

**Assessment Strategies for  
Skills-based Health Education  
with a focus on HIV prevention and related issues**

**Draft, 2003**

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## **Table of Contents**

I. Introduction.....	1
II. Types of Assessment Tools.....	15
III. Assessing Knowledge Objectives.....	27
IV. Assessing Attitude Objectives.....	53
V. Assessing Skill Objectives.....	77
VI. Assessing Behaviour Objectives.....	103
VII. Bibliography.....	113

## **I. Introduction**

### **A. Purpose of this publication**

The purpose of this publication is to show how a range of strategies can be used to assess the impact of learning activities in skills-based health education, with a focus on HIV prevention and related issues.

The main focus is on strategies that can be used to assess whether or not selected knowledge, attitude, and skill objectives for HIV/AIDS prevention are being met in the short term by classroom activities. It is intended that the assessment strategies suggested are used with an understanding that achieving knowledge, attitude and skill objectives takes time, and is unlikely to be the result of a single lesson.

This publication also suggests strategies for assessing the kinds of behavioural outcomes that may result from changes in students' knowledge, attitudes and skills. Influencing behaviour is a complex, long-term process, and is the result of a number of factors besides classroom instruction. However, teachers should be aware of strategies for assessing behaviour change or development, as this is the ultimate goal of HIV/AIDS prevention education.

#### **A note on terminology:**

**Skills-based health education** uses a combination of participatory learning experiences that aims to develop knowledge, attitudes and especially skills needed to take positive actions to create healthy lifestyles and conditions.

**Life skills-based education** is a term often used almost interchangeably with skills-based health education. The difference between life skills-based education and skills-based health education is only in the content or topics that are covered. Not all program content is considered "health related". For example, life skills-based education may focus on peace education, human rights, or citizenship education, and other social issues as well as health issues, but skills-based health education emphasises health-related topics. Both address real life applications of essential knowledge, attitudes and skills, and use interactive teaching and learning methods.

This resource focuses on life skills-based education for health related issues under the term used here "skills-based health education".

The audience for this publication is primarily teachers of adolescents and pre-adolescents who are responsible for skills-based health education (although many of the assessment strategies suggested can be adapted for use with younger children as well). While the strategies are designed for use in schools, they are equally applicable use in non-school learning environments, where adults wish to assess the impact of their health education programmes.

It is assumed that the teachers or facilitators using this publication are working in schools and other learning environments that support participatory and interactive approaches to learning.

Such teaching methods, which have been shown to have positive effects on the development of students' knowledge, attitudes, and skills, require assessment methods that are also participatory.

Whether or not skills-based health education is formally assessed, providing a variety of assessment strategies that go beyond knowledge tests can assist teachers and other facilitators of learning to monitor progress of participants, as part of routine good educational practice.

The assessment strategies in this publication have been adapted from learning activities used in life-skills and HIV prevention programmes from both developing and higher-income countries. They should be used in conjunction existing teaching or training materials, and therefore should be adapted to match the content of the programme actually in use.

### This publication is NOT...

This publication is NOT a comprehensive assessment plan for skills-based health education. These programmes vary widely from place to place in their content and methods. Therefore, locally designed assessment strategies are most likely to reflect the objectives set by the communities in which these programmes are taking place.

Rather, this publication presents a sampling of types of strategies that might be adapted for local use. It is intended that these examples will stimulate teachers to create their own assessment tools. Such tools should provide comprehensive indicators of student progress in skills-based health education that are more meaningful than “traditional” testing, and can be integrated into routine classroom practice.

The aim of presenting these strategies is NOT to make skills-based health education an examinable subject. While consensus is growing around common knowledge, attitude, skill, and behaviour objectives for HIV/AIDS prevention, there are generally good arguments locally for whether or not skills-based health education is formally examined.

Finally, this publication is NOT intended to set forth guidelines for monitoring and evaluating all aspects of the implementation of skills-based health education programmes, such as effectiveness, efficiency, relevance, and sustainability (UNICEF, 1991). Its focus is on providing educators with better ways of monitoring the progress of students, and the impact of classroom interventions on students' knowledge, attitudes, skills and behaviours.

