The World Health Organization's

INFORMATION SERIES ON SCHOOL HEALTH DOCUMENT 8

Family Life, Reproductive Health, and Population Education:

Key Elements of a Health-Promoting School

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This document is part of the WHO Information Series on School Health. Each document in this series provides arguments that can be used to gain support for addressing important health issues in schools. Each document illustrates how selected health issues can serve as entry points in planning, implementing, and evaluating health interventions as part of the development of a Health-Promoting School.

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- Local Action: Creating Health-Promoting Schools (WHO/NMH/HPS/00.4)
- Strengthening Interventions to Reduce Helminth Infections: An Entry Point for the Development of Health-Promoting Schools (WHO/HPR/HEP/96.10)
- Violence Prevention: An Important Element of a Health-Promoting School (WHO/HPR/HEP/98.2)
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AIDS	Acquired Immune Deficiency Syndrome
EFA	Education for All
FLE	Family Life Education
FRESH	Focusing Resources on Effective School Health
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
NGO	Non-Governmental Organization
PopEd	Population Education
SRH	Sexual and Reproductive Health
STI/STD	Sexually Transmitted Infections/Sexually Transmitted Diseases
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

FOREWORD

This document is part of the WHO Information Series on School Health prepared for WHO's Global School Health Initiative. Its purpose is to strengthen efforts to educate young people about family life, reproductive health, and population issues and to prevent related health problems, such as unintended and early pregnancies, HIV/STI, and sexual violence. In school, young people learn about sexuality in informal as well as formal ways. Therefore, we must ensure that our formal sources of learning provide accurate information that can enable young people to care for themselves, both now and in the future.

WHO's Global School Health Initiative is a concerted effort by international organisations to help schools improve the health of students, staff, parents, and community members. Education and health agencies are encouraged to use this document to take important steps that can help their schools become "Health-Promoting Schools." Although definitions will vary, depending on need and circumstance, a Health-Promoting School can be characterized as a school *"constantly strengthening its capacity as a healthy setting for living, learning and working"* (see the Health-Promoting School box on the following page).

At the World Education Forum in Dakar, Senegal, April 2000, held on occasion of the tenth anniversary of the Education for All (EFA) movement and after a global EFA assessment, WHO, UNICEF, UNESCO, and the World Bank launched an initiative to work together to Focus Resources on Effective School Health (the FRESH Initiative). In doing so, they are helping schools become both "Child-Friendly Schools" – schools that provide a learning environment that is friendly and welcoming to children, healthy for children, effective with children, and protective of children – and "Health-Promoting Schools". Education and health agencies are encouraged to use this document to strengthen family life, reproductive health, and population education in support of the FRESH Initiative and Education for All.

The extent to which each nation's schools become Health-Promoting Schools will play a significant role in determining whether the next generation is educated and healthy. Education and health support and enhance each other. Neither is possible alone.

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A HEALTH-PROMOTING SCHOOL:

- Fosters health and learning with all measures at its disposal
- Engages health and education officials, teachers, students, parents, and community leaders in efforts to promote health
- Strives to provide a healthy environment, skills-based health education, and school health services along with school/community projects and outreach, health promotion for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support, and mental health promotion
- Implements policies, practices, and other measures that respect an individual's self-esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements
- Strives to improve the health of school personnel, families, and community members as well as students, and works with community leaders to help them understand how the community contributes to health and education.

In addition to these general characteristics of Health-Promoting Schools, WHO Regional Offices have engaged their member states in developing regional guidelines and criteria for Health-Promoting Schools and other school health efforts. Please contact your WHO Regional Office to obtain these. For contact information of Regional Offices, you may consult the WHO Internet site (http://www.who.int) or communicate with any of these Regional Offices:

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1. INTRODUCTION

FACTS

- *Most young people start sexual activity before age 20. Studies from Africa indicate that sexual initiation of girls sometimes occurs before menarche.*
- *Fifteen million adolescents around the world give birth each year, accounting for one-fifth of all births.*
- *Contraceptive use among adolescents is very low; for example, the rate in India is 7%, and in Pakistan it is 5%.*
- *Children and young people around the world are victims of sexual exploitation for commercial gain.*
- *Girls continue to be subjected to genital mutilation; in some sub-Saharan African countries, as many as 98% of girls experience this trauma.*
- *In some societies, social pressures and norms about boys' sexual initiation involves contact with prostitutes.*
- *Sixty percent of all new HIV infections in developing countries occur among 10–24 year olds–(UNESCO/UNFPA. 1998a).*

Young people all over the world have common needs in order to achieve full and healthy development: a positive and stable family life; an understanding about their bodies, including the emotional and physical capacities that enable them to have sexual relations and reproduce; an awareness of population issues and how these issues will affect them; and the knowledge and skills to deal with these matters responsibly, now and in the future. With these assets, young people are more likely to succeed in school, have quality of life and relationships, and contribute to the economy and productivity of their countries. Without them, they face interrupted schooling, personal insecurities, ill health, and diminished economic opportunity.

This document focuses on a range of family life, reproductive health, and population issues, and how they can be integrated into the components of a Health-Promoting School to improve the overall health, education, and development of children, families, and community members.

This document makes the assumption that in almost every school there are boys and girls who:

- have inadequate understanding of the emotions and physiology of the human body and would benefit from preparation for social and emotional relationships, marriage, parenthood and adulthood
- have not engaged in sexual intercourse
- are currently engaging in sexual relations
- have engaged in sexual relations but have stopped
- are forced to engage in sexual relations (e.g., have been raped or forced by adults or peers to engage in sex in exchange for money or other favours)

School personnel need to provide a range of information, skills, and support for all of these students, enabling them to deal with concerns and issues they may face now or in the future.

1.1. CULTURAL SENSITIVITY

Any discussion of family life, reproductive health, and population issues must begin with the acknowledgement that cultural norms and religion, social structures, school environments, and economic factors vary widely around the world and will affect the way that a school and community address these issues. Rural schools may face additional challenges such as limited resources and access to information. The strategies determined appropriate for use in a Health-Promoting School are likely to reflect the beliefs, capacities, and setting of the local population and will vary from community to community.

This document attempts to provide comprehensive information to be used across cultures. School staff in various communities can adapt strategies that recognize religious beliefs, social norms, cultural values, and behavioural practices. When translating this document and its concepts into other languages, it is therefore important to find terms and examples that take into account a particular culture and its religious beliefs. We understand that one document cannot fully address the different cultural needs and issues of all of its readers. However, the examples in this document address a variety of cultural values and practices. They can trigger discussion in addition to providing theoretical concepts and practical technical information. While the concepts introduced in this document apply to all countries, some of the examples might be more relevant to some countries and cultures than others.

1.2 WHY DID WHO PREPARE THIS DOCUMENT?

The World Health Organization (WHO) has prepared this document to help people make a case for school-based efforts to address and improve family life, reproductive health, and population education, and to plan, implement, and evaluate school-based efforts as part of the development of a Health-Promoting School.

1.3 WHO SHOULD READ THIS DOCUMENT?

This document is for people who are interested in advocating for and initiating school-based efforts related to family life, reproductive health, population issues, and health promotion, including:

- Governmental policy- and decision-makers, programme planners, and coordinators at local, district, provincial, and national levels, especially those from agencies in the areas of health, education, population, religion, women, youth, community, and social welfare

- Members of non-governmental institutions and other organisations responsible for planning and implementing programs described in this document, including programme staff and consultants of national and international health, education, and development agencies who are interested in promoting health through schools

- **Community leaders and other community members,** such as local residents, religious leaders, media representatives, health care providers, social workers, development assistants, and members of organised groups, including youth groups and women's groups interested in improving health, education, and well-being in the school and community

- **Members of the school community,** including teachers, parents and students and their representative organisations, administrators, staff, and school-based service workers

1.4 WHAT IS MEANT BY FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION?

Family life, reproductive health, and population education are interrelated. While each one has a specific focus, they also overlap.

Family life education is defined by the International Planned Parenthood Federation (IPPF) as "an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, [and] ageing, as well as their social relationships in the socio-cultural context of the family and society" (IPPF, 1985).

Reproductive health education is described by UNESCO/UNFPA as educational experiences" aimed at developing capacity of adolescents to understand their sexuality in the context of biological, psychological, socio-cultural and reproductive dimensions and to acquire skills in managing responsible decisions and actions with regard to sexual and reproductive health behaviour" (UNESCO/UNFPA, 1998b).

Population education is defined by UNFPA as "the process of helping people understand the nature, causes and implications of population processes as they affect, and are affected by, individuals, families, communities and nations. It focuses on family and individual decisions influencing population change at the micro level, as well as on broad demographic changes" (Sikes, 1993). Population education addresses such issues as rapid population growth and scarce resources as well as population decline in light of increasingly elderly populations.

1.5 WHY SHOULD SCHOOLS ADDRESS FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION?

The number of young people today is the largest ever: 1.7 billion people are between ages 10 and 24 years (UN, 1998)—most of them living in Asia, Africa, or Latin America, and the majority of them attending schools. In some countries, the age at first intercourse is decreasing. The health and reproductive health behaviour of young people will have both immediate and long-term consequences. Most societies share a vision for their children: that they will reach adulthood without early pregnancy, finish their education, delay initiation of sexual activity until they are physically, socially and emotionally mature, and avoid HIV infection and other STI.

When schools do not address family life, reproductive health, and population issues, they miss an opportunity to positively affect students' education, quality of life and relationships, and ultimately the economy and productivity of nations. For example, pregnant girls often drop out of school to care for and support their babies. Without a school diploma, adolescent parents are often not qualified for jobs—or can get only low-paying jobs, which do not adequately support the family.

1.6 HOW WILL THIS DOCUMENT HELP PEOPLE PROMOTE FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION?

Family life, reproductive health, and population education can be addressed within the context of Health-Promoting Schools, based on principles and actions that were identified in the *Ottawa Charter for Health Promotion* (WHO, 1986). That charter recommended actions in five key realms (which are detailed in this document):

1. Create Healthy Public Policy at the local, district, and national levels.

2. Develop Supportive Environments, including the physical and psychosocial school environment.

3. Reorient Health Services to address issues of family life, reproductive health, population issues, and other school health promotion efforts.

4. Develop Personal Skills needed for creating a healthy family life, developing and maintaining reproductive health, and understanding population issues that affect communities and nations.

5. Mobilize Community Action to engage the school and community in efforts that call attention to current challenges related to family life, reproductive health, and population issues.

1.7 HOW SHOULD THIS DOCUMENT BE USED?

This document can be used for advocacy efforts to make a strong case for addressing family life, reproductive health, and population issues through schools. The content of Section 2 in particular is relevant to creating arguments for such interventions in schools. Subsequent Sections 3 through 6 give an overview of how these interventions and training can be planned, implemented, and evaluated while at the same time creating or expanding a Health-Promoting School.

This document can be used in conjunction with the WHO document *Local Action: Creating Health-Promoting Schools*, a practical "how to" guide for work at the local level. It includes tools and tips from Health-Promoting Schools around the world and can help tailor efforts to the needs of specific communities. Other pertinent references are listed in Annex 1.

2. CONVINCING OTHERS THAT FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION THROUGH SCHOOLS ARE IMPORTANT AND EFFECTIVE FOR PUBLIC HEALTH AND PERSONAL DEVELOPMENT

Policy-makers need good reasons to increase support for any health or education effort. They must be able to justify their decisions. Advocacy is the art of influencing others to support an idea, principle, or programme. An advocate for family life, reproductive health, and population issues must convince school policy- and decision-makers and communities that school-based efforts are appropriate and doable and that these efforts can help reach the goals we all share for young people. Annex 1 includes references to handbooks that offer guidance on advocacy efforts.

The practical benefits of greater investment in family life, reproductive health, and population education include a variety of *individual and public health benefits:*

- Delayed initiation of sex
- Reduced unplanned and too-early pregnancies and their complications
- Fewer unwanted children
- Reduced risk of sexual abuse
- Greater completion of education and later marriages
- Reduced recourse to abortion and the consequences of unsafe abortion
- Slower spread of sexually transmitted diseases, including HIV/AIDS.

Social development benefits:

- Progress towards gender equity, social participation and grassroots partnerships for development
- Better preparation of young people for responsibility now and as adults, and skills development to facilitate response to social change and opportunity
- Stronger primary health care systems with emphasis on health promotion
- Stronger, more relevant education systems

(Adapted from UN, 2000)

Though the needs for family life, reproductive health, and population education are many and the benefits are great, advocates may still have to explain the background and advantage of these programs. For example:

- Government officials may need to convince their supervisors or ministers that these programs are cost-effective and will work (see Arguments 2.2.2, 2.3.1, 2.3.2 and 2.3.3).
- NGOs and professional organisations may need to persuade elected officials that these are pressing issues that need to be addressed (see Arguments 2.1.2, 2.1.3, 2.1.4., 2.1.5, 2.1.6, and 2.1.8).
- School administrators and teachers may need to convince parents, families, community members, and religious leaders that schools can address these issues in an appropriate and effective way that does not lead to promiscuity (see Arguments 2.1.1, 2.2.1, 2.2.3, 2.2.4, 2.2.5, 2.3.1, and 2.3.2).

Explanations are often most effective when they include examples that are culturally appropriate and relevant to specific local situations; thus, the arguments below may need to be modified to suit local needs.

It is also important to consider the inter-relatedness of behaviour: individuals that engage in one kind of risk behaviour such as early sexual activity are also more likely to engage in other risk behaviour such as tobacco and drug use or violence. Thus, addressing one risk behaviour may also have positive influence on other risk behaviours. Providing a safe and supportive environment can also help prevent or decrease the chance of young people engaging in behaviours that are not conducive to health.

2.1 BENEFITS TO PUBLIC HEALTH AND PERSONAL DEVELOPMENT

2.1.1 Argument: Adolescence is a critical period of development with dramatic physical and emotional changes that affect young people's health

All adolescents[1] (youth ages 10–19) experience profound physical changes, rapid growth and development, and sexual maturation—often about the same time as they begin developing new relationships and intimacy. For many young people, adolescence is the time when they have their first sexual experience. In addition, young people experience psychological and social changes as they develop attitudes; abstract and critical thinking skills; a heightened sense of self-awareness; responsibility and emotional independence; communication patterns; and behaviours related to interpersonal relationships (Weiss et al., 1996; WHO, 1998b).

2.1.2 Argument: Adolescents need reliable information as they deal with new experiences and developments

Adolescents need to know what is happening to their bodies, for instance, when they experience menstruation or wet dreams. Many girls may have questions about how to manage their period or concerns about losing their virginity (Mensch et al., 1998). Boys may be concerned about consequences of masturbation, body image and size of their genitals, sexually transmitted infections, and sexual orientation (Kamil).

Limited knowledge about sexuality and relationships and their implications leave adolescents vulnerable to increased risks from pregnancy, sexual exploitation, and violence (UN, 2000). For instance, in Mexico, most 12 to19-year-old females did not know about the menstrual cycle or how one becomes pregnant (Pick de Weiss et al., 1991).

Media influences may sometimes convey a distorted view of sexual activity. In a variety of media, the "prevailing images imply that sex is risk-free [and] widespread and that planning interferes with romance" (Strasburger, 1993). Such media influences may lead adolescents to overestimate the extent to which other adolescents engage in sexual activities.

[1] Adolescence is a cultural construct that varies across settings and contexts. In some languages and societies, especially in traditional societies, this concept is non-existent (Villarreal, 1998).

2. CONVINCING OTHERS THAT FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION THROUGH SCHOOLS ARE IMPORTANT AND EFFECTIVE FOR PUBLIC HEALTH AND PERSONAL DEVELOPMENT

2.1.3 Argument: Many young people are sexually active, not always by their own choice

About one-fifth of the world's population, more than one billion, are adolescents (JHU/CCP, 1999). Millions of these young people are sexually active. World-wide, the age of menarche, and in some countries the age of first intercourse, is declining, and the proportion of adolescents having sex is increasing (Baldo, 1995; McCauley et al., 1995). Studies suggest that the age of sexual debut is as low as 9–13 years for boys and 11–14 years for girls in a number of developing countries (WHO, 1999b). While much of this sexual activity is pre-marital, large numbers of adolescents in developing countries are married or in similar forms of unions and also face the consequences of early sexual activity.

Both boys and girls are increasingly victims of sexual exploitation, and much sexual activity during adolescence is coerced, not consensual. This includes physical and psychological abuse, sexual harassment, sexual assault, rape, forced prostitution, and the threat of violence if contraceptive use is suggested (Kirby, 1994). Sexual exploitation may occur with family members or adults in privileged positions (UN, 2000). A study of 128 adolescents in Peru and 108 in Colombia found that 60% had been sexually abused in the previous year. Thirty-nine of the adolescent girls were pregnant as a result (Stewart et al., 1996). Studies in Africa, Asia and the Pacific, Latin America, and the Caribbean indicate that adolescent sexual experiences may be driven by economic gain for paid sex (Weiss et al., 1996). A study in the Philippines found that 3% of all students, and 10% of those who were currently sexually active, were involved in prostitution. The main reason given for this was the high cost of college education (UNDP/UNFPA/WHO/World Bank, 1997). Among girls, the early initiation of sexual activity is more likely to be associated with coercion, exploitation, and violence than among boys (Mahler, 1997). A survey of six countries showed that 36–62% of victims of sex crimes were adolescent girls under the age of 15 (WHO, 1997b).

