have a harmful effect. By creating fear, people can think that there is nothing they can do, which can result in resignation.

The intervention is 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 HIV, STIs or unintended pregnancy would affect them.

Effective interventions inform young people about their *chances (risks)* of getting STIs or HIV/AIDS or becoming pregnant 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.

Effective SRHR interventions also tell young people about the *negative consequences* associated with STIs, HIV/AIDS and unintended pregnancy, both short-term and long-term. This can be done by encouraging them to think about how they would feel if they heard that they had HIV/AIDS or another STI, or were to become pregnant.[64] This can be done by class discussions or videos with true stories of young people who have HIV/have become pregnant and describe the impact this has on their lives.

In addition to the information about risk, it's very important that the intervention motivates young people to prevent STIs, HIV/AIDS and unintended pregnancy. If this is not done properly, the information may lead to fear and even have a negative effect.[65] Young people should be aware of what they can do to prevent SRH problems (e.g. using condoms, not having sexual intercourse) and they should *feel confident* that they can actually do that.[66] Skills-building activities are an effective way of increasing confidence.

16. Does the intervention help people understand and develop their own attitudes, values and awareness of social influence?
Interventions that help people understand and develop their own values and attitudes, and give information about the influence and norms or others, are more likely to be effective.[59] Attitudes and norms are important behavioural determinants, but also difficult to change. It's a long process, as people's own values and norms are often very much a part of their social environment. It is difficult for people to stick to their own values if these 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.

1. *Understanding and developmen*t of personal values and attitudes can be encouraged by planners through a variety of activities, for example:

- Group discussions about the advantages and disadvantages of, for instance, having sexual intercourse, or using a condom during sexual intercourse
- Debates in which people have to defend opposing views on the above-mentioned topics
- Interactive theatre, with the audience having roles in a play
- Brainstorming with participants about how to avoid or escape situations that may lead to sexual intercourse, or true-life stories by role models

2. Attitudes can be changed by providing people with *persuasive arguments*.[60] This means that the intervention should emphasise the reasons for delaying, abstaining, using a condom, and always having consensual sex. Talking about the short-term consequences is more likely to have an impact than talking about the long-term consequences. For example, becoming pregnant after having unprotected sexual intercourse can be more relevant to young people than the long-term consequence of getting HIV/AIDS. Arguments are also more likely to be persuasive if they reflect the views and values of the specific target group, acknowledging the negative side of something. For example, people may see the disadvantages of using a condom during sexual intercourse. They'll say that condoms are difficult and embarrassing to get and have with you when you need them. And that they find it awkward to talk to a sexual partner about sex and condoms. Then using a condom isn't easy and there's the loss of sensation it causes. An intervention should acknowledge these negative aspects, but also stress that the advantages are more important (e.g. health, education, planning for the future).

3. The intervention is more likely to 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.

4. When planners address *social influence*, they need to address both its actual components and the way it is perceived by the target group. They should give information about the social influence itself (community norms, social pressure), while correcting misperceptions and giving people 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. So the young people can be provided with this factual information to correct misperceptions.[19]

5. Another effective way of addressing social norms and influence is the use of positive role models – examples that people can identify with, and who 'model' the way of coping with social norms and social pressure. This is called *modelling*.[19]

Encouraging people to understand their own values, norms, attitudes and the way they perceive the influence of others doesn't only apply to the interventions targeting young people. It obviously also applies to everyone who is provided with information, such as facilitators, schools, parents, the community and all others participating in intervention activities. Teachers in particular should be made aware of their own perceptions and ideas. This could be done with a session on personal values during a facilitator training.

17. Does the intervention include interactive skills training?

Skills training is one of the most important components of effective SRHR education.[59] Skills that are the most important for young people to acquire include:
- saying NO: refusing unwanted, unintended or unprotected sex
- insisting on using condoms or contraception
- using condoms correctly
- general assertiveness skills (coping with social pressure/ norms[19])
- obtaining condoms or contraception; visits with fellow students either to drugstores to locate and price condoms or to clinics to get information about using reproductive health services
- going for STI/HIV testing and treatment
- negotiation skills
- self-defence and escaping situations of sexual abuse

There are different ways to train skills. The most effective method is through role-play following these steps:
1. Start with easier situations, moving to increasingly difficult situations
2. Describe components of the skills verbally
3. Model them in role-play (created by the facilitator or from a video or modelling story in printed materials), starting with easy situations and then going to increasingly difficult situations
4. Provide individual practice through role-play in groups of two to four in which everyone practises, for example, avoiding unwanted sex or insisting on using condoms
5. Feedback by facilitator and/or other young people
6. Practising in real-life situations (e.g. buying a condom in a drugstore)

Facilitators (especially teachers) sometimes find it difficult to implement role-play activities in a group of young people. An alternative is to use modelling[37] or guided acting to train skills, by inviting a good role model with whom students can identify using a video play or using role model stories in printed materials.