## **B. WHY assess?**

Good teachers are constantly assessing in the classroom. They assess the *process* of learning, or how the curriculum is actually carried out – what methods were used, how many students took part, problems that arose with particular teaching methods, changes that need to be made in teaching materials, etc. Teachers generally assess learning processes on an informal, ongoing basis.

Teachers also assess learning *outcomes* to determine whether the objectives of the curriculum have been reached, and whether the curriculum has made a difference in students' knowledge, attitudes, skills, and behaviours (UNICEF/WHO, 2001). Teachers may assess outcomes informally, through their own observations of students' performance on daily activities. They may also assess outcomes formally, through standardised tests and those that they develop themselves.

Information about learning processes and learning outcomes is gathered for two purposes, often referred to as *formative* and *summative* assessment.

*Formative assessment* gives information about the progress being made in classroom learning. It is used to help formulate plans for teaching and learning, and to modify instructional methods and materials during the course of an educational programme. Information about both learning processes and learning outcomes is used in formative assessment.

*Summative assessment* gives information about the achievement of students at the end of a school year, or the end of a health education course or workshop. Summative assessment draws primarily on information about learning outcomes.

Both formative and summative assessments have uses for a variety of audiences (Croft and Singh, 1994, p. 29):

*Teachers:* Assessment results enable teachers to modify the curriculum for the needs of the students, and provide information about the effectiveness of a range of teaching methods. They also give information about students' strengths and weaknesses that can be helpful in determining how to group students, which ones need extra help, and which ones can benefit from additional challenges. Assessment of student performance can allow teacher to reflect on their own performance, strengths, weaknesses, and possible changes that could be made to their teaching style.

*Students:* Assessment results provide students with feedback on their own learning. Being able to monitor their own progress can increase motivation and self-esteem, as students see changes over time. The opportunity to reflect on reasons for those changes builds cognitive skills. Ideally students should be active participants in the process of assessment, rather than only objects of assessment.

*Parents:* Assessment results allow parents to know how their child is progressing according to various criteria, or in comparison to other students in the class.

*Educational planners and policy makers:* While assessment results are not usually used directly by policy makers, they may be part of the data collected during programme evaluations. They can help guide choices about curriculum content and methods, and inform policy decisions.

Skills-based health education programmes deal with potentially life-threatening issues. Therefore the importance of assessment tools that provide meaningful indicators of the effectiveness of these programmes, and their impacts on students' knowledge, attitudes, skills and behaviours, cannot be under-estimated.

### **C. WHAT to assess?**

Assessment in skills-based health education focuses on the development of key knowledge, attitudes and skills, which can be expected to influence the development of health-promoting behaviours in real life. It is important that *all* of these objectives – knowledge, attitudes, and skills – are assessed, as any one alone is not sufficient for behaviour change or development.

*Knowledge* refers to what students understand and have learned, both prior to being exposed to a curriculum and after it. Knowledge objectives for skills-based health education with an HIV prevention focus might include knowing about male and female anatomy and how the body changes during puberty, knowing how HIV is and is not transmitted, and knowing what measures can be taken to prevent HIV transmission.

*Skills* refer to students' abilities to carry out specific behaviours. These are often called "life skills", because they are the interpersonal and thinking skills that enable students to handle issues that they face in real life. Skill objectives for skills-based health education with an HIV prevention focus might include being able to problem-solve when faced with decisions on health-related matters, being able to communicate assertively when faced with pressure to have intercourse, and being able to correctly use condoms.

*Attitudes* refer to feelings, values and beliefs that are held about the self, others, and issues. Attitudes are influenced by cultural and religious teachings, as well as school, the peer group, parents, and life experience. Attitude objectives for skills-based health education with an HIV prevention focus might include a positive self-image regarding bodily changes during puberty, motivation to engage in healthy behaviour, a sense of concern for those affected by HIV/AIDS, and willingness to consider alternatives to intercourse.