Across cultures, a defining trait of masculinity is sexual activity. Adolescent boys in Costa Rica, for example, were likely to be motivated by peer pressure to be sexually active, while adolescent girls tended to give in to their boyfriend's insistence for fear of losing him (Villarreal, 1998). In addition, gender based double standards and perceptions of normative behaviour make adolescents vulnerable and influence their behaviour. For instance, sexual activity by boys may be condoned (UN, 2000) while girls might be restricted in their mobility to protect them from sexual encounters (Mensch et al., 1998).

2.1.4 Argument: Too-early sexual relationships can have profound effects on adolescent health

Serious medical hazards may occur if pregnancy takes place before age 17 or 18 (WHO, 1995; WHO, 1998b) and if the girl is not healthy. For instance, girls under age 18 are two to five times more likely to die in childbirth as women in their twenties; their children are also more likely to die during infancy (WHO, 1998b). Even in an industrialized country such as the United States, the maternal death rate among mothers under 15 years of age is 2.5 times higher than the rate among mothers aged 20–24 (WHO, 1989). Complications of childbirth before age

20 include obstructed labour, iron-deficiency anaemia, and pre-term delivery (Scholl, 1994). Delaying first births until women are at least 18 years old would reduce the risk of death for first-born children by up to 20% (Hobcraft, 1991). When girls have children early, the gap between the generations decreases, which can have a large impact on a country's population growth rate (Kirby, 1994).

There is substantial evidence that young people (aged 15–19) are at particular risk of contracting STI (UNICEF/WHO, 1995; WHO, 1997a). STI such as gonorrhoea and chlamydia can lead to pelvic inflammatory disease, which in turn can lead to infertility (Elias, 1991). Women under age 20 are also likely to have unsafe abortions, especially in resource-poor countries. Complications from abortion can result in life-long disability, infertility, or death (McCauley et al., 1995). In Nigeria, for example, complications from abortion accounted for 72% of deaths among women under the age of 19 (Unuigbe et al., 1988). Treating complications from unsafe abortions also places a heavy strain on limited community and health system resources (WHO, 1993).

Boys are also at risk of infection and causing unwanted pregnancy. Studies in Africa, Asia, and Latin America showed that 25–27% of young men had multiple partners in the past year, thus putting themselves at increased risk (UNDP/UNFPA/WHO/World Bank, 2000a).

2.1.5 Argument: Early sexual relationships and pregnancy negatively affect educational and job opportunities and the social development of young people

Early pregnancy can cause adolescents, especially girls, to drop out of school (UNESCO/UNFPA, 1998a). "If pregnancy occurs prior to the completion of education, then education is likely to be interrupted or terminated, either because the mother is expelled from school or because the additional responsibilities and costs of motherhood make it prohibitively difficult for the mother to continue her education" (Kirby, 1994). Studies in Latin America have shown that adolescent mothers are more likely to remain poor throughout their lifetime and that their children have a higher probability of being poor (Buvinic et al, 1992). Lack of education and skills limit job opportunities and may force young women to enter the sex trade (UNESCO/UNFPA, 1998a). Thus, adolescent pregnancy is an important factor in the intergenerational transmission of poverty (Villarreal, 1998).

Besides being cut short on educational and job opportunities, young pregnant women are subject to discrimination, social tensions, difficulties, and pressures, especially if they are unmarried (UNESCO/UNPFA, 1998a). In some countries, unmarried pregnant girls face severe ostracism (Kirby, 1994). Unwanted and unplanned pregnancies may also result in neglected or abandoned children or family violence (Rice, 1995). Finally, children born to adolescent mothers are usually at a disadvantage, due to adverse socio-economic conditions and low birth weight (UNFPA, 2000).

2.1.6 Argument: Adolescents have limited knowledge of and access to contraception

A survey of more than 600 young people in 54 countries revealed that almost all of the respondents said they needed more information on all aspects of their sexual and reproductive health (Senanayake & Marshall, 1997). Adolescents' knowledge of contraception and pregnancy varies considerably from country to country and region to region (Kirby, 1994). In Africa, less than two-thirds of adolescents in countries studied knew about at least one method of modern contraception, but this varied from about 30% in Mali to more than 90% in Botswana (Senderowitz, 1994). Data from various countries in Latin America, Asia, and sub-Saharan Africa indicate that in none of the surveyed countries could at least half of 15–19 year olds identify the time of the menstrual cycle when ovulation is most likely to occur and pregnancy risk is highest (Mensch et al., 1998).

The main sources of information on sexuality, conception, pregnancy, and contraception for young people are friends and the media (UNDP/UNFPA/WHO/World Bank, 2000). Numerous myths persist among young people about how to avoid conception, e.g., one cannot get pregnant at first intercourse or if standing up during intercourse, if a girl has not started menses, or if a boy is younger than the girl (Watson, 1999). Adolescents may believe that abstinence will cause infertility, poor sexual performance, or painful childbirth at a later date (Watson, 1998). Such myths can lead adolescents to engage in behaviours that put their health and development at risk.

Case studies in various countries have shown that contraceptive use is as low as 1% among female and 9% among male 17–24-year-old college students in Vietnam. Only 10% of female and 20% of male secondary school students in urban areas of Nairobi, Kenya, and 12% of females and males under the age of 20 from Chile practice contraception regularly (UNDP/UNFPA/WHO/World Bank, 2000b). Lack of access to contraceptive methods is related to a variety of issues: poverty that leaves people unable to afford contraceptives, policies and practices that make it difficult for adolescents to obtain reproductive health services, and reluctance to provide information and access to young people. And even when services are available, adolescents may face hostility and disapproval from health workers, or fail to use the services because they fear disclosure of their sexual activity (Watson, 1999; Senderowitz, 1997b).

2.1.7 Argument: Education about family life, reproductive health, and population issues supports the concepts of human rights and gender equity

The Universal Declaration of Human Rights proclaims that "men and women of full age....have the right to marry and to found a family." Likewise, the Declaration grants everybody a right to "a standard of living adequate for the health and well-being of himself and his family" (UN, 1948). Human rights that support founding a family and reproduction include rights relating to life, liberty, and security of the person; rights relating to the foundation of families and of family life; rights relating to the highest attainable standard of health and the benefits of scientific progress, including health information and education; and rights relating to equality and non-discrimination on such grounds as sex, marital status, race, age, and class (Starrs, 1997; UN, 1948). Most of these rights are also contained in the International Convention on Children's Rights (CRC). In addition, the CRC

contains a pledge of all states to specifically protect children from "all forms of sexual exploitation and sexual abuse" (UN, 1989).

2.1.8 Argument: There is a demand from both students and parents for education about family life, reproductive health, and population issues

In a UNFPA essay contest, adolescents from all over the world expressed their support for responsible reproductive health programs. They highlighted the lack of equality between the sexes and argued the need for the following: better information regarding the joys and dangers of sexual relationships, accurate information about AIDS and other STI, access to advice relating to early marriage, greater male involvement in family responsibility, and support and guidance as they make their transition to adulthood (Popnews, 1996). Students in Ugandan schools listed the following topics as priorities for learning about sexual development: girl-boy relationships, bodily changes during puberty, dealing with parents, and HIV and STI (Watson, 1998). A Youth Counselling Centre in Asmara, Eritrea, funded jointly by UNFPA and Norway's Save the Children Fund, was packed with children and young adults only six weeks after it opened in early November 1996. The Centre provided adolescent counselling on sexual health and STI/AIDS, and advice on reproductive health and family planning (UNFPA, 1999a).

A national poll in the United States found that 89% of public school parents feel that public high schools should include education about family life and reproductive health in their curriculum (Rose & Gallup, 1998). A study in Germany showed that, although some parents discussed sexuality with their children, 90% of the parents would like the schools to provide such instruction (Rehman & Lehmann, 1998). Data from 34 case studies in developing countries revealed that young people wanted much more explicit focus on sexuality in the school curriculum, preferably provided by health providers (Brown et al., 2000).

2.2. SCHOOLS AS APPROPRIATE SITES FOR FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION

2.2.1 Argument: Schools are strategic entry points for addressing family life, reproductive health, and population education

Schools have the potential to reach a large portion of the world's children and adolescents. More children than ever attend school. In the developing world, where the last 30 years have seen an impressive improvement in enrolment rates, more than 70% of children currently complete at least four years of school (UNICEF, 1996a). Between 1985 and 1995, the global gap in school enrolment between boys and girls narrowed in developing countries because of efforts to enrol more girls (Cooper, 1999). Those gains are now threatened by the devastating effects of the HIV/AIDS pandemic and by attrition, especially among girls. Still, with more children than ever in schools, schools are an efficient way to reach school-aged youth as well as teachers and staff. Children who attend school can also be involved in school-based activities that include outreach to family and community members and out-of-school children. Since schools are part

of the communities where they are located, they are in a good position to have insights into how best to address these issues in a culturally appropriate and acceptable way (Rice, 1999).

During the critical developmental period of adolescence, schools have the opportunity to improve children's health, self-esteem, life skills, and behaviour with interventions to promote health and prevent diseases (WHO, 1996). Many young people initiate sexual intercourse while they are enrolled in school (Weiss et al., 1996). Schools have the opportunity to address young people before they initiate sexual and other risk behaviours. Educating adolescents at this key juncture in their lives can lay the groundwork for a lifetime of healthy habits since it is often more difficult to change established habits than it is to create good habits initially (Kirby, 1994). How reproductive health is addressed in childhood will set the stage for how the population will deal with many health issues in years to come (Rice, 1995).

Teachers can play an important role in influencing health. The president of Education International, a world trade union for the education sector representing more than 23 million teachers in 148 countries and territories, points out that "teachers are absolutely critical, not only to the development of individuals but to the development of nations as well. Teaching, more than any other profession, influences who we are and influences societies in which we live" (Education International, 1997).

2.2.2 Argument: Schooling is a cost-effective means of improving the health of the current and next generation of young people

Research has shown that "women with more education stay healthier and raise better-nourished, healthier and better-educated children" (Cooper, 1999). Education has been found to expand choices for men and especially women (Jejeebhoy, 1995). In most areas, women who attain more formal education are more likely to delay childbearing and marriage than their peers with little or no schooling (McCauley et al., 1995). Cross-country studies have shown that an extra year of schooling for girls reduces fertility rates by 5–10% (UNICEF, 1996b).

Compared with various public health approaches, school health approaches that provide safe and low-cost health interventions, such as screening and health education, have been identified by the World Bank as one of the most cost-effective investments a nation can make to improve health (World Bank, 1993).

2.2.3 Argument: Schools can encourage and support parents and families to communicate with their children about family life, reproductive health, and population issues

Many parents either lack knowledge about sexual matters or are afraid to discuss them with their children (DeBouck & Rees, 2001; Oikeh, 1981). Intergenerational studies have found that when there is communication between parents and children regarding reproductive health issues, it is often limited to threats and warnings without explanations (Wilson, Mparadzi & Lavelle, 1992). A study in Germany found that among parents, 90% of mothers and 80% of fathers believed

that they knew the most favourable time for conception; however, only 78% of mothers and 67% of fathers actually knew the correct information (Kluge, 1994).

Schools may offer classes or brochures directly to parents to help them become more effective in addressing reproductive health and population issues with their children, including questions related to sexual orientation and related depression. Schools may also give homework assignments that students have to complete with their parents and that may lead to increased family communication about family life and reproductive health issues (UNESCO/UNFPA, 1998b).

2.2.4 Argument: Schools can provide an avenue for facilitating change in thinking about harmful traditional practices

Some traditional practices, such as female genital mutilation, norms that favour early marriage, and fewer reproductive health options for women than for men, have been harmful to young people's health. Female genital mutilation, the most serious of these, is deeply entrenched by strong cultural dictates, but it can cause severe physical and psychological damage (UNFPA, 2000).

Female genital mutilation is considered "violence against women and even more so against children on whom it is practised without their consent"(UNESCO/UNFPA, 1998a, p. 27). Immediate complications are very common and include violent pain, shock, haemorrhage, injury to adjacent organs, infection (including HIV and tetanus), and even death. Later problems include scarring, painful and prolonged menses, recurrent urinary tract infections, sexual complications, psychological trauma, and difficult childbirth (UNFPA, 2000).

Between 85 and 114 million females in the world have been subjected to female genital mutilation, most of them when they were young girls or just before puberty—a time when they might still be in school. Thus, the school may provide a timely and effective avenue for intervening in an effort to facilitate a change in thinking about this practice, as well as considering its role and function in society. It is important for the younger generation to be included, together with their parents, in open and challenging discussions of the practice. Family life, reproductive health, and population education enhances women's and men's autonomy and ability to make informed choices about this and other practices (Jejeebhoy, 1995).

2.2.5 Argument: For better or worse, schools play a significant role in family life, reproductive health, and population education

Intentionally or unintentionally and for better or for worse schools play a significant role in contributing to or hindering efforts to address family life, reproductive health, and population education. Examples of the roles schools can play are listed below.

2. CONVINCING OTHERS THAT FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION THROUGH SCHOOLS ARE IMPORTANT AND EFFECTIVE FOR PUBLIC HEALTH AND PERSONAL DEVELOPMENT

UNDER GOOD CONDITIONS, SCHOOLS...	UNDER DIFFICULT CONDITIONS, SCHOOLS...
• ...provide access to education and opportunities to reach students, staff, parents, and community members with information and services about family life, reproductive health, and population education • ...enhance gender equality by being responsive to the needs of young men and women in addressing reproductive health • ...involve young people in promoting healthy lifestyles by engaging them in planning efforts, peer education, and a variety of other learning experiences addressing family life, reproductive health, and population issues • ...reinforce family life, reproductive health, and population education through other relevant subject areas, such as social studies, home economics, science, health, and life skills • ...foster healthy sexual development by practices that foster caring, respect, self-esteem, and decision-making, and through both physical and social conditions that support the health of students, teachers, and staff • ...encourage adults to follow an ethics code and model healthy behaviours • ...take part in national and community initiatives to promote healthy sexual development and prevent HIV, STI, and other negative consequences of sexual activity • ...involve teachers and education leaders in creating a momentum to promote health and rights through schools • ...have a code of conduct for staff and have a responsible adult designated to whom students can turn in confidentiality to report any suspicious or inappropriate behaviour or abuse, who can alert law enforcement officials, if appropriate, and who can refer students to appropriate counselling and health care services, as required	• ...may be limited by national or provincial policies and traditions in the extent to which they can address sexual development and reproductive health • ...do not believe they have the responsibility or right to address reproductive health and population education • ...have policies that restrict clear and accurate information about reproductive health, resulting in unanswered questions, concerns, and suspicion among students and staff • ...offer poor-quality family life, reproductive health, and population education that is not clear, complete, or accurate, creating disillusionment and misinformation • ...ask or require individuals without proper training to teach about family life, reproductive health, and population issues or provide related counselling and health services • ...sustain gender inequality by not teaching young men and women how to interact respectfully with one another • ...do not have policies in place that clearly allow teachers to communicate information about sexual development and reproductive health • ...fail to recognise and address concerns and demands of community leaders who oppose interventions addressing family life, reproductive health, and population education • ...fail to implement policies and procedures that are designed to protect students from sexual exploitation by teachers

2.3. KNOWN EFFECTIVENESS OF SCHOOL-BASED EFFORTS

"The content and goals of school-based reproductive health curricula are often a source of great controversy. One major concern frequently voiced by parents, teachers and school officials is that sex education and the availability of family planning services will increase young people's interest and involvement in sexual behaviour. Research overwhelmingly points to the contrary" (Birdthistle & Vince-Whitman, 1997).

2.3.1 Argument: Research has repeatedly shown that reproductive health education does not lead to earlier or increased sexual activity among young people and can in fact reduce sexual risk behaviour

A study that analysed 1,000 reports on reproductive health programs (Grunseit & Kippax, 1993), and a review of 19 published evaluations of sex education (Baldo, et al., 1993), both primarily from developed countries, found no evidence that the provision of sex education, including the provision of contraceptive services, encourages the initiation of sexual activity. On the contrary, in some cases, sex education delayed the initiation of sexual intercourse, decreased sexual activity, and increased the adoption of safer sexual practices among sexually active young people. These findings have recently been confirmed again by a study in the United States (Kirby, 2001).

In 1997, UNAIDS conducted a comprehensive literature review of more than 60 articles from 13 literature databases and international experts in the field to assess the effects of sexual health education on young people's sexual behaviour. The major findings confirmed the following:

- Education on sexual health and/or HIV does not encourage increased sexual activity.
- Good-quality interventions can help delay first intercourse and/or reduce the frequency of sexual activity, pregnancy, abortion, or birth-rates
- Good programmes can increase the condom use of sexually active youth and thus protect them from STI, including HIV, and pregnancy.
- Responsible and safe behaviour can be learned (UNAIDS, 1997).