Skills building should also be one of the most important activities in training for facilitators. Important skills for them include open, non-judgemental communication with young people about sexuality, and how to use an interactive 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.[67]
When young people are provided with SRHR education, this may lead to earlier recognition of individual problems (related to adolescent development or to HIV/AIDS, STIs, pregnancy, sexual abuse and harassment, or stigma) and more awareness of the need to seek help.

Implementing organisations or schools should therefore be prepared to provide individual support, for example counselling. This means that they should have trained staff who are able to provide the support in a youth-friendly way or are able to refer the young person to a professional health care provider or counsellor outside the school or organisation. They should have a referral system in place with the names of people and where to find them, for example youth centres, health centres, testing centres and individual counsellors.

The services and the referral system can be part of a wider health policy. This policy should also include regulations and facilities within the organisation or school regarding the protection of young people's SRHR. There should be rules on not tolerating stigma, harassment, abuse or discrimination of, for instance, gender, ethnic background, religion, sexual orientation or HIV/AIDS.

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

When planners develop interventions for young people, parents and other adults or extended family should be involved too. This increases the effectiveness of the intervention.[2]

Involvement could range from very intense (e.g. discussions, training) to less intense (e.g. information in leaflets or letters), depending on the context and openness about sexuality. Sometimes it's necessary to gain consent from the parents before young people may participate in sexuality education lessons.

One way of increasing communication between parents (or other adults) and young people is, for example, homework assignments which encourage a young person to talk to their parents, and other adults they trust, about the SRHR programme or specific topics.

In addition, planners can provide parents and other adults with information about adolescent sexual behaviour and relevant topics such as pregnancy, STIs, HIV/AIDS, stigma and discrimination, and sexual abuse and harassment. This can be done during events, discussions, workshops or training.

20. Are the topics in the intervention covered in a logical sequence?

Part of a programme's effectiveness involves its presentation of activities and materials. Often, interventions 1) enhance someone's motivation to avoid HIV, other STIs and pregnancy by emphasising their susceptibility and how serious the matter is. 2) Give a clear message about the behaviour needed to reduce the risks and 3) address the knowledge, attitudes and skills, needed to change this behaviour.

The sequence may vary in different contexts and depends on the content of the intervention. An example of a logical sequence of topics in comprehensive SRHR education is:[2;68;69]

1. Self-esteem, as a basis for learning to make your own decisions. However, there is strong evidence that self-esteem is hard to change and requires very different kinds of programmes than the usual sexuality education; for example, training teachers to teach very differently, and courses on parenting skills. There is no consistent link shown in evidence between self-esteem and sexual risk-taking.
2. Adolescent development:
   a. Physical changes (e.g. menstruation, masturbation)
   b. Emotional changes
   c. Psycho-social changes (e.g. relationship with parents, friends, peers)
3. Explanation of rights that empower young people to make their own decisions, including gender, culture, relationships and social support
4. Sexuality (sexual practices, sexuality and pleasure, intimacy, love and relationships)
5. Sexual health problems (basic information about HIV, living with AIDS, other STIs, pregnancy and abortion; why you are susceptible and how serious the problem is)
6. Safe and consensual sexuality (sexual harassment and abuse)
7. Behaviour to reduce vulnerability and prevent health risks (abstinence, delaying sexual intercourse, condom use, contraception use)
8. Knowledge, values, attitudes and barriers related to this behaviour
9. Skills needed to perform this behaviour
10. Support in sexual health problems (in their own environment, professional support such as counselling, testing, care, references for further support)
11. Future plans, including young people making a commitment to remain faithful to their decisions about what they want to do and not do sexually
12. Sharing lessons learned

Some SRHR interventions specifically address stress management or use of alcohol and drugs. Usually it is more difficult in settings outside schools to implement a very structured intervention, as young people may drop in and out whenever they like.