*Behaviours* refer to what young people actually do when confronted with decisions about health-related issues. Behavioural objectives for skills-based health education with an HIV prevention focus might include refusal to share needles if injecting drugs, consistent use of condoms when having intercourse, and delaying the age of first intercourse.

In considering what to assess, a distinction is sometimes made between "impact" and "outcome" (Hawe, Degeling, and Hall, 1990, p. 102). Both can provide useful information, but are usually collected at different points in time:

*Impact assessment* is concerned with the immediate or short-term effects of a programme. These are usually directly related to the programme's objectives. Impact assessment generally looks for changes in students' knowledge, attitudes and skills, as

these can potentially be affected by classroom activities in a relatively short period of time (although some changes, particularly attitude changes, may take longer).

*Outcome assessment* is concerned with the medium to long-term effects of a programme. These are usually related to the programme's goals. Outcome assessment generally looks for changes in students' behaviours. While some types of behaviour change or development can be measured in the short term, most behaviours related to HIV prevention are complex, take time to learn or change, and may not be put to use until an opportunity arises. They are also not easily observable, and therefore are generally beyond the scope of assessment by a classroom teacher.

#### **D. WHEN to assess?**

The timing of assessment is crucial to obtaining meaningful results. Assessment should not be carried out too frequently (after every lesson is too frequent!), because students need time to absorb and retain new knowledge, and to develop new attitudes and skills. It is also important to avoid a "testing effect" where correct answers become obvious because of the test design, enabling students to guess at answers rather than indicate what they have genuinely learned.

Four approaches to the timing of assessment (Hawe, Degeling, and Hall, 1990, p. 119-121) are worth considering:

*Assessment at the end of a curriculum unit* is typical in many classrooms. It is the least time-consuming way of structuring assessment, and provides results indicative of students' knowledge, attitudes, and skills at a given point in time. However, it does not provide any information about knowledge, attitudes, or skills prior to the curriculum intervention, so it is not possible to know what sort of changes have taken place as a result of exposure to the lessons. Assessment at the end of a curriculum unit is most meaningful if there are clear norms or standards for achievement and a score or grade can be developed (for example, 65% correct answers indicates a passing level).

*Assessment at the end of a unit, with a comparison group* provides teachers with a sense of how the curriculum is impacting the class. In this model, assessment measures are given to both a group that has received a curriculum intervention, such as a skills-based health education programme on HIV prevention, and to a group that has either received a different intervention, or no intervention at all. A comparison of the scores yields information on how the curriculum is impacting the knowledge, attitudes and skills of the group that received instruction. However, this type of assessment design may be too time-consuming for the classroom teacher to carry out. The identification of an appropriate comparison group may be difficult. And ethical issues may arise around deliberately withholding a potentially life-saving intervention such as HIV-prevention education from students only so that they may serve as a comparison group.

*Assessment before and after a curriculum unit* involves giving selected assessment instruments to the class before lessons begin, for example on HIV prevention. The same instruments are given at the end of the curriculum unit, and the pre-intervention and post-intervention results are compared. This is a more reliable means of assessing change in individual students, and whether the programme objectives have been met, than the previous two designs. This pre-/post-intervention design is most meaningful if knowledge, attitudes, and skills are assessed, rather than only one of these domains of learning. While this may be a time-consuming process, it is not necessary to assess every programme objective both before and after exposure to the curriculum in for assessment results to be useful.

All of the assessment activities described in the later chapters of this publication can be used in a pre-/post-intervention assessment design.

*Continuous assessment* can be an extension of the pre-/post-intervention design. If a class will be meeting over a substantial period of time (such as a year), assessments can be made prior to beginning lessons, and at intervals (such as every two months) leading up to the end of the class. Drawbacks are that assessing and analysing results makes demands on the teacher's time, and students may begin to give answers that they think the teacher expects. However, this design can be particularly useful for formative assessment, in which the teacher wishes to receive information on whether or not objectives are being met, in order to modify the curriculum during the course of the year.

## **E. WHO should assess?**

Assessment is often thought of as an activity carried out only by teachers, with the students as the objects. Yet using a mix of teacher, peer, self, and other third party assessment can yield far more accurate information about changes in students as a result of a skills-based health education programme than assessment by one group alone.