Education about family life, reproductive health, and population issues has been found effective in countries and regions throughout the world. Here are some specific examples:

- Latin America: In five Latin American cities, researchers found that young women who took a sex education course were more likely than their counterparts to delay having sex (Blaney, 1993). A study that examined data from five Mexican cities found that use of contraception at first intercourse was greater for those who had previously had some sex education than for those who had not (Population Communication Services, 1992).

- Africa: Research in the Gambia showed that family life education in school had a significant positive impact on knowledge and use of contraceptives when students became sexually active (Kane et al., 1993). A population/family life education curriculum in secondary schools in Nigeria significantly increased

health-supportive attitudes related to monogamy, family planning, and family size. Among the group that received the curriculum, the percentage of students that agreed that they would decide with their partners how many children they would have and that a couple has the right to limit the number of children they have increased significantly (Centre for Development and Population Activities et al., 1993).

- The Netherlands: In schools in The Netherlands, where sexuality education is integrated into many school courses and starts with pre-school children (Berne & Huberman, 1999), data demonstrate no lowering in the age of sexual initiation (Gianotten, 1995).

- United States: A review of 23 U.S. school-based interventions to reduce adolescent sexual risk behaviours showed that good-quality programs did delay the initiation of intercourse, reduce the frequency of intercourse, reduce the number of sexual partners, or increase the use of condoms or other contraceptives (Kirby et al., 1994). The Centers for Disease Control and Prevention in the United States identified several school-based interventions that effectively reduced sexual risk behaviours that contribute to unintended pregnancies and STI/HIV infections. In "Reducing the Risk," after 18 months students in the intervention classes who had not had sexual intercourse before the intervention reported significantly less initiation of intercourse than students in the comparison group. Also, those students in the intervention classes who did initiate sexual intercourse reported more frequent use of contraception than students in the comparison group. Finally, students who received the intervention reported increased communication with their partners about abstinence and contraception (CDC, 2000). Characteristics of effective programs and curricula are included in section 4.2.

2.3.2 Argument: Openness about family life, reproductive health, and population education reduces risk factors

In a comprehensive UNAIDS review of sexual health education, five comparison studies indicated that "when and where there was an open and liberal policy as well as the provision of sexual health education and related services (e.g., family planning), there were lower pregnancy, birth, abortion, and STI rates" (UNAIDS, 1997, p. 17). A 37-country comparison study found that countries that address young people's sexual health in a frank, open, and supportive manner experienced fewer of the negative consequences of sexual activity, yet did not see greater sexual involvement. The study concluded that "increasing the legitimacy and availability of contraception and sexual health education (in its broadest sense) is likely to result in declining adolescent pregnancy rates" (Jones et al., 1985, p. 61).

In Uganda, the Straight Talk Foundation has produced and distributed nation-wide a newspaper that addresses adolescent concerns about sexual and reproductive health. Counsellors and clinicians visiting schools allow students to ask them questions directly. Recent studies in Uganda indicate that young people are adopting safer sex practices and waiting longer to initiate sexual activity than they did a decade ago (Gender-Aids, 1999). There has been little or no backlash to the Straight Talk newspaper, despite its matter-of-fact approach to sexual health.

Straight Talk has used research from elsewhere in the world to reassure adults that reproductive health education does not increase adolescent sexual activity (Watson, 1999).

The youth in France, Germany, and the Netherlands experience an open, matter-of-fact approach to sexuality education. When compared to youth in the United States, who experience a more restricted approach to sexuality education, the former initiate sexual intercourse later, report more use of effective contraception methods, and have significantly lower rates of births, abortions, and sexually transmitted diseases than do their American counterparts (Berne & Huberman, 1999).

2.3.3 Argument: Education about family life and population issues can prepare young men and women for responsible parenthood

Before a couple can make decisions about family size, they must first understand that it is possible to make such a decision; they must have the means to implement their decisions (e.g., family planning methods); and they must be motivated to take action (UNFPA, 1993). In India, an unpublished UNFPA study found in 1994 a number of newly married couples practising family planning, and in some cases significantly postponing first pregnancy, in areas where this practice would be against the norm. When asked what led them to their decision to go against tradition, the couples responded that they had learned in school about the risks associated with adolescent pregnancy (Sikes, 1999). Evaluations of UNFPA's population education projects indicate that "in China, pilot school projects reported that following exposure to population education, students who had agreed to postpone marriage were sticking to their agreement.... In rural Bangladesh, health officials started to notice a sudden and steady influx of young couples coming to health centres to ask for family planning. The timing of this event coincided with the graduation from school of the first cohort of young people who had been exposed to several years of population education in the classroom" (Sikes, 2000, p. 43).

3. PLANNING EFFORTS TO ADDRESS FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION AS PART OF A HEALTH-PROMOTING SCHOOL

Once the importance and feasibility of addressing family life, reproductive health, and population issues are understood by citizens, school officials, and policy- and decision-makers, the next step is to plan the interventions. This involves determining specific local needs and conditions and planning activities that will address the identified needs.

Planning for family life, reproductive health, and population education involves a number of important steps (which are outlined in Figure 1). These steps are also relevant in planning and implementing efforts that address other health issues and in developing an effective school health programme, such as a Health-Promoting School. One particular document in the WHO Information Series on School Health, *Local Action: Creating Health-Promoting Schools*, describes in more detail how to implement each step; other resources are listed in Annex 1. This chapter will discuss the particular issues related to each step that tend to surface in planning and implementing family life, reproductive health and population education.

Figure 1: Planning Overview

Who will make this happen?

3.1 ESTABLISHING CORE TEAMS

School and community involvement is important. Health-Promoting Schools involve members of the school and community in planning interventions that respond to their needs and that can be maintained with available resources and commitments.

A Health-Promoting School should have a designated **School Health Team** to co-ordinate and monitor health promotion policies and activities. The School Health Team receives input from a **Community Advisory Committee**, which represents groups and individuals outside of the school. The "School Health Team" and "Community Advisory Committee" may be called by different names but should be designated with the responsibilities described below.

3.1.1 School Health Team

A School Health Team is a group of various individuals within the school working together to maintain and promote the health of all people who are working and learning at school. Ideally, the team co-ordinates and monitors health promotion policies and activities.

- If your school is a Health-Promoting School and a School Health Team already exists, you might consider establishing a task force to integrate family life, reproductive health, and population education into the various components of your Health-Promoting School.
- If your school does not have a team organised to address health promotion, the effort to address family life, reproductive health, and population education could provide an opportunity to form one. A School Health Team can lead and oversee all health promotion efforts in the school, and if given the responsibility, time, and authority to do so, can be responsible for planning, designing, and evaluating family life, reproductive health, and population education interventions; clearly defining roles and responsibilities; and facilitating communication about plans, progress, and challenges.

3.1.2 Community Advisory Committee

A Community Advisory Committee represents a wide spectrum of local groups, organisations, and individuals. It can provide ongoing advice and support, information, and resources to the School Health Team.

- If your school or school district has community advisors, it is essential to find out whether they address health promotion, family life, reproductive health, and population issues. In some settings it may be useful to collaborate with existing community groups, such as councils, youth groups, and women's groups.
- If your school does not have community advisors, the effort to implement a process that addresses family life, reproductive health, and population issues provides an opportunity to initiate partnerships with advisors from outside the school.

For more detailed information on establishing these teams, see *Local Action: Creating Health-Promoting Schools,* WHO/NMH/HPS/00.4 (available online at http://www.who.int/school-youth-health; select "WHO Information Series on School Health").

Whose support is needed?

3.2 GAINING/ACCESSING COMMITMENT FROM VARIOUS STAKE-HOLDERS

Gaining commitment from political stakeholders, communities, families, teachers, school staff, and youth will be important to support family life, reproductive health, and population education in your school.

3.2.1 Political support

Political support, such as national policies, guidelines, and support from ministries of education, health, and population, can be of immense help to local schools. Political commitment can be evidenced in many ways, for example:

- Public acknowledgement by ministries and local officials of the importance of the issues and efforts to address family life, reproductive health, and population education
- Favourable policies and national/local plans, e.g., strengthening family life, reproductive health, and population education, ensuring retention in school after pregnancy, and confidentiality of health services
- Designation of someone with responsibility and authority to ensure implementation of these policies and plans
- Provision of financial support, technical equipment, services, and materials for such programmes
- A clear code of conduct and ethical standards to prevent sexual abuse and harassment, bullying, and discrimination related to sexual orientation

3.2.2 Family and community support

Family and community members can play an integral part in discussions and sensitisation about family life, reproductive health, and population topics. Parent-teacher associations, adult education activities, formal and informal presentations, open houses, civic clubs, religious centres, and community group meetings can be appropriate venues for communicating with families and community members around these topics.

Success is the best advocate. Local interventions that prove to be successful can help gain support from individuals and groups that were initially not supportive. It may not be necessary to achieve full support from all groups before beginning. Resources may be better spent on building evidence of need, interventions that meet the needs, and allies that do support it.

3.2.3 Support of teachers and school staff

Teachers and school staff play a key role in carrying out efforts to address family life, reproductive health, and population education. A staff meeting is one useful forum for developing teacher and school staff's support and commitment. Important ideas to discuss include:

- Information and data that support the need for family life, reproductive health, and population education, such as rates of adolescent pregnancy, STI and HIV infection
- The roles teachers play as role models, facilitators, and partners of parents and students
- Plans for teacher training and support to address their needs and concerns about family life, reproductive health, and population education
- How teachers and staff members will be affected by efforts to address these issues

3.2.4 Youth involvement and participation

Young people – boys and girls representing all sectors of society – should be involved in all stages of programme design, provision, and evaluation. In doing so, they become part of the solution rather than the problem (UN, 2000). They often can identify issues and ideas that others have not considered or find difficult to consider. Young people's participation can also build their sense of ownership. They have tremendous potential to contribute to efforts within and outside of the school. "Programme planners and international agencies, such as WHO, UNESCO and UNICEF, recommend that the energy and creativity of young people be involved on many levels: needs assessments; identification of problem areas; design and planning; promotion of programmes; implementation; teaching; counselling; organising activities; distributing information and over-the-counter contraceptives; assessing materials; and evaluation" (Birdthistle & Vince-Whitman, 1997, p. 23).

There are numerous ways in which young people can be involved:

- As members of the School Health Team
- As peer educators and counsellors
- As planners and participants in school and community projects
- As writers, speakers, mobilizers, parent educators, and distributors of resources
- With various other tasks in planning, implementing, and evaluating needs and progress related to programming

In any of these roles, students could identify reproductive health and gender-related issues, such as male involvement in family life education, or inadequate and limited services and programmes for males or females, and then take a lead in developing and carrying out actions that address these issues.

Case Study

In 11 African countries, approximately 13,000 young people were involved in developing a questionnaire based on role playing and discussion of prototypical behaviour of their own peer groups. Young people then administered the questionnaire to representative samples of youth in their target areas. The information generated about sexual and contraceptive behaviour was used for programme planning as well as broader policy discussion (Senderowitz, 1998; WHO/ADH/ROA, 1993).

Where should we begin?

Once commitment is assured to the extent possible, and the School Health Team and Community Advisory Committee are established, members can start the planning process by conducting a situation analysis. It is important to make the analysis manageable and practical so that activities can proceed quickly to the action planning and implementation stage. Too many projects never proceed beyond the assessment.

3.3 CONDUCTING A SITUATION ANALYSIS

A situation analysis can ensure that interventions are relevant to the local situation. It consists of needs and resource assessments, conducted prior to planning and implementing the interventions. The results of the analysis also serve as baseline data for subsequent evaluations.

Situation analysis on the national, district, and/or local level is important for several reasons:

- Policy- and decision-makers need a strong basis for their support, especially when their policies and decisions involve the allocation of resources.
- Accurate and up-to-date information provides a basis for setting priorities for action and for identifying groups in special need of interventions.
- Data obtained through the situation analysis are essential for planning to be relevant to the local situation and actual health needs, perceptions, experience, motivation, strengths, and resources of the target population.
- Data obtained in the situation analysis serve as baseline data for future evaluation of interventions.
- Information from the situation analysis can be used for advocacy purposes to more specifically tailor advocacy to the context of the target audience.

The situation analysis may involve gathering qualitative data including anecdotal information, and quantitative (numeric) data on needs and resources inside and outside of school that will be used for planning interventions and as a baseline to which changes can be compared later. Qualitative information includes perceptions and feelings from individuals, which might be gathered through observations, focus groups, and in-depth interviews. Quantitative information includes statistical information on health status, knowledge, attitudes, and skills related to the issues in question; it might be gathered through surveys and reviews of existing data. It is important to be able to break down the data by gender, urban/rural settings, migration status, etc. A situation analysis should include assessments of needs and resources, as described below.

3.3.1 Needs assessment

A needs assessment helps to gain an understanding of the family life, reproductive health, and population issues in your community. Accurate and up-to-date data can help ensure that efforts focus on the health and developmental needs of the target population. Concerns and perceptions vary by age and gender and by demographic and socio-economic characteristics. Thus, a range of stakeholders

and types of information need to be considered; e.g., when assessing the needs of teachers and other school staff or students, quite different but related issues may arise. Policy- and decision-makers will be more likely to support activities that are based on documented needs.

The following types of information might be considered in a needs assessment:

- Health status: Data from health statistics and interviews with knowledgeable professionals and community members will assist in gaining an understanding of family life, reproductive health, and population issues in the target population. Information may include the extent and consequences of pregnancy, parenthood, and coerced sexual relationships during adolescence; morbidity, and mortality; and rates of abortion, STI, and HIV/AIDS. For more specific examples, see Figure 2.

- Knowledge, attitudes, beliefs, values, practices, behaviours, and skills related to family life, reproductive health, and population education: Information from focus groups, interviews, and surveys with young people and community members can reveal what they know and believe about sexuality, how relationships among youth are formed and how they get risky, which cultural and religious practices influence sexual expression or health-seeking behaviour, and how sex-related roles are defined. This information is crucial for designing effective learning experiences. For instance, students might not have the knowledge of when in the menstrual cycle ovulation and pregnancy are most likely to occur; social norms and attitudes may not support family life, reproductive health, and population education through schools; religious beliefs might deter unmarried adolescents from engaging in sexual relationships or prevent a pregnant adolescent from seeking prenatal care; social values might encourage early pregnancy and large numbers of children; cultural practices might introduce adolescent girls to genital mutilation; youth risk behaviours might include high school students engaging in unprotected sexual intercourse; and students may not have sufficient skills to feel confident in their ability to negotiate contraceptive use in a sexual encounter.

Without information about these helping or hindering forces, efforts are not likely to target the most relevant factors that contribute to health and healthy sexual development.

3.3.2 Resource assessment

A resource assessment helps planners gain an understanding of the school's and community's capacity to provide services and resources that support family life, reproductive health, and population education. A resource assessment should examine the following:

- Relevant policies: A review of the school's and community's policies is needed to determine the extent to which they support family life, reproductive health, and population education — and, if supportive policies are in place, the review must determine the extent to which they are enforced.
- Available resources and existing programmes: This includes determining the nature and extent of current resources (e.g., staff, time, funding, services, programmes, materials) in the school and community that are available to

address the issues, understanding why prior attempts to address them might have been unsuccessful, and determining the availability of specific resources and services that might help in implementing new interventions. The amount and nature of resources will affect the scope and amount of services that can be provided, the availability of trained staff, and the capacity to plan and evaluate efforts. Knowing this information allows the team to draw on available personnel and financial resources and set reachable goals and objectives.

Figure 2 below provides sample topics from which specific questions can be devised to assess needs and resources for specific audiences and localities.

Figure 2: Sample Basic Questions and Data Sources

SAMPLE QUESTION TOPICS	SAMPLE DATA SOURCES / METHODS
Needs Assessment	
What are the rates of adolescent fertility, pregnancy-related mortality and morbidity, unintended pregnancy, STI, HIV infection, and abortion among young people?	Existing data from health authorities and health care providers
How prevelant is sexual behaviour that can result in unintended pregnancy, STI and/or HIV infection, and contraception use among school-age children and youth in the community or nation?	Existing data from health authorities and health care providers, possibly supplemented by interviews and/or surveys
Which conditions related to family life, reproductive health, and population issues are causes of concern in the community?	Interviews, focus groups sample surveys, and review of existing data
What are the important behaviours, behaviour determinants, and conditions that place young people at risk for early sexual relationships, unintended pregnancies, abortions, and STI in the nation or community?	Same as above
What basic knowledge about physical and psychological development during puberty, the menstrual cycle, and contraception do teachers, parents, and young people have?	Same as above
What knowledge, attitudes, values, and skills might young people need to enable them, to deal positively with family life, reproductive health, and population issues?	Same as above
What are parents' and teachers' attitudes toward sexual relationships, abstinence, and contraception?	Same as above

Figure 2: Sample Basic Questions and Data Sources (continued)

SAMPLE QUESTION TOPICS	SAMPLE DATA SOURCES / METHODS
Resource Assessment	
What policies exist in the community for allocating resources to address reproductive health and population issues with young people? What do these policies call for?	Interviews with school and community leaders and representatives from health and education authorities, review of documents
In this community, what programmes are in place that addresses issues related to family life, reproductive health, and population education, *or* what programmes exist that these issues could be integrated into?	Same as above
What kind of human, financial, and physical resources exist in the school and community to provide family life, reproductive health, and population education? To what extent do these resources reach and serve young people?	Same as above

For guidance on how to collect, manage, and analyze data related to adolescent reproductive health, see *Coming of Age and A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programmes* (references included in Annex 1) or other relevant publications.