21. Does the intervention appeal to the target group?
An important characteristic of effective interventions is that they appeal to the target group. If an intervention is tailored to a specific group, it's more likely to be attractive, functional and, as a result, more effective.[70] In this tool we look at the attractiveness of materials and activities for young people as well as the attractiveness and functionality of the materials and activities for facilitators (teachers, peer educators, youth workers). How appealing an intervention is, depends on a number of factors.

1. 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.

2. The *form and packaging* of the education should be appealing:
- Attractive presentation of material (clear, vivid, pictures, graphs)
- Content and examples relevant to the target group

For print materials (brochures, leaflets, workbooks):
- Images, colours, graphs, etc. appropriate to the target group
- Pictures, graphs, etc. not racist, sexist, homophobic, coercive or judgmental; gender-sensitive and sensitive to the values and culture of the target group
- Font and readability of lettering appropriate to the target group

For video materials:
- Pictures, colours, setting and role models attractive to the target group

3. Planners may have to avoid or overcome ***obstacles to young people's attendance***. For example, to be able to recruit young people, they may have to notify their parents, provide transportation, implement activities at convenient times, and ensure confidentiality and safety. Although this characteristic may be obvious, there are many reported examples which very few young people chose to participate in voluntary SRHR education programme, so that programmes were not effective.[2]

4. Whether the intervention is ***attractive to facilitators*** depends on a number of factors in addition to the above-mentioned:
- 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 logically described in a facilitator's manual for each lesson or topic (outlining objectives, 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 finally approved for use.[71;72] 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, gender-balanced) and a few facilitators. They provide feedback about what works and what doesn't and whether they liked 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 strongest 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 the facilitators for a certain period of time. For instance, all the lessons and sessions of a SRHR curriculum are given in schools during one school year. Planners (and donor agencies) tend to immediately start with full-scale implementation once the definite intervention materials have been produced. Evidence, however, shows that piloting the intervention on a relatively small scale (e.g. in three schools or youth centres) gives a good opportunity to closely monitor and evaluate the implementation process and adapt the intervention if necessary.

E. Adoption and implementation (step 5)

Intervention Mapping step 5 addresses adoption (by facilitators or organisations) and implementation (actual use of the intervention). In other words: what should be done to make sure that the facilitators are willing and able to implement the intervention materials and activities?

23. Have you done anything 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 facilitators who are supposed to implement them.[29;73] Based on the situation analysis, planners may decide to first arrange special activities to overcome any barriers for adoption.

1. The most important group to approach with adoption activities are ***new facilitators*** (both in schools and outside school). They may well need to be convinced that it's important that they give sexuality education. Saying that the programme is effective might not be convincing enough. The fact that it will help them develop a better relationship with the young people concerned may be a more convincing reason for them to adopt it. But this may vary, depending on the cultural context.

2. Another important group of adopters may be the ***parents*** (and wider community), both for in school and outside school settings. Planners could decide to provide them with information about the intervention through printed materials or meetings.

3. One of the adopters of SRHR education in schools is the ***school management*** and board. Planners could organise meetings or personal interactions with the decision-makers at the school to convince them that they should adopt the intervention. It is important to first assess the advantages and disadvantages as seen by these people to be able to come up with persuasive arguments.

24. Is the intervention implemented by appropriate facilitators?

Selection of facilitators is critical for effective implementation.[2] Desirable characteristics for implementing SRHR education for young people include:
- Ability to relate to young people and be youth friendly[74]
- Some experience with 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

Evidence shows that matching the young people's race/ethnic background or gender with that of the educators does not have a significant impact on behaviour change[75] and that the age of the educators (adult-taught or peer-taught sexuality and HIV/AIDS education) has no influence on the effectiveness of the intervention.[76;77;78]

A number of sexuality education programmes are implemented by peer educators.[79;80] Some researchers have concluded that peer education interventions tend to influence the behaviour of small numbers of peer educators, but not necessarily that of the target groups. These interventions are therefore not cost-effective enough to justify implementation on a large scale. Peer education only works under certain conditions, such as with extensive support, training and follow-up.

In many settings it's difficult to find facilitators that have the desirable characteristics. Training and support for facilitators is then particularly important.