*Teacher assessment:* Teachers are responsible for developing an overall assessment plan. They may be responsible for designing assessment tools, as few standardised measures have been developed for skills-based health education. Teachers are often in the best position to develop assessment tools that are appropriate to their curriculum and the learning styles of their students. Teachers' must also interpret results of assessment, whether those are scores on paper and pencil tests, observational data, student performance during a role play, or responses to stimuli such as pictures, photos, or videos.

*Peer assessment:* Peers are an under-used resource for assessment. Students often welcome the opportunity to be involved in assessment, and take their responsibilities seriously. Students can assess each other's skills during a role play, or gather information on each other's attitudes through interviews. Their views may provide perspectives on the impact of a skills-based health education programme that teachers do not have; for



example, their assessment of whether strategies used to refuse intercourse would actually work in real life may be more accurate than adults’.

*Student self-assessment:* Students are capable of providing valuable feedback on the personal impact of a skills-based health education programme. They can use self-reporting scales or checklists to assess changes in their own knowledge, attitudes, and skills. When assessment is carried out using a pre-/post-intervention design, students can look at their results both before and after being exposed to the curriculum, describe the changes they see, and tell why they think those changes occurred. This involves students in a participatory way as subjects, rather than objects, of assessment, while developing the ability to think critically about their own learning process.

*Other third parties:* Administrators and other teaching staff can also be involved in assessment. They can carry out observations and record knowledge and skills demonstrated, for example. Or they can conduct interviews using a set of prepared questions. When using such assessment tools, they are potentially more objective than a teacher who may have a desire to see or hear particular responses.

Parents are third parties who can also be involved in assessment. They may be able to provide information on their children’s skills and behaviour through observation checklists, anecdotal records, or interviews.

The following table indicates who assesses in each of the activities in this manual.

ACTIVITY	WHO ASSESSES?			
	Teacher	Self	Peers	Others
<b>Knowledge</b>				
K-1. Puberty Quiz	X			
K-2. Transmission Picture Sort	X			
K-3. Dear Doctor	X			
K-4. Safe Condom Use	X			
K-5. Birth Control: Advantages and Disadvantages	X			
K-6. A Visit to the Clinic			X	
<b>Attitudes</b>				
A-1. How Do I See Myself?	X	X		
A-2. Would You Be Willing?	X	X		
A-3. Attitudes Toward Gender Roles	X	X		
A-4. Poster Design			X	
A-5. Interviews			X	
A-6. Captions	X			
<b>Skills</b>				
S-1. Peer Influence		X		
S-2. Parent Observations				X
S-3. Speech Bubbles			X	
S-4. Assessing Risk	X			
S-5. Mapping	X			
S-6. Saying No				X
<b>Behaviours</b>				
B-1. My Intentions		X		
B-2. Behaviour Survey	X	X		
B-3. Community Service Project				X

## F. HOW to assess?

Skills-based health education programmes have a range of knowledge, attitude, skill and behaviour objectives. What questions does a teacher want to ask about those objectives? And how does s/he know if those objectives have been met?

Programme objectives determine assessment questions, and those questions determine the criteria that indicate change has occurred. Assessment tools can then be developed that measure those criteria. The table below shows the relationship between objectives, assessment questions, criteria, and assessment tools.