What should we do?

3.4 ACTION PLANNING

Using the information gathered in the situation analysis and the support from various individuals and groups, the School Health Team — in collaboration with the Community Advisory Committee — can develop a vision for change and an action plan.

Action planning involves the development of goals, objectives, activities, and a means of monitoring and evaluation to determine whether the activities are being implemented as planned and achieving the stated objectives and goals. Annex 2 includes a sample worksheet that can be used or adapted to develop goals, objectives and an action plan.

Experience gained from reproductive health programmes for adolescents around the globe has led to the following important programming principles that can help ensure success for this population (UN, 2000):

- Plan a holistic and comprehensive approach: Develop policy and deliver the various interventions, such as information, skills development, counselling, and clinical services, in a co-ordinated and collaborative approach in a variety of settings.
- Take diversity into account: Recognise that concerns vary by demographic and socio-economic characteristics, age, gender, etc.
- Focus on prevention and health promotion: Foster self-esteem and resistance skills before adolescents become sexually active.
- Integrate health promotion into reproductive health services: Combine information with provision of or referral to health services (for prevention and treatment).
- Strengthen the gender component of programmes: Consider the distinct gender differences in behaviour patterns, socialisation processes, and expected roles within the family, the community and society.
- Ensure youth participation in programmes: Involve adolescents in the design, planning, implementation, monitoring, and evaluation of activities that concern them.
- Involve parents, teachers, and community leaders: Seek support from community leaders, social workers, NGOs, and members of civil society.
- Establish multi-sectoral partnerships: Strive for concerted action from all sectors, e.g., education, health, and finance, as well as various stakeholders: governments, UN agencies, donor agencies, NGOs, private sector, and civil society.

3.4.1 Goals

Goals describe in broad terms what the interventions hope to achieve. The School Health Team can generate overall goals related to family life, reproductive health, and population education, in collaboration with school policy-makers and the Community Advisory Committee. Goals should be related to the findings of the situation analysis. For instance, if the needs assessment revealed that myths related to sexual activity and contraception are very prevalent, a goal might be to

decrease or eliminate the existence of sexual myths by providing accurate information about sexual development and contraception to all students. If the resource assessment showed that few or no reproductive health-related health services exist for adolescents, one of the goals could be to establish such services in schools or linked to schools through referrals.

Examples of goals:

- Family Life Education: To help young people have meaningful social relationships in the context of family and society and to prepare them for adulthood, marriage, parenthood, and ageing (IPPF, 1985, adapted)
- Reproductive Health Education: To explore a broad range of reproductive health issues that are the reality of today's adolescents and to stress the development of skills and making informed choices through participatory approaches (UNESCO/UNFPA, 1998b, adapted)
- Population Education: To help shape students' knowledge and attitudes so that they will make responsible population-related decisions (UNFPA, 1996, adapted)

3.4.2 Objectives

Objectives are steps that lead to the achievement of the overall goals. *Outcome objectives* define in specific, measurable, and achievable terms what is to be accomplished through the interventions, such as changes in the health-related behaviours, knowledge, attitudes, beliefs, skills, or conditions associated with health status. *Process objectives* describe what will be changed or implemented in order to achieve the outcome objectives.

Specific short-term and long-term objectives or steps make clear what needs to be done and when. The clearer and more specific the objectives, the easier it will be to select appropriate activities to achieve them and to monitor and evaluate how successfully objectives are being met. Thus, the objectives serve as standards against which to measure progress.

Here are two examples of specific, measurable objectives:

- Outcome objective: By the end of this academic year, at least 80% of the students in grade 8 will be able to describe correctly three different methods of contraception. (Knowledge)
- Process objective: By the end of this calendar year, our school will have provided one workshop for teachers and parents, respectively, discussing how to talk to young people about at least three different methods of contraception.

For examples of health, behavioural, and KABS (knowledge, attitudes, beliefs, skills) objectives for family life, reproductive health, and population education, please see Section 4.2: Skills-based health education.

3.4.3 Activities

Once the goals and objectives are delineated, the School Health Team can develop activities, or, preferably, a combination of activities that are feasible for the school and community to implement and that will most likely help achieve the goals and objectives. Section 4 introduces numerous approaches that schools can take to promote health and address family life, reproductive health, and population education, and can provide guidance on developing activities to reach the identified goals.

3.4.4 Evaluation design and monitoring

Evaluation—a review of what has been done and how well it worked—is important for many reasons and should be considered from the outset. An evaluation plan and mechanism for monitoring will help track a school's progress in implementing activities and achieving objectives. The groundwork for evaluation is laid at the very beginning with the situation analysis, when needs are assessed, objectives set, and activities planned. Specific recommendations for process and outcome evaluation are discussed in Section 6 of this document.

4. INTEGRATING FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION INTO VARIOUS COMPONENTS OF A HEALTH-PROMOTING SCHOOL

A Health-Promoting School strives to help the total school population achieve healthy lifestyles and to integrate health promotion into all aspects of the school's daily routines. This section describes numerous actions that schools can take to promote family life, reproductive health, and population education, as well as health in general. Not all schools will have the resources to integrate important aspects of family life, reproductive health, and population issues into all components at one time. However, this need not discourage any school from addressing these issues; even small steps can make a difference. Each school should choose activities that are the most important and most feasible to address first. A Health-Promoting School enables students, parents, teachers, and community members to work together to make such decisions.

International Consensus

Health-Promoting Schools share the philosophy and approach of a major international initiative called FRESH (Focusing Resources on Effective School Health), fostered by WHO, UNESCO, UNICEF, the World Bank Education International, EDC, and Partnerships for Child Development. FRESH was initiated at the World Education Forum in Dakar, Senegal, in April 2000. This initiative focuses on four basic components of an effective school health programme:

- Health-related school policies (see Section 4.1)
- Provision of safe water and sanitation as essential first steps towards a healthy school environment (see Section 4.3)
- Skills-based health education (see Section 4.2)
- Access to or linkages with school-based health and nutrition services (see Sections 4.4 and 4.8)

The agencies noted that these four components should be made available together in all schools. They are a framework for the development of effective interventions in broader efforts to develop child-friendly and Health-Promoting Schools (UNESCO/UNICEF/WHO/World Bank, 2000).

The effectiveness of these components, and all the components of a Health-Promoting School, is influenced by the extent to which they are co-ordinated to complement and reinforce one another. For instance, school policies can ensure that pregnant and HIV-positive students are not excluded from school. This can be coupled with providing school-based or -linked health and nutrition services that offer HIV and STI testing, counselling to pregnant (and non-pregnant) students, and offer nutritious food which is especially important for the healthy physical development of girls. Skills-based health education can teach about developmental changes during puberty and communication and refusal skills that students can use to negotiate limits of expressions of affection with their partners. This can be reinforced by ensuring single-sex toilets where girls have privacy to wash and care for themselves.

4. INTEGRATING FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION INTO VARIOUS COMPONENTS OF A HEALTH-PROMOTING SCHOOL

4.1 SUPPORTIVE SCHOOL POLICIES

School policies provide an essential framework to guide schools in planning, implementing, and evaluating efforts to promote health. School policies and practices should promote a clear set of school norms and be developed through participatory policy-making, with careful consideration paid to gender equity.

Case Study

In Europe, students have been actively involved in developing and implementing school health policies. In the United Kingdom, schools set up working parties, consisting of pupils, teachers, school governors, the school nurse, the school education social worker, the school's police liaison officer, and a local health promotion officer to revise the sex education policy. Regular meetings immediately after school examined principles on which school policy should be based, objectives in terms of education, and the structure of the existing curriculum. A list of curriculum subjects, developed with the help of pupils, was sent to parents. Pupils who were team members provided valuable insights and advised on the suitability of resources. The school did not receive any requests to exclude children from the curriculum. The success of the development strategy for this sex education policy encouraged the school to use the same approach to develop a policy on drug education (Bowker & Flint, 1997).

Written policies are developed by the School Health Team in collaboration with the Community Advisory Committee. They should guarantee health interventions for all levels of schooling, starting in the earliest grade and continuing through the last grade. Policies ideally address all components of a Health-Promoting School that will be modified.

Examples of supportive policies include:

- A code of conduct for teachers ensuring that students and staff of all sexual orientations are treated with respect and not discriminated against, harassed or abused
- Policies that ensure that pregnant and HIV-positive students are not excluded from school
- Policies that support developmentally appropriate education about family life, reproductive health, and population issues
- Policies that require co-ordination between health and education authorities at local and district levels in planning and implementing family life, reproductive health, and population education
- Rules about extra-curricular activities for males and females and criteria for allowing outside groups to take part in school-based interventions
- Requirements for appropriate training of teachers who will teach about family life, reproductive issues, and population education

4.2 SKILLS-BASED HEALTH EDUCATION

Young people learn about family life, reproductive health, and population issues in a variety of ways, for instance, from their parents, siblings, peers, and the media. These sources may support cultural myths about sexuality and related issues, and where they do, some adolescents may not have accurate information about the physical and emotional changes they are encountering, nor how they can manage these changes safely. Thus, it is important that schools provide accurate information, opportunities to develop healthy attitudes, and skills-based learning experiences, using active teaching methods, to help students make informed decisions and to reduce risk behaviours.

4.2.1 Content and objectives

Skills-based health education is designed to help students acquire the knowledge, attitudes, beliefs, and skills that are needed to make informed decisions, understand the consequences of a particular behaviour, adopt healthy behaviours to avoid risks, and create conditions that are conducive to health. Thus, the clear and precise delineation of behaviours and conditions that are to be influenced to positively affect family life, reproductive health, and population goals and objectives is essential for the development of effective skills-based health education efforts. When delineating behaviours and conditions, it is important to keep in mind that efforts need to address two types of audiences: those who have not begun sexual activity and those who are already sexually active.

Examples of health, behavioural, and KABS (knowledge, attitudes, beliefs, skills) objectives for family life, reproductive health, and population education are listed below. Each grouping addresses slightly different aspects of these related issues and provides a range of content that can be considered when developing skills-based health education to address these issues. The decision to address particular objectives should be based on the results from the situation analysis.

Examples of health objectives:

- Family life education helps students to minimize or avoid domestic violence and sexual coercion.
- Reproductive health education helps students minimise their risk of or avoid unwanted pregnancies, abortions, STI, and HIV/AIDS.
- Population education helps students to have their desired number of children, with fewer pre- and postnatal complications, when they are ready to start a family of their own.

Examples of behavioural objectives:

- Family life education helps students assume responsibility according to their expected roles within the family and their friendships.
- Reproductive health education helps students negotiate abstinence or the use of contraceptives.
- Population education helps students to delay marriage and space their children.

Continued from previous page.

Examples of KABS objectives:

Family life education enables students to:

- explain how relationships, such as friendship, love, dating, marriage, and raising children, play a central role throughout our lives (SIECUS, 1999) (K)
- appreciate the similarities and differences among families and family members (UNESCO/UNFPA, 1998b) (A)
- practice important skills for developing and maintaining friendships (UNESCO/UNFPA, 1998b) (S)
- develop skills to deal with the conflicts and changes that occur in families over time (UNESCO/UNFPA, 1998b) (S)

Reproductive health education enables students to:

- describe what information and attitudes are needed to avoid unwanted consequences of sexual behaviour, such as abortions, STI and HIV infection, and sexual abuse (SIECUS, 1999) (K+A)
- explain how human development in the areas of reproductive anatomy and physiology, reproduction, puberty, body image, and sexual identity and orientation is characterised by the interrelationship between physical, emotional, social, and intellectual growth (SIECUS, 1999) (K)
- describe how social and cultural environments such as gender roles, the law, religion, the arts and the media, shape the way individuals learn about and express their sexuality (SIECUS, 1999) (K+A)
- dispel myths related to sexuality and reproduction (UNESCO/UNFPA, 1998b) (A+B)
- demonstrate life skills, such as decision-making, communication, assertiveness, negotiation, and looking for help in practising skills specific to reproductive health, for example, deciding when to try to become pregnant (SIECUS, 1999). (S)

Population education enables students to:

- explain the relationships between population and environment, population and resources, population and economic development, and population and socio cultural factors (UNFPA, 1996) (K)
- show concern about implications and consequences of rapid population growth (UNFPA, 1996) (A)
- feel confident that they will have the desired number of children with a minimum amount of complications when they are ready to have a family (A)
- get involved in extra-curricular activities related to such issues as population growth or environmental protection (UNFPA, 1996) (B)

The curriculum should be **age-appropriate** in both content and teaching methods, focusing on the established goals and objectives and on different aspects, questions, fears, and challenges of youth at different ages. To assure age-appropriateness, a person trained in child development could be asked to be part of the curriculum development team. It is also important to consider that some students may drop out of school early, especially students at high risk. This means

that careful consideration must be given to the selection of content, as this may be a young person's only opportunity for formal learning about family life, reproductive health, and population issues before needing to apply this learning in practice. In addition, some repeaters or drop-outs may be older than their classmates when they return to class and will require separate, age-appropriate counselling (Sikes, 1999).

Folade, a 20 year old from Nigeria, says a family life education programme taught him a lot about life: *"Even boys can now understand why a girl has to say 'no'....I have learned so many things I didn't pay attention to in my biology class"* (UNFPA, 1999b, p. 9).

Sample Curriculum Content

Figure 3 provides a small sample of curriculum content and objectives related to family life, reproductive health, and population education, including suggested age levels, to give a sense of the range of topics that could be considered in developing such interventions. Core areas and objectives have to be adapted to make them age-appropriate and culturally relevant to the implementation. Not all listed examples are relevant to all countries. (Most of the information comes from UNESCO/UNFPA [1998b] and UNFPA [1993].)

Figure 3. Sample Curriculum Content

CORE AREAS (CONTENT)	OBJECTIVES
Family life, including relationships	Young children: • To clarify the definition of family • To better understand family relationships and responsibilities Pre-adolescents: • To identify the components of positive friendships and relationships Adolescents: • To clarify what level of intimacy might be appropriate for which kind of relationships and to reinforce one's right to set limits • To understand what enhances and what damages a relationship

Figure 3. Sample Curriculum Content (continued)

CORE AREAS (CONTENT)	OBJECTIVES
Reproductive health, including human and sexual development and family planning	Young children: • To develop self-awareness and self-esteem • To identify positive health habits • To introduce correct sexual terms and to increase comfort with them Pre-adolescents: • To identify basic structures of the male and femal reproductive systems • To identify physiological and emotional changes taking place during puberty • To understand the process of conception • To define what human sexuality is and how it affects our behaviour • To dispel myths related to sexuality and reproduction Adolescents: • To recognise and articulate some of the emotions that accompany adolescent sexual development • To describe how human reproduction occurs • To discuss personal concerns and questions about puberty in a group of same-sex peers • To identify what is safe and unsafe sexual behaviour and how to reduce sexual risk • To describe how selected factors influence a pregnancy • To identify different kinds of contraceptive methods • To learn where to go for and how to avail oneself of family planning services
Population education, including responsible parenthood	Young children: • To understand the concept of parenthood Pre-adolescents: • To understand that pregnancies can be planned • To understand that parenthood can be an option rather than an obligation Adolescents: • To evaluate the readiness of adolescents for parenthood • To explain how delaying first pregnancy and spacing births can be beneficial • To understand the impact of growing population sizes on our planet

For information on curriculum content related to HIV/AIDS and STI, please refer to a WHO document in the same series, *Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools* (WHO/HPR/HEP/98.6).

Skills-based health education is an important means of enabling students to acquire **knowledge and understanding** about family life, reproductive health, and population issues, including gender relations, social and emotional relationships, and other related factors. A wide range of information on these topics can be taught in schools; however, relevant and appropriate content areas should be determined by local concerns and objectives agreed upon in the planning stage (Birdthistle & Vince-Whitman, 1997; SIECUS, 1991). In a 1997 survey of more than 600 young people in 54 countries, some young people, particularly from Africa and South Asia, believed that sex education should incorporate moral and religious teachings in relation to sexual relationships, and a number of respondents felt that sex education should also include positive aspects of sex, such as the role of sex within a relationship (Senanayake & Marshall, 1997).

Case Study

In Zimbabwe, a randomized study was undertaken on reproductive health knowledge and behaviour among adolescent pupils. It showed a significant increase in correct knowledge about aspects of menstruation as compared to control schools. Pupils from intervention schools were more likely to know that a boy experiencing wet dreams was physically mature enough to make a girl pregnant and that a girl could get pregnant at her first sexual intercourse. Knowledge of family planning had increased significantly in the intervention group after five months. The findings point to the value of early school-based reproductive health education in helping young people acquire correct information on reproductive biology and in preventing ill health related to sexual activity (Mbizvo et al., 1997; Rusakaniko et al., 1997).