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 enable them to do so as intended by the planners.[58;81;82]

Not implementing all the activities, or implementing the intervention in a different type of setting (e.g. during school instead of after school) may reduce effectiveness.[82] Interventions are less likely to be effective if they are shortened considerably, and activities that focus on increasing condom use are left out.[82]

1. Minimal ***training*** for facilitators to implement SRHR education includes:
- Young people's SRHR
- Interactive teaching skills, participatory educational techniques and non-judgmental and open communication with young people
- Understanding attitudes and values (e.g. no gender bias) and communication skills for talking about sexuality
- Carrying out some of the more difficult activities in the intervention
- Confidence-building for implementation of the intervention activities
- Becoming familiar with the content of the intervention and convinced that all activities need to be implemented as planned

2. One week's training usually isn't enough for implementing the intervention, especially for facilitators who are doing it for the first time. In addition to the training, they should be ***supported*** in other ways. This could include refresher courses, review/feedback meetings (sharing experiences and solving common challenges), individual supervision and monitoring, and on-the-job support and feedback.

26. Is implementation sustainable?
Most planners aim to make implementation of the intervention sustainable. 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 other settings and target groups.

1. 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 main programme and policy of the organisation, with particular incentives for the facilitators (e.g. certificates) and funds allocated to implementation. Sustainable implementation of SRHR interventions often depends on voluntary contributions from organisations and facilitators. There should then be sufficient incentives for them to continue participation. Implementing the intervention on a wider scale often means a certain loss of control and, possibly, effectiveness.

2. Another way of making an SRHR intervention sustainable is by making it part of a general national/regional/organisational programme. The support and involvement of relevant decision-makers is then important.29 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. Also, lobbying may be needed to get the intervention included in mainstream programmes.

F. Monitoring & evaluation (step 6)

The final step in intervention planning is monitoring and evaluation. The two characteristics that give insight into the effectiveness of SRHR education are an outcome evaluation and a process evaluation. In an outcome evaluation, planners measure change among the target population as a result of the intervention. With process evaluation, they evaluate the intervention's development and implementation. Process evaluation relates to monitoring.

27. Have you evaluated the change in behavioural determinants (outcome evaluation)?
In SRHR education, one of the challenges is to measure the changes that are created as a result of the intervention. For small organisations that are not specialised in research, it's almost impossible to measure whether the intervention has improved health (e.g. less HIV or STI infections or teenage pregnancy). This is usually done as part of more extensive research. And if particular health problems are decreasing, it's still difficult to identify the exact contribution of the intervention to the outcome.[5]

Systematic, evidence-based planning of interventions can, however, predict effectiveness. For instance, if the needs assessment is of good quality (identifying behavioural and environmental factors plus their determinants), AND if these needs are sufficiently addressed in the intervention, there is a greater chance of a change in people's behaviour.

Measuring behaviour change is difficult, especially with limited resources and in the short term. One way is to measure change in behavioural determinants. 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 1000) and a comparison group that didn't participate in the intervention is included in the study (another 1000 students).

28. Did you monitor the intervention's design and implementation (process evaluation)?

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.[5] A process evaluation can provide valuable information that can be used to improve implementation (e.g. training for facilitators and support), which may result in increased effectiveness.

Process evaluation can be conducted to address the following categories of information:

- Design: extent to which intervention design meets effectiveness characteristics
- Content: extent to which the content of the intervention meets effectiveness characteristics
- Implementation: assess whether all stages of implementation are optimally performed
  - Number of young people that completed the intervention and reasons for dropping out
  - Training for facilitators, their teaching behaviour and determinants
  - Actual implementation of the intervention activities by facilitators (did they implement all activities as designed, and if not, why not?)

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

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Organisations worldwide have designed programmes to address Sexual and Reproductive Health and Rights (SRHR) needs of young people, including HIV/AIDS, STIs, teenage pregnancies, gender inequality and discrimination. Developing effective programmes is not easy. Experience and evidence gained from work done all over the world shows what does contribute to quality and what doesn't.

This planning and support tool provides the most important evidence, in a way that is useful for organisations who are working in the day-to-day practice of SRHR education for young people but have limited time and resources. The tool can be used to plan new interventions, but also to analyse existing interventions.

The Intervention Mapping model, a model for systematic planning of health interventions, as well as a behaviour change model are explained and are key aspects of the tool.

The evidence is documented in a checklist with 28 characteristics, with questions such as 'are young people involved in the planning of the intervention?'; 'do facilitators create a safe setting for young people to participate?'; 'does the intervention include interactive skills training?'.

The tool was developed together with experts in sexuality education for young people and with organisations in Pakistan and South Africa.