Programme objective	Assessment question	Criterion	Possible assessment tools
<p><b>Knowledge:</b></p> <p>Students will learn how HIV is and is not transmitted.</p>	Can students correctly identify means by which HIV is and is not transmitted?	When presented with a list of ways that HIV is and is not transmitted, students will place each item on the list into its correct category.	<p>Set of pictures to sort, showing ways HIV is and is not transmitted.</p> <p>List of descriptions of possible means of transmission; students circle those that describe ways HIV is spread.</p>
<p><b>Attitude:</b></p> <p>Students will demonstrate care and concern toward persons affected by HIV.</p>	Do students feel empathy and concern for people living with HIV/AIDS?	When presented with a description of a situation involving a person with HIV/AIDS, students will express emotions that indicate caring.	Description of the daily life of a person living with HIV/AIDS; students circle words, from a page of “feelings” words, that describe their reaction to the description.
<p><b>Skill:</b></p> <p>Students will be able to negotiate less risky alternatives to intercourse.</p>	If students are pressured to have unsafe sex, can they assertively negotiate safer behaviour?	When faced with pressure to have unsafe sex, students will suggest at least one safer alternative, will demonstrate confidence in proposing that alternative, and will not give in to pressure.	<p>Role play scenario in which first student pressures second student to have sex, and second student demonstrates the ability to negotiate.</p> <p>Written scenario involving pressure to have unsafe sex; students write a sample dialog in response.</p>
<p><b>Behaviour:</b></p> <p>Students use condoms each time they have intercourse.</p>	Do students use condoms consistently if they are sexually active?	When asked to report on sexual behaviour, students report using a condom each time they have intercourse.	Self-report checklist on sexual behaviour, including questions on condom use in a given time period (for

			example, the past six months).
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Several different types of assessment tools are mentioned in the table above. There are many others that can be used in skills-based health education programmes. These include:

- Closed ended questions: true-false questionnaires, multiple choice questionnaires, matching items (often used in self-report checklists)
- Open-ended questions: essays, short answer questionnaires, sentence completion items
- Observation
- Collection of various types of records (attendance, visits to clinic, etc.)
- Scales (such as Likert scales, semantic differential scales, social distance scales)
- Role plays
- Writing and performing skits and plays
- Interviews
- Time lines
- Diaries and journals
- Analysis of videos, case studies, photos, pictures, or scenarios
- “Stimulus” activities such as picture sorting; writing photo captions; writing speech bubbles for cartoons; writing responses to letters; or creating posters, slogans or advertisements promoting delaying sex, using condoms, fidelity, anti-discrimination, etc.

These types of tools, and advantages and disadvantages of each, are discussed further in Chapter II. It is worth noting that each of these tools may be educational for students, in addition to being means of assessment.

When selecting an appropriate tool for a specific objective in life skills-based education, it can be useful to make a distinction between *norm-referenced* assessment and *criterion-referenced* assessment (Croft and Singh, 1994, p. 68).

*Norm-referencing* aims to provide information on the students’ level of achievement in relation to others in the class. This is done by scoring assessment measures and giving students a grade, or ranking them in comparison with each other. An example of norm referencing might be “Students achieve a score of 70% correct answers on a true-false test of ways that HIV is and is not transmitted.”

Norm-referenced assessment tools use quantitative measures. They are particularly appropriate for assessing knowledge objectives, where there are clear right and wrong answers.

However, learning life skills, including those needed for HIV prevention, requires more than acquiring knowledge. Attitude, skill, and behaviour change or development are also essential. It is difficult to establish norms for these types of objectives. Therefore, criterion-referenced tools, which may involve the use of qualitative as well as quantitative measures, are used widely throughout this publication. Note that these more complex assessment systems are most appropriate for assessing more complex learning and performance of tasks related to learning.

*Criterion-referencing* aims to provide information on the students' level of achievement in relation to a specific criterion, or a set of criteria or standards. This can be done by determining the assessment question and tool, and setting from three to five criteria that indicate increasing levels of achievement. Scoring is not based on percentages of "correct" answers, but rather on whether or not a specified level of competency is demonstrated. This might be referred to as the "pass point".

**A three-point criterion-referenced scale** for a skill related module, which also draws on key knowledge, might cover the following levels:

Level 1: Not met. The student does not demonstrate core knowledge and skills covered in class

Level 2: Not yet fully met. The student can demonstrate a core of basic knowledge and skills covered in class

Level 3: Fully Met. The student demonstrates mastery of the knowledge and skills covered in class including application to contexts beyond that covered in class.

***Note:** Additional clarification of each of the three criterion would be required to illustrate the exact features of the knowledge and skills that are expected and at what level.*

**A sample three-point criteria scale**

Assessment question: Are students able to resist peer pressure to engage in unhealthy behaviour?