In regard to **attitudes and beliefs**, authors and programmers increasingly recommend the inclusion of *gender sensitisation* in reproductive health curricula (Consensus Panel, 1997). Gender sensitisation aims to facilitate self-respect among young women and men and sensitise young people to the notion that they have no rights over another person's body. Gender issues and power differentials can be taught in the context of human rights, along with explanations of rights violations and respect for the rights of others (Birdthistle & Vince-Whitman, 1997). Experts convening at the Netherlands Institute for Health Promotion and Disease Prevention also recommended that activities include building *self-esteem, respect, and awareness of gender stereotypes* among both boys and girls (UNFPA, 1994).

Information alone rarely equips young people with **skills** that lead to a healthy life or the adoption of behaviours that prevent reproductive health problems (Tones, 1981). Students need to learn about and practice skills to protect themselves. Education in life skills, such as decision-making, negotiation, conflict resolution, and resistance to peer pressure, can enable children and adolescents to make healthy choices and adopt healthy behaviour throughout their lives (Birdthistle & Vince-Whitman, 1997).

Research has highlighted the value of **addressing multiple learning domains**, specifically intellectual, emotional, social, and physical, in health education curricula (EDC, 1990; SIECUS, 1991), as well as **multiple family planning**

options. Approaches that have had success in delaying intercourse and reducing risky sexual behaviour have also promoted a variety of family planning options, including monogamy, abstinence, and condom and spermicide use (Birdthistle & Vince-Whitman, 1997).

4.2.2 Teaching and learning methods

Skills-based health education has been shown to reduce the chances of young people engaging in high-risk sexual activity that can result in pregnancy, STI, or HIV infection (Kirby, 2001 & 1997; UNAIDS, 1997; WHO/GPA, 1994; Postrado & Nicholson, 1992; Scripture Union, n.d.; Zabin et al., 1986). To implement effective skills-based health education, teaching methods need to correspond to the content to be taught. A lecture, for instance, can be an effective way to increase students' knowledge, but there are other methods that are more effective in influencing skills, attitudes, and beliefs. For instance, a classroom debate on gender stereotypes in which the teams change sides and thereby force themselves to think from different perspectives can influence attitudes.

Active, informal, personalised, and participatory learning methods, that are culturally sensitive and age-appropriate are most effective in changing health-related behaviour and skills (Birdthistle & Vince-Whitman, 1997) and in improving the relationship between teachers and pupils (Parsons, Hunter, & Warne, 1988). Some programmers and researchers found that testing students on reproductive health information encourages them to take the class more seriously (Consensus Panel, 1997). Examples of participatory teaching and learning methods for skills building include:

- Class discussions
- Brainstorming
- Role plays
- Small group activities
- Educational games and simulations
- Case studies
- Story telling
- Debates
- Audio and visual activities such as arts, music, theatre, dance
- Practising life skills specific to a particular context with others, with verbal feedback and coaching
- Visits or telephone calls to relevant health and social support programmes, such as family planning clinics

Case Study

In Kingston, Jamaica, high school students performed a skit about two sex education tutors and a class of curious boys. Reflects one of the 17-year-old student actors, "The people who saw the skit were awed by its boldness. But the real beneficiaries were the performers—the boys. We learned that having sexual feelings is normal, and in instances where we get sexual urges it is important that we exercise self-control." This student understands the importance of sharing the lessons he learned from participating in this creative exercise. He writes, "Obviously, we cannot prevent boys from having sexual intercourse. What we can do is what the sexually explicit movies don't do, and that is to teach boys how to practice safe sex" (Network, 1993).

[Note: This quote shows a particular student's belief on this issue.]

Models that are based on theories of **behaviour change** and **social learning** have been shown to help youth who have not initiated sex continue to delay onset (Kirby, 1997 & 2001). If students in the target group are sexually active, the reasons why they have sex should be considered in determining what strategies are most appropriate for them to protect themselves (Consensus Panel, 1997). For instance, efforts to build refusal skills are not likely to be effective interventions if students are engaging in sexual activity for financial gain. Young people themselves can be an excellent source of the information needed to create effective learning experiences. They can also be involved in selecting and implementing the methods to help them acquire information or skills.

Case Study

In Bogota, Colombia, the Colombia Human and Social Development Foundation brought together a group of 15 youth volunteers who identified, designed, and tested the following strategies to bring the subject of preventing risky sexual behaviour into their peers' daily lives: suggestion boxes to collect the questions and opinions of adolescents; radio programmes with brief, upbeat messages on prevention; word murals, posters, flyers, bulletin boards, and pamphlets to share the project's work; sexuality education workshops hosted in schools; and community involvement (Saavedra, 1996).

Peer counselling and peer education are two ways of involving students in family life, reproductive health, and population education. As peer counsellors, young people may counsel, inform, make referrals, and in some cases distribute contraceptives to their peers. As peer educators, they may lead workshops for their peers, focusing on skill building through interactive and experimental

activities, with the twin goals of reducing high-risk behaviour and promoting healthy behavioural choices (Advocates for Youth, 1997). In some cases, peer educators, or "child to child" educators, have been involved in developing teaching plans and selecting topics and teaching approaches (Jensen, 1997). Qualitative information indicates that peer education and peer counselling are valuable assets to school-based health promotion in countries all over the world (Birdthistle & Vince-Whitman, 1997).

Case Study

In the Marshall Islands, young people are organisers, educators, and counsellors for a programme designed to help their peers take charge of their reproductive health. Run mainly by young people themselves, "Youth to Youth in Health" is credited with reducing the number of births to adolescent mothers from 21% of all births to 14% over recent years. In 1996, the group became an NGO. Health education is the main focus of the initiative, which has trained more than 340 peer educators and counsellors to convey information on contraceptives, sexuality, and staying healthy. By the end of 1996, 50,000 "contacts" had been made with young people, families, and communities—providing health education through person-to-person counselling, small-group discussions and large outreach meetings. Topics range from how to avoid STI and HIV/AIDS to good nutrition. The young educators use music, dance, drama, and video to combine local cultural elements with their health messages (UNFPA, 1999b, p. 20).

Peer educators have several advantages: they are with young people whenever the topic comes up, they know how to talk to their peers and what motivates them, and they themselves can benefit from participation (McCauley & Salter, 1995). For instance, in the Gambia, 90% of respondents in a peer education programme responded that they applied the health information to their own lives (Wong & Travers, 1997). Peer educators can also act as agents of change in their families and communities. Since peer education experiences high turnover (Senderowitz, 1997a), it is important to continually train new peer educators.

Case Study

Peer educators for reproductive health issues often become respected by students as a source of credible information. Researchers in Chiang Mai, Thailand, found that being a peer educator gave girls social legitimacy to talk about sex without the risk of being stigmatised as someone who is sexually promiscuous. The peer educators were successful in facilitating group discussions about sex, educating their peers about their bodies, helping them to develop communication and assertiveness skills, and changing social norms (Cash & Anasuchatkul, 1995).

4.2.3 Characteristics of effective curricula

Based on extensive reviews of effective curricula with positive behavioural results, a panel of experts identified nine characteristics that effective curricula share:

1. A narrow focus on a small number of **specific behavioural goals and a clear message** that continually reinforces the curriculum's stance on these behaviours
2. **Appropriate to the age, sexual experience, and culture** of the students in regard to behavioural goals, teaching methods, and materials
3. **Based on social learning theories**, such as social cognitive theory, social influence theory, social inoculation theory, cognitive behavioural theory, or the theory of reasoned action[2]
4. **Last a sufficient length of time**, that is 14 or more hours–or, if they last fewer hours, they are implemented in small-group settings with a leader for each group
5. Employ **a variety of active learning methods** designed to involve the participants and to have them personalize the information
6. Provide **basic, accurate information,** e.g., about the most relevant risks of unprotected intercourse, methods of contraception, and population factors
7. Include activities that **address social pressures** on sexual behaviour, including activities that address gender relations
8. Provide **modelling and practice of communication, negotiation, and refusal skills**
9. Select teachers or peers who believe in the programme they are implementing and then provide **training** for those individuals (adapted from Kirby, 1997)

A comprehensive literature review by UNAIDS identified the following principles that underlie effective approaches:

- Education about sex is best started before the onset of sexual activity.
- Education has to be gender-sensitive for both boys and girls.
- Young people are a developmentally heterogeneous group, and not all can be reached by the same technique.
- Learning materials and curricula should be based on frameworks with foundations in research (UNAIDS, 1997).

4.2.4 Placement of skills-based health education

Skills-based health education, ideally, is provided as a planned **sequential** course of instruction from the first grade through the last grade, addressing the physical, mental, emotional, and social dimensions of health. A sequential series of learning experiences is benefical so that learning can be reinforced at regular intervals, and students are able to relate knowledge and skills to specific situations encountered at different ages (OPS/PAHO, 1997).

[2] **Social learning theory** teaches that children learn to behave both through instruction and through observation. **Social cognitive theory** puts forward that teaching interpersonal cognitive problem-solving skills to children can reduce and prevent negative behaviours. **Social influence and social inoculation** theories recognize that children and adolescents will come under pressure from peers and others to engage in risk behaviours. **Cognitive behavioural theory** views an individual's cognition and thoughts as playing a vital role in that person's behaviour. **Theory of reasoned action** proposes that an intention to perform a behaviour is a function of a person's normative beliefs, i.e., what others will and do think about the behaviour.

Family life, reproductive health, and population education - where culturally appropriate - may be provided in a **co-educational** setting, where open and realistic discussions with both boys and girls can take place, to give children practice for a lifetime of healthy female-male communication (UNESCO/UNFPA, 1998b). Research has shown that providing opportunities to work in **single-sex** groups can also be beneficial (Forrest & Vermeer, 1997, pp. 67–70).

There are different approaches to including family life, reproductive health, and population education in a school curricula:

- **Separate subject:** Family life, reproductive health, and population education is taught as part of a specific class on skills-based health education.
- **Single "carrier" subject:** Family life, reproductive health, and population education is incorporated into an existing subject that is relevant to the issues, such as biology, civics/social studies, or religion.
- **Infusion across many subjects:** Family life, reproductive health, and population education is included in many existing subjects through regular classroom teachers.

Each option has general pros and cons, although these may vary according to the local situation. A separate subject can be an excellent long-term goal. It has several advantages: Teachers are likely to be specifically trained and focused on health, and a separate subject is most likely to have congruence between the content and teaching methods, rather than the short-cutting that may occur through infusion or "carrier" subjects. However, not all schools are able to have a separate class on skills-based health education. A carrier subject can be a good short-term solution. It is cheaper and faster to incorporate family life, reproductive health and population education into materials of one subject than to infuse them across all. Also, the training of teachers is faster and cheaper and teacher support tends to be better than for infusion across all subjects. In the long term, the carrier subject can be reinforced by infusion through other subjects. In general, the infusion option in isolation risks losing the salience of the issue amid the competing demands of the other subjects.

4.2.5 Curriculum selection/development

Curricula for family life, reproductive health, and population education and other health-related issues may be available through governmental and non-governmental agencies, universities, student groups, or teachers unions. Supplemental materials specific to the local situation can also be generated by teachers and students themselves. If new curricula are needed, it may be feasible to collaborate with health personnel and specialists from universities in curriculum development and creating learning and teaching materials. Teachers should be involved in curriculum development, as they often are, so that they are comfortable with the material they will present (Birdthistle & Vince-Whitman, 1997). For specific resources, please see Annex 1.

4.3 HEALTHY SCHOOL ENVIRONMENT

A Health-Promoting School provides a safe and healthy environment that presents a realistic and attractive range of choices that encourage a healthy lifestyle. It also provides a supportive social structure that promotes self-esteem and helps students and others develop their physical, psychosocial, and social potential. In a Health-Promoting School, the physical and psychosocial school environment should be consistent with and reinforce other health promotion efforts. The school environment must protect students and staff from discrimination, harassment, abuse, and violence.

4.3.1 Physical environment

The physical environment includes the school building, classrooms, food service, and health care facilities on school grounds; water and food provided at school; and the surroundings in which the school is situated. The condition of the physical environment can have a powerful effect on reinforcing or contradicting education about family life, reproductive health, and population issues in the school. The following aspects of a healthy physical environment can be integrated into a Health-Promoting School, supported by related school health policies, to complement skills-based health education:

- Physical facilities: Safe water and sanitary facilities; functional lighting, heating, ventilation; and cleanliness are essential to good health. In relation to reproductive health, adequate sanitation, water facilities, and single-sex toilets are especially important to encourage the participation of girls, particularly during the days when they are menstruating and need to wash and care for themselves in privacy (UNICEF, 1996c).
- Healthy food choices: A Health-Promoting School promotes and provides nutritional and high-quality foods to offer opportunities for healthy choices (WHO, 1998). A school environment that reinforces education about healthy nutrition is especially important for girls because nutritional status is closely linked to achieving healthy pregnancies.
- Safe environment: A safe environment in a Health-Promoting School ensures that students are protected from physical danger on school grounds and provided with surroundings that are conducive to learning and comfortable for socializing. For instance, a safe environment ensures that students are protected from sexual assaults; e.g., by having chaperones at school activities, guards for night events, and a trusted person in whom students can confide in.
- Resources/displays: A Health-Promoting School uses various occasions and venues, such as meetings, assemblies, classrooms, libraries, hallways, and blackboards, to provide messages and resources that promote family life, reproductive health, and population education.
- Special facilities: A Health-Promoting School may have health care facilities to provide services to students, teachers, and other school personnel, or may maintain referral services. This may include, where locally acceptable, providing products, services, or referrals for menstrual hygiene and birth control. Some schools provide condoms or make them easily accessible to students who need them.

4.3.2 Psychosocial environment

The psychosocial environment relates to conditions that affect social and mental health. Part of the psychosocial environment includes cultural norms and expectations regarding sexual behaviour as expressed by friends, parents, and school personnel. WHO and UNESCO (1992) recommend that school activities take place in "an environment based on respect, trust, and acknowledgement of similarities and differences so as to facilitate the growth of knowledge, the development of skills, and the examination of values." A Health-Promoting School provides an ambience that respects the individual and fosters confidence in healthy choices. The following aspects of a healthy psychosocial environment should be integrated into a Health-Promoting School to support family life, reproductive health, and population education:

- Respect/caring: A Health-Promoting School supports an environment that fosters understanding, caring, and empathy for others and contributes to positive values, beliefs, and attitudes among students, teachers, staff, and the community. This includes values of mutual respect, gender equity, acceptance, and a safe and trustful environment. Success in reproductive health initiatives is most likely to occur when schools deliver education and services in an environment where there is gender equity and respect, where social norms favour the delay of sexual activity or faithful use of contraceptive methods, and where pregnant girls are accepted at school (Birdthistle & Vince-Whitman, 1997).
- Non-discrimination: A Health-Promoting School advances relations between girls and boys that are respectful, non-discriminatory, and non-abusive. Instances of discrimination, double standards, harassment, and violence or abuse between students and between staff and students should be openly condemned in order to promote social and emotional well-being (WHO, 1996).
- Teacher role models: Teachers play an important role as adult role models and as mentors. Teachers, and other school personnel, can encourage healthy behaviours by demonstrating healthy practices themselves and by ensuring that students are protected from sexual abuse and harassment.
- Peer reinforcement: Students can provide positive reinforcement to their peers by discussing and reminding one another of healthy behaviours, such as keeping their commitment to abstinence or safe sex. It is important to ensure that peer influence is used in a positive way, because peer pressure can also reinforce negative behaviours.

Additional psychosocial factors are addressed in Section 4.6 (Mental health promotion, counselling and social support).

4.4 SCHOOL HEALTH SERVICES

Health services should complement and be coordinated with health education and other components of a Health-Promoting School. Sometimes it may be possible for schools to link with clinics and health workers in the community.

Case Study

In Ethiopia, the Youth Counselling Services and Family Planning Education Project of the Family Guidance Association provides clinical services to youth through its four community clinics, and links with 35 area schools to promote its services and expand the reproductive health knowledge of youth. The programme has collaborated with area schools to develop a curriculum for reproductive health education. The programme trains volunteers and peer educators to deliver the educational sessions, provide counselling services, and distribute condoms and non-prescriptive contraceptives in the school setting. For additional services, the volunteers refer youth to the area clinics. The programme encourages sustainability of this education by the school and carefully evaluates each school's progress in this direction (Hanson, 2000).

The following points may be useful to persons who are trying to increase support for improved school health services, including those that correspond to family life, reproductive health, and population education:

- In many countries, young people have little or no regular access to primary health care services. In some areas, the school is the only social institution with which young people have contact.
- Despite evidence that school health services are viable and effective public health interventions, and the growing evidence of their need, school health services are not well developed, if available at all, in many countries. This is unfortunate, because learning and academic achievement are strongly influenced by students' physical and emotional health.
- School health services can significantly contribute to the development of young people and should be advocated as a means of community and economic development.
- As school health services are revised and new services proposed and developed, they should be planned and implemented as an integral part of the existing school health programme and available to all students, as appropriate and relevant. Services that respond to reproductive health needs and related health issues are likely to be most effective when integrated and coordinated with other school health and support services (WHO, 1999a).

School-based or school-linked health services may offer treatment of minor injuries, primary care, routine physical exams, immunizations (such as vaccines against tetanus and German measles, which can be important for girls in promoting safe motherhood), health promotion, and counselling. Services may include those specifically related to reproductive health, such as gynaecological examinations, family planning counselling,

and pregnancy detection, as well as services for males' reproductive health concerns, and screening and treatment of STI. In some countries, provision of such services to adolescents or unmarried young people may be restricted or prohibited by the law. It has been shown, though, that strengthening connections between sexuality education and family planning services can both delay sexual intercourse among students who have not had intercourse and increase contraceptive use among those who are sexually active (Koo, Dunteman, George, Green & Vincent, 1994).