Assessment tool: A cartoon in which an under-age student is being pressured by an older student to drink alcohol. Students are asked to fill in a blank speech bubble with a response from the younger student that demonstrates effectively resisting the pressure to drink.

Assessment criteria:

Level 1: Not met. The student has no feasible response, or agrees to drink alcohol.

Level 2: Not yet fully met. The student is able to demonstrate refusal to go along with peer pressure, with limited ability to address rebuttals and further pressure.

Level 3: Fully Met. The student's response indicates refusal to go along with peer pressure, and is able to give reasons and additional arguments to address rebuttals and further pressure to drink alcohol.

Pass point: Level 3.

Assessment tool S-6, "Saying No", on page 100 of this publication, is an example of a three-point criteria scale.

**A four-point criterion-referenced scale** might cover the following levels:

Level 1: Unsatisfactory. The student does not demonstrate core knowledge, attitudes, and skills covered in class.

Level 2: Needs improvement. The student demonstrates aspects of the core knowledge, attitudes, and skills or incompletely demonstrates the core knowledge, attitudes, and skills.

Level 3: Satisfactory. The student demonstrates the core knowledge, attitudes, and skills covered in class.

Level 4: Very good. The student demonstrates *mastery* of the core knowledge, attitudes, and skills in a variety of contexts that exceeds level 3, (for example can apply knowledge, attitudes, and skills to contexts beyond those covered in class).

*Note: Additional clarification of each of the three criterion would be required to illustrate the exact features of the knowledge and skills that are expected and at what level.*

#### **A sample four-point criteria scale**

Assessment question: How well do students advocate for effective prevention of sexually transmitted infections?

Assessment tool: Students are asked to write a one-minute radio announcement that will encourage other young people to take precautions to prevent the transmission of sexually transmitted infections.

Assessment criteria:

Level 1: Unsatisfactory. The student is unable to write a text for the announcement, or is unable to give one accurate, practical strategy for preventing transmission of STI's.

Level 2: Needs improvement. The student is able to write a text, but suggests limited or inaccuracies in practical strategies for preventing transmission of STI's.

Level 3: Satisfactory. The student writes an announcement that accurately gives two or more ways of preventing transmission of STI's and uses persuasion or other effective communication appropriate to the medium. ("pass point")

Level 4: Very good. The student writes an announcement that gives two or more ways of preventing transmission of STI's that is accurate, appealing, persuasive, and demonstrates effective communication appropriate to the medium. It may also emphasise values or attitudes such as the importance of communication with a potential sexual partner, or sharing responsibility for health.

(Assessment tool A-4, "Poster Design", on page 65 of this publication, is an example of a four-point criteria scale.)

**A five-point criterion-referenced scale** might cover the following levels:

Level 1: Very low achievement. The student does not competently demonstrate core knowledge, attitudes, and skills.

Level 2: Low achievement. The student can demonstrate aspects of the core knowledge, attitudes, and skills covered in class and/or with limited competency.

Level 3: Satisfactory achievement. The student competently demonstrates the majority of the core knowledge, attitudes, and skills covered in class.

Level 4: High achievement. The student demonstrates all of the core knowledge, attitudes, and skills covered in class with a high level of competency and ease and in a range of contexts.

Level 5: Very high achievement. The student demonstrates *mastery* of the domain of skill development beyond level 4, including applying knowledge, attitudes, and skills to contexts not covered in class. The student demonstrates initiative and creativity in her/his application of the knowledge, attitudes, and skills.

**Note:**

- *Additional clarification of each of the three criterion would be required to illustrate the exact features of the knowledge and skills that are expected and at what level.*
- *And it should not be assumed that achievement across these five levels will be evenly distributed throughout the class, or even that the distribution of achievement will follow a “bell curve”, with small numbers of students at the highest and lowest levels, and the majority of the students falling in the middle. There may not be any students who demonstrate mastery at level 5 in a class.*

### A sample five-point criteria scale

Assessment question: Do students show willingness to encourage others to change unhealthy habits?

Assessment tool: A role-play in which a student has a conversation with another young person who is using drugs.

Assessment criteria:

Level 1: Very low achievement. Student does not demonstrate feasible methods for encourage the other to stop using drugs.