A paper delivered at a World Health Organization consultation called for females to enter their reproductive years protected against tetanus so that neither they nor their future babies get the disease. Tetanus can be prevented easily through a highly effective, safe and inexpensive series of immunisations. Countries which have a high enrolment rate of girls in the early grades of primary school can take advantage of the long-lasting duration of immunity from each successive dose and immunise both girls and boys in the early grades, before the girls start to drop out of school. Several countries now offer tetanus immunisation in early primary school, particularly in Asia and the Middle East. (Steinglass, 1997).

The provision of reproductive health services needs to consider the social, cultural, and economic environment and offer privacy, confidentiality, and, ideally, staff who are trained to work with young adults - both males and females - on sensitive issues. Schools need to make students aware of the availability of these services. Adolescent-friendly reproductive health services should adopt some or all of the following key features identified by young people (UNFPA, 1998):

- Confidentiality
- Comfortable and welcoming surroundings
- Non-judgmental attitude
- Provision of information and services that young people want
- Acceptance of youth as they are, without moralizing or demoralizing
- Asking about and respecting youths' opinions about services
- Allowing young people to decide for themselves
- Provision of services within the timeframe available to young people

In addition, health services may be structured around the following key features (UN, 2000):

- Male and female staff trained in adolescent sexual and reproductive health and development
- Adequate supply of accessible and affordable drugs and contraceptives (where permitted by law and acceptable in the community)
- Multiple interventions that include information, counselling, telephone help lines and referral mechanisms to community-based services
- Linkages to existing structures, such as recreational, educational, vocational, and sports programmes

To help prevent reproductive health problems and unintended pregnancies and to support healthy development among students and school personnel, health workers could do the following:

- Provide information and advice to students and school personnel.
- Provide opportunities for school personnel, students, and parents to ask questions and clarify any doubts or concerns they have about development during puberty, menstruation, pregnancy, and methods of menstrual care and pregnancy prevention.
- Serve as a confidant to whom students and school personnel can express fear and anxiety about physical and emotional changes during puberty or pregnancy without facing ridicule or judgement.
- Provide health products (such as contraceptives or condoms) when they are permitted to do so by prevailing laws and practices, or refer students and school personnel to an easily available source.
- Identify and collaborate with organisations that can provide appropriate non-health services when required, such as legal or social support for children and adolescents who are being abused or neglected (WHO, 1999a).

To help meet the needs of students and school personnel with reproductive health related concerns, health workers could do the following:

- Be alert to the possibility and presence of health problems (such as STI) and/or unhealthy practices (such as injected drug use) and detect them early, if and when they arise.
- Appropriately manage health issues to the best of their abilities and based on the facilities at their disposal. This could include providing medical treatment, responding to childrens'/adolescents' psychological needs, and helping them deal with the social implications of their conditions.
- Refer students and school personnel to the next "level" of health service delivery and/or to organisations that provide relevant support services.

To help strengthen the school's/community's response to reproductive health issues, health workers could do the following:

- Advocate for supportive school policies and strong school programmes with policy- and decision-makers and relevant community leaders.
- Engage and support education officials and representatives from other relevant sectors in providing information, building skills, and providing counselling services in the school setting (and be actively involved in these efforts themselves).
- Collaborate with school officials, students, and teachers to mobilize school and community support for efforts that respond to reproductive health needs, for example, developing peer networks among students that promote understanding about and support for healthy sexual attitudes and behaviours, prevention programmes, and care; and linking such networks to relevant programmes and networks in the school and community.

(Adopted from WHO/UNAIDS/UNESCO, 1999, pp. 30–31.)

4.5 COOPERATION WITH COMMUNITIES AND FAMILIES

A Health-Promoting School is an important part of the community that surrounds it, and the community is a critical component of the school environment. Community members should feel that their neighbourhood school is open and receptive to their ideas and participation. Schools and students in turn should be supported by community members through their participation in developing and supporting school-based initiatives and providing social support (WHO, 1996).

It is essential that schools, parents, and communities work together. "Adults play a vital role in the healthy development of young people and can contribute to a supportive climate for behavioural choices through positive relationships" (UN, 2000). Students are most likely to adopt healthy behaviour patterns if they receive consistent information and support through multiple channels, such as teachers, parents, peers, community members, and media. Thus, parents and other caregivers play an important role as nurturers, teachers, disciplinarians, role models, and supervisors in providing an environment that is safe and supportive with opportunities for full adolescent development. Far too often, however, parents and other caregivers do not have the resources, skills, or community support to carry out these roles as effectively as possible. As a result, the messages students receive in the classroom may not be reinforced—or sometimes may even be contradicted—once students go home.

A Health-Promoting School can provide parents and caregivers with information, resources, and skills. Educating parents about their own and their children's health and development may be necessary. Parent involvement should begin early and be sustained throughout school-based interventions (WHO, 1996). Parent education or training can inform parents of the need for family life, reproductive health, and population education and provide them with activities to enhance their skills in addressing these issues with their adolescent children.

Case Study

School-based initiatives can help parents communicate with their adolescent children. In one activity in the United States, parents were made more aware of the social pressures on their children to become sexually active. Then parents rehearsed ways to help their children resist these pressures (McCauley & Salter, 1995, as cited by Rice, 1997).

A Health-Promoting school can also equip students with knowledge and skills that they can share with their parents and other family members. Family and community members can be involved in a Health-Promoting School in various ways:

- Taking part in planning and decision-making, for instance, by participating in the School Health Team or Community Advisory Committee, and making decisions through which components of the school family life, reproductive health and population education will be addressed.
- Participating in activities and services offered through schools, for instance, attending events to gain specific knowledge and skills about child, adolescent, and sexual development or effective communication with adolescents; such events

include health fairs, festivals, drama presentations, classroom discussions, exhibitions, and special parental guidance programmes. Families may also be involved in their children's homework exercises related to topics in family life, reproductive health, and population education.

- Providing support and resources, for instance, supplying financial or material donations, being guest speakers, or providing specialist services related to health promotion, family life, reproductive health, and population education. Midwives from the community can offer informal discussion groups for students and parents, and pharmacists can offer products for feminine hygiene and contraception.
- Advocating for health, for instance, knowledge and skills acquired in a school/community project can be used by community and family members to take actions that support healthy sexual development, such as freedom from sexual coercion and access to family planning services.

Schools can be the centre for a number of community enhancement projects (WHO, 1996). For instance, when early marriage and childbearing is common, a major educational effort could be mounted through the schools to help communities understand the health risks and lifelong impact involved (Rice, 1995). Equally important, if there are legal minimum ages at marriage that are overlooked, educational efforts could apprise youth, parents, and communities of the existence of these laws and other legal requirements, their rationale, and the consequences of disobeying them. Schools can benefit greatly from partnerships with local businesses and representatives from various agencies, such as health departments, youth-serving agencies, and non-governmental organisations. Together, partners can discuss common problems, develop joint interventions, and integrate services.

Case Study

In Thailand, more than 80% of secondary and vocational school students have been reached with family life and sex education primarily because of the close collaboration between the Planned Parenthood Association of Thailand (PPAT), schools, and the government. PPAT helped to train teachers, while the government supported the programme (Ford, D'Auriol, Ankomah, Davies, & Mathie, 1992).

4.5.1 Reaching out-of-school youth

Involving the community can help affect young people who have dropped out of school, are chronically truant, and who are at high risk of coerced sexual relations and STI. Schools can co-ordinate activities with other sectors and plan joint projects, for instance, with community health centres, health extension agents, local entertainment centres, or law enforcement officials. Peer initiatives, which can be based at schools, have been successfully used to identify and contact out-of-school youth and street children (Senderowitz, 1997a). In some communities, schools have organised health fairs that brought together parents, students, other community members, and out-of-school youth to spend an enjoyable afternoon

learning about health and the availability of preventive services and to screen for important and treatable health conditions. These types of events are particularly valuable in countries with a large proportion of out-of-school youth (Birdthistle & Vince-Whitman, 1997). In some communities, religious services include information about the importance of family planning. Schools may also use media, such as radio broadcasts, to reach out-of-school children. The consequences of not reaching out-of-school youth are likely to negatively affect in-school youth as well as the community as a whole.

4.5.2 Involving mass media

Mass media can be a powerful influence in promoting and damaging the health of young people. "In most parts of the world, young adults are exposed to media that refer to sex and romance, often with little or no mention of responsible sexual behaviour. Casual sex is depicted, but without references to sexually transmitted disease or unintended pregnancy. Nevertheless, television, radio, music, magazines and other media can also become powerful tools for giving young adults perspectives on the consequences of sexual activity" (Keller, 1997). When messages appear in different media simultaneously, their effect is intensified. Various partners in the field of reproductive health, such as governmental and non-governmental agencies, industry and trade, and women's and youth groups, can take a lead in mass media work. Schools can facilitate or develop partnerships with mass media representatives to co-ordinate and collaborate on efforts that address family life, reproductive health, and population issues and to ensure consistent messages.

Examples how media outlets and schools can collaborate to promote family life, reproductive health, and population education and to make it more acceptable to discuss these topics:

- Providing free air time or space for messages to schools, especially for messages created by youth that inform young people and encourage healthy behaviour
- Enabling children and adolescents in schools to produce youth-oriented newspapers or television and radio shows on family life, reproductive health, and population education.
- Collaborating with schools in organising discussions or call-in radio or television programmes that include accurate information about family life, reproductive health, and population issues
- Collaborating with schools to address parents with accurate information and guidance on talking with their adolescent children

4.6 MENTAL HEALTH PROMOTION, COUNSELLING AND SOCIAL SUPPORT

Case Study

A staff person at a school-linked health centre recounts how counsellors helped her when she was a pregnant adolescent: "I was cushioned by counsellors who made me realise that despite my unplanned pregnancy, my dreams and aspirations could still be realised. They showed me where I had made mistakes and helped teach me how to love and care for the unborn child who was already mine" (Johnson, 1997).

Adolescents often feel like there is no one with whom they can privately discuss questions, concerns, or crises related to reproductive health or sexual assault. Many adolescents may also be concerned with developmental issues relating to changes during puberty and relationships or how to protect themselves from HIV and STI. Maintaining and supporting the mental health of students and staff is important to complement and support education about family life, reproductive health, and population issues. An individual's psychosocial well-being, including self-esteem, self-confidence, or self-efficacy, is critical in maintaining physical health and the ability to make healthy decisions and avoid risk behaviours.

Counsellors and other health care providers can help adolescents improve their self-esteem, make informed decisions, and feel more confident and in control of their own lives. Counsellors can also help young people understand the other gender's expectations regarding sexuality and sexuality outcomes (FAO/WHO/ILO/UNESCO, 1998). Schools can serve as a credible venue for counselling services related to family life, reproductive health, and population issues. In hiring counsellors to work with young people, schools should only consider individuals who are:

- empathetic
- knowledgeable
- trustworthy
- clear about their own values regarding sexuality
- interested in and friendly towards adolescents
- able to develop respectful and caring relationships with adolescent clients
- able to address broader issues of physical and emotional development of adolescents, including relationships, family conflict, and drugs
- used to working in a setting that ensures privacy and confidentiality

(Adapted from Senderowitz, 1997b.)

Case Study

In the United States, girls enrolled in a school-linked pregnancy prevention programme in Baltimore, Maryland, have been shown to postpone sexual involvement seven months longer than girls not enrolled. Pregnancy rates were reduced by 30% over two years among participating girls who received sexual education complemented by individual and group counselling and medical and contraceptive services. Pregnancy rates among other girls in a comparison group increased by 58% in the same time period (Zabin et al., 1986).

Besides counselling, it is also important, especially for students, to have social support that encourages healthy behaviours. Individuals from the school, community, family, and religious affiliation can informally offer information and activities that provide adolescents with answers to their questions and healthy options for their leisure. For instance, religious and other organisations in the community can offer social activities that address adolescent-related topics and provide opportunities for young people to talk informally with adults and among themselves about sexuality, reproductive health, family life, and population issues. Teachers and other school staff can help students in coping with difficulties, adjustments, growth, and development.

4.7 PHYSICAL EXERCISE, SPORT, RECREATION, AND EXTRA-CURRICULAR ACTIVITIES

Physical exercise, recreation, and sport help individuals acquire and maintain physical fitness and serve as a healthy means of self-expression and social development. Recreation activities can restore strength and spirits after school and work. Physical education and recreation activities can provide opportunities for building self-confidence and strengthening friendships between boys and girls in non-pressured group situations (WHO, 1996). However, physical education and recreation activities can also turn into a site of ridicule, physical compromise, and embarrassment if the activities are not developed with consideration to the young person's sensitivity to body image and differences in physical development. Often, students learn about sexual and reproductive health from the physical education teacher; thus such educators should be well-trained in dealing with issues of puberty and sexual development.

Extra-curricular activities can include occasional events, organised either for the entire school or for all students of a particular age, to address key social, cultural, and environmental factors that relate to family life, reproductive health, and population issues (Rice, 1995). These may include call-in media shows about relationships and love; hotlines to discuss issues related to sexuality and reproduction; discussion groups among youth to talk about friendships and expressions of sexuality; discussion groups with parents and youth to talk about the transition to adulthood; youth camps that include discussions about population issues—especially in highly populated countries—and their relevance to young people; peer-education groups in schools about marriage and the family; or drama presentations about a young couple that struggles with an unintended pregnancy (adapted from UNESCO/UNFPA, 1998b). To design extra-curricular activities that appeal to

youth, it is important to find out from young people where and how they spend their time and what their current needs and health-seeking behaviours are (UNESCO/UNFPA, 1998b), and if schools have rules and limits to support the safety of and protect young people from situations they may not be ready to handle.

4.8 NUTRITION AND FOOD PROGRAMMES

Children who are not adequately nourished are more likely to be absent from school, are less likely to concentrate and perform well, and are thus less likely to benefit from family life, reproductive health, and population education offered in schools. Adolescent females who are not adequately nourished are also more likely to experience problems with childbirth and have a greater risk of maternal death from obstructed labour (Kurz, Peplinsky, & Johnson-Welch, 1994).

Health-Promoting Schools can implement nutrition interventions in various ways to promote healthy development of students and staff:

- Micronutrient supplementation: Distributing micronutrients to children who have nutritional deficiencies can contribute in the long term to reproductive health, especially in girls. For example, promotion of medical (e.g., daily ferrous sulphate tablets) and food-based (e.g., consumption of meat, legumes, or green leafy vegetables) solutions can treat iron deficiency (where it has been identified as a problem) and thus prepare young girls for less dangerous childbirth.
- School feeding: Providing free nutritious meals at school for children of low-income families is of great importance to relieve short-term hunger and to ensure sufficient nourishment for physical development, especially during the adolescent growth spurt. School feeding programmes can also be an incentive for parents to send children to school where they may consequently have the opportunity to learn about health, including family life and reproductive health (WHO, 1996).
- School meals: The composition of school meals and their nutritive value plays an important role in fostering educational achievement and health, both of which have an important influence on reproductive behaviour. Also, if students become accustomed to healthy food choices, they may develop and share habits of healthy eating with other members in their family.
- Nutrition education: Teaching boys and girls about nutritional needs during pregnancy and for new-born babies (e.g., the importance of breast milk) and the importance of balanced meals for their future families can be taught by food service staff as part of skills-based health education or in specially arranged sessions.

4.9 HEALTH PROMOTION FOR SCHOOL STAFF

A Health-Promoting School aims to promote healthy lifestyles for all who study and work in and use the school, including teachers, administrators, and other school staff, some of whom might be in their late adolescent years themselves and have sexual health needs or be affected by HIV/AIDS or other STI. Strategies to promote family life, reproductive health, and population education should become an integral part of health promotion for

school staff. Health promotion for staff is intended to increase their interest in health, help them acquire healthy lifestyles, help them model respect and gender equity, and prevent sexual harassment or abuse. Addressing sexual and reproductive health in schools can benefit teachers and other staff, rather than adding an additional burden (which some staff may initially be concerned about).

School personnel need to be educated about, and to develop skills, in health promotion, including healthy sexual development. There are several reasons why health promotion for staff is important:

- Healthy employees are better able to fulfil their responsibilities.
- Teachers and school personnel are role models to students and others.
- School personnel can help identify policies and practices that are needed to support health and well-being in schools.

Examples of staff development activities related to family life, reproductive health, and population education include workshops, such as the one described below, and distribution of printed materials, which might be available from national or local agencies.

Case Study

Education Development Center, Inc., a non-profit organization in the United States, held workshops for its staff entitled "What's Sex Got to Do with It? Exploring Issues of Sexuality in the Workplace." This workshop addressed the complex interpersonal changes that staff must make in order to ensure that they treat one another and their clients fairly and with respect. Participants were presented with different and challenging case studies and asked to engage in a lively discussion on the many grey areas of this important issue. Key topics and learning points included the following: what legally constitutes sexual harassment; what is appropriate behaviour in the workplace; relating one's perception of sexual harassment to case studies; how sexual harassment affects morale, productivity and trust in the workplace; and one's responsibility as a trainer entering a school setting (adapted from Stier, 1999).

5. TRAINING TEACHERS, SCHOOL PERSONNEL, PEER EDUCATORS, AND OTHERS TO ADDRESS FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION EDUCATION AS PART OF A HEALTH-PROMOTING SCHOOL

Training of various individuals involved in school-based efforts related to family life, reproductive health, and population issues is crucial in a successful approach to school health. This document can only give a brief overview of some concepts and principles related to training of teachers, school personnel, and peer educators. For information on co-operating with families and training parents, please see Section 4.5 of this document. Annex 1 includes references to training curricula.

Team training of teachers, school personnel, and others can help assure building a critical mass of people who share the same educational objectives and who are trained to carry out some new practice. A critical mass is needed for change to happen in schools (Birdthistle & Vince-Whitman, 1997) and for a consistent application of health promotion and reproductive health interventions in classrooms and other services at the school.

Team training for family life, reproductive health, and population education instructors, administrators, and the School Health Team may include the following (adapted from Birdthistle & Vince-Whitman, 1997):

- Review of relevant national and local policies
- Inspirational keynote address for the vision or "big idea"
- Understanding the concept of a Health-Promoting School, and how and where family life, reproductive health, and population education can be supported across components
- Review of leadership, management, and co-ordinating mechanisms for school-based interventions, including the roles and responsibilities of teachers
- Information on when, how, and to what extent staff should be involved in the prevention of and/or early intervention regarding pregnancy, STI, HIV/AIDS, sexual abuse, and sexual harassment
- Overview of factors and techniques that influence family life, reproductive health, and population issues
- Overview of policies and procedures for handling sensitive issues, e.g.:
    - Informing teachers about what they can and cannot discuss with students in regard to homosexuality and sexuality in general and when they can refer students to outside resources
    - Giving clear guidance about handling suspected cases of sexual abuse among students or school personnel
- Factual information about human development, family life, reproductive health, and population patterns that will facilitate an understanding of the way young people develop physically, socially, and emotionally, with particular emphasis on gender roles and various forms of relationships within the current cultural, social, and legal climate of the country (Rice, 1995)
- Self-awareness about feelings about one's own body and sexuality
- Awareness of available community-based services for student referral and how to link with and use them (Majer, Santelli, & Coyle, 1992)
- Reassurance that classes will vary and presentation of the curriculum will not be uniform among educators
- Addressing the concerns of parents or community leaders
- Instilling an understanding of the nature and type of local issues in regard to addressing sexual development
- Providing counselling to teachers who are concerned about their own reproductive health status

Training should sensitise the trainees for promoting family life, reproductive health, and population education and the concept of a Health-Promoting School. It is important to realize that this training may be the first time participants have openly discussed issues of reproductive health (Birdthistle & Vince-Whitman, 1997). Training needs to "dispel the myth that knowledge about reproductive health, including sexuality and contraception, will increase promiscuity. [It] should also include participatory exercises" (Rice, 1995). In addition, training may include techniques to monitor performance and evaluate learning experiences and interventions.

Materials for training of teachers and others may be available through governmental and non-governmental organisations and UN agencies, such as WHO Regional Offices, UNESCO, UNICEF, UNAIDS, and UNFPA, as well as universities or teachers unions. Supplemental training and learning materials specific to the local situation can also be generated by schools within that country, community, or district. Guidelines are needed for the creative training of current teachers as well as new teachers.

Case Study

In a UNESCO population education initiative on the island of Galapagos, Ecuador, teachers, parents, and pupils from rural schools identified their own learning needs and produced training materials to cover specific problems in the community. The programme aimed to promote self-esteem and good family relationships in order to help learners plan their futures and adopt responsible parental attitudes. Teaching and learning aids, including a video and newsletter that spread educational messages in clear, straightforward language, were carefully designed (Beverley Kerr, UNFPA, as cited in Birdthistle & Vince-Whitman, 1997).

How can we prepare teachers, staff, and peer educators for these tasks?

5.1 TEACHER TRAINING

Teachers, especially those who are asked to teach family life, reproductive health, and population education, need to receive training and accurate information to effectively address these issues in their content areas. Health education research has found a significant difference in student learning outcomes when teachers are trained. Research has also shown that training teachers in the use of health curricula improves their implementation of the programme (Ross, Nelson & Kolbe, 1991; Connell, Turner & Mason, 1985). Education and training should inspire and equip teachers with knowledge and skills to make a curriculum exciting in order to encourage students to establish healthy behaviours. In addition, training should include exercises that address teachers' self-awareness about sexuality and gender issues, help them assess their own practices, and make them aware of the behavioural messages they give as role models.

Countries or individual schools may develop criteria for selecting educators to teach about sexuality and reproductive health specifically. The Swedish Association for Sex Education, for example, explains that a teacher of sexuality education needs to feel comfortable talking about sexuality and have a desire to educate. This person must also command trust and give respect, and young people must have faith in this individual and feel comfortable asking questions, discussing issues, listening and learning (Lindahl & Laack, 1996).

Teachers who are primarily responsible for family life, reproductive health, and population education may receive specific relevant training in implementing a selected curriculum. This training can address content and a variety of teaching strategies, including active learning methods, such as discussions, debates, role plays, group activities, games, case studies, and community education projects, that engage students and parents. Training ideally provides a chance to practise some of these methods and demonstrates strategies for integrating concepts and skills into various subject areas, such as social studies, language arts, science, religious education, and/or math.

Ideally, teacher training is offered both pre-service and in-service. Both, approaches to teacher education "should involve an understanding of the latest educational research, relevant discipline studies, progressive pedagogical studies and classroom management techniques" (Education International, 1998).

Non-governmental organisations or institutions of higher education that train professionals and paraprofessionals in nursing or medicine may each provide training for teachers and school health service providers. Teacher unions can also provide a leadership role in training of school personnel. Continuing education should be offered to practising professionals so that practitioners can acquire the skills they need to intervene early and appropriately.

5.2 PEER EDUCATOR TRAINING

In countries where peer education is not common or even prohibited, peer education first needs to be advocated for and accepted, and then proper guidelines need to be set up. Peer educators need to receive training similar to that of teachers in family life, reproductive health, and population education, as well as motivation and continued support. "Training of peer educators to work with other students in educational and counselling activities should focus on providing accurate reproductive health information and practising techniques of problem solving, listening, non-judgmental communication, giving feedback, conflict resolution, decision making, counselling, and basic education. Peer educators should also be aware of sources of support for students who need information, counselling or health services. Training methods and resources that are practical, interactive, and can be replicated in the classroom should be used. As there is often a high turnover of peer educators, some recommend regular retraining of peer educators each year" (Ford et al., 1992, cited in Birdthistle & Vince-Whitman, 1997).

How do we know if our efforts have been successful?

Evaluation is a powerful tool that can be used to inform and strengthen Health-Promoting School activities. It has the potential to provide solid evidence of effectiveness and information on which interventions work best, which do not work, and how to advance efforts in the future.

The primary intention of most evaluations is to provide information about the extent to which interventions are being implemented as planned (i.e., process evaluation). Evaluation is also used to provide evidence of the effectiveness of the interventions in achieving the intended objectives at the school level (i.e., outcome evaluation) and more broadly to convince communities and governments of the interventions' importance. Data collected through carefully designed evaluations can be used to improve programmes and provide information to national, state, and local institutions as they set goals and objectives for current and future efforts.

The value of evaluation includes:

- providing feedback to those involved in project planning
- making improvements or adjustments in the programme
- demonstrating the value of efforts of schools, parents, and communities
- documenting experience so that it can be shared with others

Evaluation as an important element of a school-based approach must be considered from the outset and remain ongoing. The basis for evaluation is established **at the very beginning** of the planning process when needs are assessed, objectives set, and activities planned. At the same time, a monitoring and evaluation plan should be established to track process in accomplishing objectives and carrying out activities. **During the implementation**, evaluation is necessary to monitor the process in order to make adjustments or corrections where needed. **At the end** of the interventions, or after a pre-determined period, evaluation activities assess the results and impact of the interventions and determine if the programme achieved its objectives or if it needs to be improved. The cycle will then start again with the question of what further change is desirable.

During evaluation, as well as during all other stages of planning and implementing school health interventions, it is recommended to involve youth in a meaningful way. Engaging young people in actual delivery and evaluation efforts fosters active involvement, ensures that activities are relevant to young people's needs, and provides continuing feedback for improvement of the approaches (Senderowitz, 1998).

6.1 PROCESS EVALUATION OR MONITORING

Process evaluation measures the achievement of the process objectives: It provides information about the extent to which activities were implemented as planned. It is an ongoing process of monitoring those objectives to record what has been done, with whom, and when to see if the programme is being carried out as planned. This documentation can help others understand what led to success and avoid any

problems that occurred in their future programmes. Methods for process evaluation include teacher or student diaries, tallies, school records, and interviews with teachers, school administrators, parents, and others.

Process evaluation is necessary to answer such questions as these:

- To what extent are the interventions being implemented the way they are intended? For example, how many class sessions were held on family life, reproductive health, and population education; which materials were produced and distributed; how many parents and community members were counselled; and what other activities are being implemented?
- To what extent are the interventions reaching the individuals who may need them e.g., children and adolescents, parents, teachers, counsellors, and/or community members?

Case Study

The West African Youth Initiative, a collaborative adolescent reproductive health project for in-and out-of-school youth, organised by Advocates for Youth in Washington, D.C., USA, and the Association for Reproductive Health and Family Health in Ibadan, Nigeria, has successfully engaged its peer educators in evaluation, using their management information system (MIS) services. Peer educators use special MIS forms and quarterly reporting forms to monitor services provided, such as number of clients counselled and referred, and number of contraceptives distributed. Currently, peer educators are involved in monitoring of services by taking a basic count; however, as peer educators become more comfortable and skilled, they will also document the types of counselling encounters, types of referrals made, etc. (SIECUS, 1998).

6.2 OUTCOME EVALUATION

Outcome evaluation provides information about whether what has been done has made a difference and to what extent the outcome objectives have been achieved. Outcome evaluation is conducted to determine any changes that have occurred over the time period from before an intervention is implemented to after implementation, and to demonstrate that the identified changes are the result of the intervention itself, not some other factors. Data items that have been assessed during the situation analysis, and that are directly related to intervention objectives, should be relatively easy to collect again for outcome evaluation.

Assessments may include quantitative and qualitative information of reproductive health-related health status, practices, knowledge, behaviour, and attitudes. Quantitative information includes objective numerical measures, such as prevalence of students practising abstinence, or level of knowledge about how to avoid unwanted pregnancies. Qualitative information contains subjective perceptions and feelings, such as feeling in control about choosing how many children a couple wants.

Outcome evaluation is necessary to answer such questions as these:

- Are the activities accomplishing what we expected (e.g., to what extent did the programme achieve increases in students' knowledge, attitudes, and skills related to family life, reproductive health, and population issues)?
- Which specific interventions or components of our efforts work best? With whom? Under what circumstances?
- Are programme planners and participants satisfied with the outcomes?
- What components did not work? What went wrong?
- Where should we place more of our efforts in the future?
- What can be improved?

Where resources such as time, personnel, and budget for evaluation may be scarce, it may be sufficient and more feasible to conduct a process rather than an outcome evaluation. Too often, programmes rush to study their impact on youth without fully understanding whether or how well implementation of the interventions occurred.

To conduct an evaluation, it is necessary to have the following:

- A good understanding of interventions, including goals and objectives
- A commitment to learning more about the strengths and weaknesses of the efforts and to improving their delivery
- At least one person who is willing to be responsible for the evaluation and who may receive some training in design and analysis of an evaluation
- Preferably, a trained researcher or social scientist as consultant, e.g., from the department of health or education or a local college or university, who has experience and can help lay out baseline analysis and outcome evaluation

Annex 3 provides tools for process and outcome evaluation, based on the action plan developed in Annex 2. Annex 1 refers to resources that can be utilised to plan evaluation efforts.

6.3 SAMPLE EVALUATION QUESTIONS FOR VARIOUS COMPONENTS

The following table provides an overview of various components that can be evaluated and examples of quantitative and qualitative questions for process and outcome evaluation. It might not always be possible to evaluate outcomes for each component separately. This table is not all-inclusive and needs to be adapted to different settings and fields of work, as approaches and objectives vary with local conditions. Evaluation should be based on the objectives established in the planning phase and should be conducted in collaboration with the School Health Team and Community Advisory Committee.

COMPONENTS	EXAMPLES OF *PROCESS EVALUATION* QUESTIONS	EXAMPLES OF *OUTCOME EVALUATION* QUESTIONS
Supportive School Policies	• Does the school have a comprehensive policy on health promotion and family life, reproductive health, and population education? • Does the school enforce a policy on sexual harassment? • What do administrators, teachers, students, and parents think of the policies?	• What impact did the school policy have on any of the components of a Health Promoting School? (Use specific questions tailored to a particular school, e.g. enrolment rates for girls; increase in knowledge, attitudes, and skills; and service utilization rates related related to reproductive health.) • Has the incidence of sexual harassment declined?
Skills-Based Health Education	• Is there a curriculum for family life, reproductive health, and population education? • Are interactive educational methods applied? • Are gender-sensitive, age-appropriate materials utilized? • Is training for peer educators and in-service training for teachers provided? • Do teachers and peer educators feel comfortable implementing the various parts of the curriculum?	• To what extent have knowledge attitudes, skills, and practices of students and staff changed? (Use specific questions tailored to the objectives and activities of family life, reproductive health, and population education conducted at school.)
Healthy School Environment	• Are separate sanitary facilities provided for girls and boys? • To what extent are resources and displays provided that promote family life, reproductive health, and population education?	• To what extent has attendance changed since sanitary facilities have been improved? • What impact do students and staff report that resources and displays had on them?
School Health Services	• To what extent have school health services provided screening, diagnosis, and treatment of conditions related to reproductive health? • If appropriate: To what extent are contraceptives available? • Are students, teachers, and parents satisfied with the confidentiality and privacy provided?	• To what extent have unintended pregnancies, STI, and HIV infection rates changed among students and teachers? • To what extent has the rate of contraceptive use changed? • To what extent has the number of visits to reproductive health-related services changed?

COMPONENTS	EXAMPLES OF *PROCESS EVALUATION* QUESTIONS	EXAMPLES OF *OUTCOME EVALUATION* QUESTIONS
Cooperation with Communities and Families	• How have community members and parents been involved in school-based interventions that address family life, reproductive health, and population education?	• Which changes in knowledge, attitudes, skills, and practices occurred in community members who participated in school-based interventions that addressed family life, reproductive health, and population education? • What changes in conditions have occurred in the community?
Mental Health Promotion, Counselling, and Social Support	• How many youth have been counselled by qualified staff on family life, reproductive health, and population issues?	• For those who participated in mental health counselling, what changes were observed in knowledge, attitudes, and behaviour?
Physical Exercise, Sport, Recreation, and Extra-Curricular Activities	• Which events in sports and extra-curricular activities include components that address healthy family life, reproductive health, and population education?	• What effect in individuals' lives did participation in sports and extra-curricular activities have?
Nutrition and Food Programmes	• Which healthy food choices are offered on school grounds? • To what extent are feeding programmes and micronutrient supplementation taking place?	• Do nutrition and food interventions demonstrate any perceptible results?
Health Promotion for School Staff	• Are reproductive health-related services offered for school staff? • How many staff members participate in these activities?	• To what extent do health promotion initiatives for school staff help staff to adopt healthy behaviours or create conditions that foster family life, reproductive health, and population issues?

Any evaluation is useful and complete only when its results are reported and communicated to those who need and can use them, including those involved in planning and managing the interventions. The value of evaluations is increased if the results are reported using repeatedly the same objective criteria to ensure continuity and comparability. Evaluation reports should contain interesting and easily understandable material for many individuals and groups, including school staff, students, community members, and families. Evaluation results can be used to initiate discussion, debate, and proposals that can contribute to the development and support of family life, reproductive health, and population education in schools and communities.

Annex 1 includes helpful resources and tools that can be used to conduct monitoring and evaluation of young adult reproductive health initiatives.

7. CONCLUDING REMARKS

This document provided an overview of how to advocate and plan for school-based efforts to address family life, reproductive health, and population issues. Since these issues are so crucial for the life of all individuals, schools—with the support of the appropriate ministries—should make every effort to address these topics in a culturally relevant matter.

Addressing these issues provides a good opportunity to establish or improve Health-Promoting Schools and to support the FRESH (**F**ocusing **R**esources on **E**ffective **S**chool **H**ealth) initiative (UNESCO/UNICEF/WHO/WorldBank, 2000).

Documents listed in Annex 1 can be utilised to implement these efforts. In addition, other documents in the *WHO Information Series on School Health* (listed on the inside of the front cover) may also be helpful, especially *Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools* (WHO/HPR /HEP/98.6) and *Local Action: Creating Health-Promoting Schools* (WHO/NMH/HPS/00.X).

"Young people are the partners of today, the leaders of tomorrow, and the parents of the future. Much can be done today to enable them to succeed and help prepare them for future roles" (UN, 2000, p. 8).