Level 2: Student tells the other not to use drugs, but is limited in ability to address rebuttals and further arguments, for example, does not present reasons confidently and/or appears hesitant.

Level 3: Student gives a minimum of one feasible reason discussed in class why the other should stop using drugs, but may not act confidently and is not able to address further rebuttal or arguments.

Level 4: Student gives a minimum of two feasible reasons as to why the other should stop using drugs; including reasons discussed in classwork. Student speaks in a confident and assertive tone of voice and is able to respond to rebuttals and further arguments.

Level 5: Student gives three or more reasons why the other should stop using drugs. Student uses at least one piece of information that has not been covered in class. Student speaks confidently and assertively, persists if the other is unconvinced, and uses creative arguments.

Pass point: Level 3.

(Assessment tool K-6, "A Visit to the Clinic" on page 48 of this publication, is an example of a five-point criteria scale.)

### Assessment tools - Rubrics

In education circles, a particular tool used for criterion referencing is called a "rubric". This tool is usually the table or guideline which outlines the overall assessment question and gives the full list of criteria against which participants will be assessed. Descriptions of the level of achievement for each of the criteria are usually provided also. The rubric should be available to *both* the participants/learners and the teacher/assessor prior to the assessment, so that all concerned are aware of exactly what is expected, what a high standard requires, and what lower standards would look like. Equally, students and teachers can prepare rubrics together, that is, to set up the criteria by which students will be assessed. In this way, assessment is as much a learning task as a monitoring tool. Rubrics can be applied to all aspects of learning however, they are especially useful for organising procedures for assessing "performance tasks" designed to demonstrate skills such as oral presentations (see example below), performance of a physical task, demonstration of an interpersonal skill such as listening or being assertive. Further examples of these appear in the section on Skills.

**Example Rubric - or Performance Profile for a (generic) Oral Presentation**

Student Name:

Grade Level:

Date of Assessment:

Assessor:

**Assessment Question:** Is the student able to make an effective presentation (on whatever topic)?

*Criteria for assessing the skill*

*Standards/level of proficiency  
Beginning(1) Novice(2) Proficient(3) Expert(4)*

<p><b>1. Understanding the Assignment (preparation)</b>                      1.1 Explains the reason for the oral presentation                      1.2 Identifies the audience for the presentation                      1.3 Identifies the format for the oral presentation                      1.4 Identifies the criteria to be used to judge the quality of the oral presentation</p>																									
<p><b>2. Planning the oral presentation</b>                      2.1 Lists research questions that will direct the search for information for the oral presentation                      2.2 Finds and uses appropriate information                      2.3 Organises information from research on note cards or into a graphic organiser in preparation for writing the outline or script for the oral presentation</p>																									
<p><b>3. The content of the oral presentation</b>                      3.1 The thesis or main idea is clear and appropriate to the task                      3.2 The content is accurate                      3.3 The examples given are sufficient and appropriate to both audience and topic                      3.4 Thinking skills are used which organise the content appropriately to the task and to help the audience understand                      3.5 Organisation shows a clear beginning, middle, and end                      3.6 Vocabulary is appropriate to the topic and audience</p>	<table border="1"> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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<p><b>4 Supporting graphs/props/aids</b>                      4.1 The presentation has greater impact because of the aids used                      4.2 The audience can easily see the aids used</p>	<table border="1"> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	_____	_____	_____	_____	_____	_____	_____	_____																
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<p><b>5 Presentation Strategies</b>                      5.1 The speaker provides an attention-getting introduction appropriate to the task and audience                      5.2 The audience is actively or passively involved eg. asked to think about what is being said is given time to think or process aspects of the presentation                      5.3 The speaker recognises and uses the perspective of</p>	<table border="1"> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	_____	_____	_____	_____	_____	_____	_____	_____																
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the audience 5.4 The speaker tells the audience what he or she is going to say, follows the plan (or adapts appropriately), and highlights key elements 5.5 The rate of speech and inflections used help the audience understand 5.6 Eye contact is made with the entire audience 5.7 Body language adds to the presentatin 5.8 The speaker sticks to the time allocated 5.9 The speaker uses tactics that make key elements memorable	_____ _____
<b>6. Presentation Mechanics</b> 6.1 The voice is clear and loud enough to be heard by everyone in the audience 6.2 Grammar and dicton are correct 6.3 Posture is appropriate to the task 6.4 The use of note cards, graphics, tachtology, props and other aids are handled smoothly 6.5 The speaker presents her/himself (physically) appropriately	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
<b>Overall level of proficiency:</b>	
<b>Goals for Improvement:</b>	