USEFUL RESOURCES FOR IMPLEMENTING THE VARIOUS SECTIONS

Section 2: Convincing others that Family Life, Reproductive Health, and Population Education through Schools are Important and Effective for Public Health and Personal Development

- *Communication and Advocacy Strategies: Adolescent Reproductive and Sexual Health. Booklet 2: Advocacy and IEC Programmes and Strategies. Booklet 3: Lessons Learned and Guidelines*, (2001), co-published by UNESCO and UNFPA, available from UNESCO Principal Regional Office for Asia and the Pacific, P.O. Box 967, Prakanong Post Office, Bangkok 10110, Thailand.

  Booklet 2 includes advocacy strategies, such as generating the interest and commitment of decision-makers, winning support by various sectors, and developing recommendations and other documents. Booklet 3 summarises lessons learned for advocacy and communications as well as a discussion of factors that may help or hinder advocacy.

- *After Cairo: A Handbook on Advocacy for Women Leaders,* (1994), available from the Centre for Development and Population Activities (CEDPA), 1717 Massachusetts Avenue NW, Suite 200, Washington, DC 20036, USA.

  Several chapters in this handbook describe how to plan and implement strategies for advocacy: Planning for advocacy, Taking your message to the public, Forging alliances, Advocating for resources, and Advocacy profiles.

- *TB Advocacy: A Practical Guide,* WHO/TB/98.239, (1998), available from the Global Tuberculosis Programme at the World Health Organization, Geneva, Switzerland.

  Even though on a different topic, this practical handbook contains useful step-by-step information for planning advocacy efforts: documenting the situation, packaging the message, working with the media, and mobilising others.

- *Communications Briefings: 101 Ways to Influence People on the Job*, (1998), published by Briefings Publishing Group, 1101 King Street, Suite 110, Alexandria, VA 22314, USA.

  This practical guide on how to influence people gives guidance on the role of the influencer, the messages, and the audience, and includes tactics on how to persuade others, especially in workplace settings.

- *Influence: The Psychology of Persuasion* by Robert B. Cialdini, (1993), published by William Morrow, New York.

  This book explains the six psychological principles that drive our powerful impulse to comply to the pressures of others and shows how we can put the principles to work in our own interest or defend ourselves against manipulation.

Section 3: Planning efforts to address Family Life, Reproductive Health, and Population Education as part of a Health-Promoting School

- *Coming of Age: From Facts to Action for Adolescent Sexual & Reproductive Health*, WHO/FRH/ADH/97.18, (1997), available from Adolescent Health & Development Programme, Family & Reproductive Health, World Health Organization, Geneva, Switzerland.

  This manual includes steps for planning, doing, and using a situation analysis specifically for adolescent sexual and reproductive health. Steps for doing a situation analysis include collecting existing information, collecting new information, managing collected-information, analysing collected information and data, and drawing conclusions.

- *Local Action: Creating Health-Promoting Schools,* WHO/NMH/HPS/00.4, (2000), available from Department of Noncommunicable Disease Prevention and Health Promotion, World Health Organization, Geneva, Switzerland, or online at http://www.who.int/school-youth-health.

  This implementation manual for Health-Promoting Schools at the local level includes tools to assess resources, local health problems, and opportunities; involve members of the school and community; define objectives and goals and develop an action plan; and document progress and plan for the future.

- *Strategic Assessment Tool for Planning Young Adult Reproductive Health Programmes at Country Level*, (2000), available from Pathfinder International, 9 Galen Street, Suite 217, Watertown, MA02472, USA, Phone. 1-617-924-7200. Fax: 1-617-924-3833 or online at http://www.pathfind.org/.

  This resource includes tools for conducting a situation analysis.

Section 4: Integrating Family Life, Reproductive Health, and Population Education into various components of a Health-Promoting School

- *Annotated Bibliography of Training Curricula for Young Adult Reproductive Health Programmes,* (1998), available from Pathfinder International, 9 Galen Street, Suite 217, Watertown, MA02472, USA, Phone. 1-617-924-7200. Fax: 1-617-924-3833; also available online at http://www.pathfind.org/guides-tools.htm.

  This document includes information about curricula from countries all over the world. Sections include Family Life Education Programmes; Prevention of STI/HIV/AIDS Programmes; Pregnancy Prevention, Reproductive Health, or Sex Education Programmes; Programmes Working to Reduce the Incidence of Female Genital Mutilation; Programmes Dealing with Violence Prevention, Negotiation Skills or Substance Abuse; Programmes Promoting Empowerment of Adolescent Girls; and Adapting Curricula.

- *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk Among Adolescents,* (2001), available from Pathfinder International, 9 Galen Street, Suite 217, Watertown, MA02472, USA, Phone. 1-617-924-7200. Fax: 1-617-924-3833; also available online at http://www.pathfind.org/.

  This user-friendly tool has been prepared for those who design and deliver programmes and who formulate policies and programme objectives concerned with the well-being of young people, especially in the developing world and in regard to

reproductive health. It helps the reader understand adolescent developmental needs during pre-puberty, early adolescence, middle adolescence, and young adulthood, which helps them design more practical, age-appropriate programmes.

- *Handbook for Educating on Adolescent Reproductive and Sexual Health. Book Two: Strategies and Materials on Adolescent Reproductive and Sexual Health Education,* (1998), developed jointly by UNESCO and UNFPA, and published by the UNESCO Principal Regional Office for Asia and the Pacific, P.O. Box 967, Prakanong Post Office, Bangkok 10110, Thailand, under UNFPA Project RAS/96/P02.

  This book addresses problems, responses, and gaps related to adolescent reproductive and sexual health; requirements and strategies for introducing an effective adolescent reproductive and sexual health education programme; and suggestions for incorporating reproductive and sexual health into an existing curriculum. Selected strategies include grounding programmes in social learning theory and social constructions; highlighting gender equity issues and male participation; using life skills approaches and strategies to ensure responsible behaviour development; and balancing cognitive and affective behavioural components.

- *Growing Into Healthy Sexuality* (for grades 6–8)
- *Respecting Healthy Sexuality* (for grades 9–12)

  These are part of the Teenage Health Teaching Modules (THTM), developed by Education Development Center, Inc. (EDC), 55 Chapel Street, Newton, MA 02458, USA; Phone 1-617-969-7100; to order materials, please contact EDC, P.O. Box 1020, Sewickley, PA 15143, USA, or order online: http://www2.edc.org/THTM/.

  THTM is a comprehensive school health education curriculum for adolescents. The modules have been designed primarily for the use in the United States but they have also been adapted for use in other countries. The overall goal of THTM is to provide students with the knowledge, skills, and understanding necessary to act in ways that enhance their immediate and long-term health and that of the families, schools, and communities to which they belong. The essential health skills of risk assessment, self-assessment, communication, decision-making, goal setting, health advocacy, and healthy self-management are highlighted in all of the modules.

Section 5: Training teachers, school personnel, peer educators, and others to address Family Life, Reproductive Health, and Population Education as part of a Health-Promoting School

- *Counselling Skills Training in Adolescent Sexuality and Reproductive Health: A Facilitator's Guide*, (1993), WHO/ADH/93.3; published by the World Health Organization; available on request from the Adolescent Health Programme, Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

- *Annotated Bibliography of Training Curricula for Young Adult Reproductive Health Programmes,* (1998), available from Pathfinder International, 9 Galen Street, Suite 217, Watertown, MA02472, USA, Phone. 1-617-924-7200. Fax: 1-617-924-3833, also available online at http://www.pathfind.org/guides-tools.htm.

  This document includes sections with summaries of curricula and references for working with parents and for training counsellors, along with listings of numerous other reproductive health curricula.

- *EI/WHO Training and Resource Manual on School Health and HIV/AIDS Prevention,* (2001), published jointly by Education International and WHO; available online at http://www.ei-ie.org/educ/aids/eepublication.htm or available from Education International, 5 Bd du Roi Albert II (8th), 1210 Brussels, Belgium; Phone: + 32 (2) 224 0611; Fax: + 32 (2) 224 0606.

  This manual provides teachers and other staff with useful activities and resources to strengthen their advocacy skills and use of participatory teaching methods to prevent HIV/STI and related discrimination. Included are materials that help teachers address their own risks and concerns as well as resources that teachers can use to conduct interactive learning experiences to help young people acquire the skills to avoid risky behaviours. Most of this HIV/STI-specific material might be easily adaptable to family life, reproductive health, and population education.

Section 6: Evaluation of Process and Outcome

- *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programmes,* (2000), published by FOCUS on Young Adults, 1201 Connecticut Avenue, NW, Suite 501, Washington, DC 20036, USA. Phone: 1-202-835-0818; Fax 1-202-835-0282; Website: http://www.pathfind.org/focus.htm.

  This 450-page document guides readers through the how-to's of monitoring and evaluation, including developing a monitoring and evaluation plan, indicators, evaluation design and sampling, data collection, and analysis. It also contains 15 different instruments and questionnaires that can be adapted to particular monitoring and evaluation needs.

  • *Evaluating Family Planning Programmes—with Adaptations for Reproductive Health* by Bertrand, Magnani, and Rutenberg
  • *Handbook of Indicators for Family Planning Programme Evaluation* by Bertrand, Magnani, and Knowles (1996), published by The Evaluation Project, Carolina Population Centre, University of North Carolina at Chapel Hill, CB 8120 University Square, Chapel Hill, NC 27516-3997, USA.

  These documents were written for programme administrators and managers, in-country evaluation specialists, family planning researchers, and donor agency personnel. The manuals prepare readers to differentiate between the main types of programme evaluation, evaluate alternative methods for impact assessment, select the most appropriate method for a given setting, and design an evaluation plan. The handbook compiles and defines those indicators most useful in family planning programme evaluation in an effort to make indicators better known and easier to use.

  • *Guidebook: Evaluating Teen Pregnancy Prevention Programmes,* (2001), available from Sociometrics, 170 State Street, Suite 260, Los Altos, CA 94022-2812, USA; Phone: 1-650-949-3282; Fax 1-650-949-3299; also available online at http://www.socio.com.

  This how-to book is a comprehensive evaluation resource for pregnancy prevention among adolescents. A field-tested resource for those who manage evaluations and those who carry them out, it guides the integration of evaluation methods into all aspects of adolescent pregnancy prevention programmes.

SAMPLE ACTION PLAN FOR SCHOOL-BASED EFFORTS RELATED TO FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION ISSUES

For more information, please refer to
Local Action: Creating Health-Promoting Schools (WHO/NMH/HPS/00.4), Geneva: WHO, 2000.

I. GOAL STATEMENT

Based on your situation analysis, discuss in your planning team (e.g., School Health Team) what you want to accomplish in regard to family life, reproductive health, and population education.

Five Year Goal

Example: To ensure that all students are provided with relevant education and services related to family life, reproductive health, and population issues to prepare them for a safe and healthy life now and in the future.

What would you like to accomplish during the next year to meet this goal?

Year One Goals

Examples:

1. *To provide skills-based health education to all students with accurate information about sexual development, pregnancy and pregnancy prevention, and STI.*
2. *To provide confidential school health services to all students that offer diagnosis, treatment, and counselling in reproductive health issues.*

II. MEASURABLE OBJECTIVES

Measurable objectives describe specific outcomes that will help you determine whether you are reaching your goals. Objectives should be set for each goal individually.

Year One Objectives for Each Goal

Examples

Objectives for Goal 1

I. *Those responsible for creating and changing school policies will establish a policy for the school to address family life, reproductive health, and population issues in the curriculum.*
II. *Locate or develop age-appropriate reproductive health curricula for each grade.*
III. *Train teachers to implement family life, reproductive health, and population education.*

Objectives for Goal 2

I. *Hire or train staff to address reproductive health issues confidentially.*
II. *Outreach to students to invite them to participate in family life and reproductive health-related school health services, as needed.*

III. HELPING AND HINDERING FORCES

Identify below the forces that will help or hinder the achievement of your goals and objectives. Helping forces are anything that will assist in the completion of your goal. Hindering forces are whatever makes reaching your goal difficult.

HELPING FORCES	HINDERING FORCES
Examples: • *Community support* • *Supportive teachers and student volunteers* • *Political climate*	*Examples:* • *Lack of funding* • *Lack of available trainers*

IV. STRATEGIES

Activities related to strategies that have evidence of being effective need to be chosen to address each of your objectives. To be realistic, the helping and hindering forces that you identified need to be taken into account when making decisions about which strategy to use in a particular situation. Multiple strategies may be chosen to address a single objective.

YEAR ONE OBJECTIVES	STRATEGIES	ACTIVITIES
I. Those responsible for creating and changing school policies will establish a policy for the school to address family life, reproductive health, and population issues in the curriculum. *II. Locate or develop age-appropriate reproductive health curricula for each grade.* *III. Train teachers to implement family life, reproductive health, and population education.*	Supportive School Policies Skills-Based Health Education (e.g., skill training, participatory learning, peer education) Healthy School Environment (e.g., physical environment, psychological environment) School Health Services (e.g., screening, diagnosis, referral availability of contraceptives) Cooperation with Communities and Families (e.g., parent education, reaching out-of-school youth, involving mass media)	Ia. At a meeting, present arguments to convince policy-makers of the importance and effectiveness of family life, reproductive health, and population education. Ib. Draft sample supportive school policy. II. Contact local, regional, and international agencies to identify effective skills-based health education curricula that address family life, reproductive health, and population education.

YEAR ONE OBJECTIVES	STRATEGIES	ACTIVITIES
	Mental Health Promotion, Counselling and Social Support Physical Exercise, Recreation, and Extra-Curricular Activities Nutrition (e.g., micronutrient supplementation, school feeding, nutritious school meals) Health Promotion for School Staff Other:	IIIa. Identify suitable trainers of teachers, with the help of local, regional, and international agencies. IIIb. Identify funding source(s). IIIc. Develop training schedule and arrange logistics. IIId. Conduct participatory teacher training.

V. ACTION PLAN

From the information you gathered, you can develop an action plan. On the form below, list an objective. Use a separate page for each goal or objective. Identify the activities needed to achieve each objective, who will take responsibility for the completion of the activity, when the activity will be completed, what resources will be required, and how effectiveness will be measured.

Goal # 1

I. Those responsible for creating and changing school policies will establish a policy for the school to address family life, reproductive health, and population issues.

II. Locate or develop age-appropriate reproductive health curricula for each grade.

III. Train teachers to implement family life, reproductive health, and population education.

ANNEX 2

Examples:

ACTIVITY	PERSON(S) RESPONSIBLE	COMPLETED BY WHEN	RESOURCES REQUIRED	EVALUATION PLAN
Ia. Present arguments at a meeting of those responsible for school health policies.	*Headmaster*	*March 2004*	*Arguments on the evidence of effective family life and reproductive health interventions*	*Positive decision to establish school policy to require family life education in each grade*
II. Contact local, regional and international agencies to identify effective skills-based health education curricula.	*Health education teachers, administrator*	*May 2004*	*Contact information of agencies, resources*	*Availability of skills-based health education curricula for family life, reproductive health, and population education*
IIIa. Identify suitable trainers of teachers, with the help of local, regional and international agencies	*Vice headmaster*	*May 2004*	*Contact information of agencies, resources*	*Availability of trainers*

SAMPLE EVALUATION PLAN FOR SCHOOL-BASED EFFORTS RELATED TO FAMILY LIFE, REPRODUCTIVE HEALTH, AND POPULATION ISSUES

I. PROCESS EVALUATION

List the activity for each objective from the Action Plan (Annex 1). To create an ongoing record of the actions that have been conducted to implement each activity, record in the table below all dates of implementation, the number and description of people who participated (e.g., 30 eight-grade students; 12 teachers), and the number and description of resources used (e.g., 30 handouts depicting male and female sexual anatomy, and 3 newspaper clip-outs with reports on current sexual violence and harassment cases in the community).

Objective # 1 - III
Example
Train teachers to implement family life, reproductive health, and population education.

ACTIVITY	DATE(S) IMPLEMENTED	NUMBER AND DESCRIPTION OF PEOPLE WHO PARTICIPATED	NUMBER AND DESCRIPTION OF RESOURCES USED
Teacher training workshop	*September 20, 2004*	*Five first grade teachers, three second grade teachers, four fourth grade teachers, two administrators*	*Training material adopted from EI/WHO Training and Resource Manual on School Health and HIV/AIDS Prevention*

II. OUTCOME EVALUATION

For each activity, list the data sources/indicator(s) that you plan to examine, according to the Evaluation Plan you identified on your Action Plan, to determine if the activity has achieved its goal. Record in the next columns the date when you examined each data source and the measurement taken of the data source. In the last column, record the result, i.e., to what extent the goal has been achieved.

Goal # 1
Example
Train teachers to implement family life, reproductive health, and population education.

ACTIVITY	DATA SOURCES(S) EXAMINED/INDICATOR	DATE	MEASUREMENT	RESULT
Teacher training workshop	*Teachers completed an evaluation form; practice of interactive teaching methods*	*September 2004*	*12 out of 14 participants answered a short quiz on content with at least 90% accuracy; all participants checked off that they felt comfortable implementing interactive methods after practice*	*Training was successful; booster training session recommended in 1-2 years*

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