### Interpreting assessment results

It is essential that assessment results be interpreted without bias. All teachers want to see positive outcomes on assessment, as this is generally interpreted as meaning that their teaching has been effective. However, negative outcomes should not be overlooked, as these can provide the teacher with insight about changes that may need to be made to the curriculum, materials and methods being used.

Any assessment results should be interpreted with caution. If an assessment indicates the desired change in knowledge, attitudes, skills or behaviour has been achieved, the teacher still cannot be absolutely certain that it is the curriculum that has brought about the change. Other influences – such as the media, a personal experience that has had a powerful impact, current events, or peer pressure – may also have influenced behaviour.

Similarly, if an assessment indicates that the desired changes have not been achieved (either by the whole class or specifically by some students), the teacher must ask whether the tool used adequately assessed the student’s knowledge, attitudes, skills, and behaviour. Who scored well, who didn’t? Are these results consistent with past performance? Were results poor because the

tool required reading a scenario, for example, and the student in question was a poor reader? Would her/his results have been better if questions had been asked in an interview format? Were results poor because the assessment tool used was incompatible with that student's preferred learning style? For example, did the assessment tool require role-play from a student who is hesitant about speaking in front of groups and would be more comfortable with a "paper and pencil" test? Did gender differences appear in the types of results that were obtained? Is there a balance in the types of assessment strategies used, including those that might be more favoured by girls as well as by boys?

These types of questions point to the importance of "triangulation". Triangulation refers to asking the same basic question in different ways, and using all the results to draw a more accurate conclusion. This might mean, for example, using several different ways of assessing communication skills, such as observation in typical interactions, a self-report checklist, and role-play. It may involve using information from different sources: the teacher, the student, peers, and parents or others. And it may suggest that continuous assessment should be carried out to allow for comparison of results over time. Triangulation provides the teacher with more information, gives a more holistic view of the child, and balances out the advantages and disadvantages of various assessment tools.

## II. Types of Assessment Tools

There is an enormous variety of tools available to the teacher for assessing knowledge, attitude, skill, and behaviour objectives in skills-based health education (Health and Human Development Programs, EDC, 2001). While traditional “paper and pencil” tests have many uses, there are other creative means of assessing student progress as well. The descriptions below list advantages and disadvantages of each tool, which can be considered when designing an assessment strategy.

With any assessment tool, it is not possible to conclude with certainty that changes in knowledge, attitudes, skills or behaviours are the direct result of the programme; other social factors may also be influential. While one tool alone may not provide entirely reliable information about the impact of skills-based health education, the use of more than one can provide more accurate assessment.

It can be particularly important to have information from different sources – the teacher, students themselves, peers, third parties – as each group may have slightly different views on what effective skills are, what constitutes a change in knowledge, or how to interpret different attitudes.

Some types of assessment tools lend themselves more naturally to the assessment of knowledge, attitude, or skill objectives. In the descriptions below, the suitability of particular tools for specific objectives is emphasised, and teachers should feel free to create self-made tools that will reflect their own curriculum objectives. In the overall assessment plan for a skills-based health education programme, a variety of different types of tools should be used so that students with a range of learning styles have an opportunity to be assessed in a manner that draws upon their strengths.

Any of the tools described below can be used with students both before and after a skills-based health education programme is implemented, in order to give a stronger indication of changes brought about by the programme.

Closed-ended questions are effectively used in assessing **knowledge** objectives. As part of a self-report survey, they can also be used to assess **attitude**, **skill** and **behaviour** objectives.

Closed ended questions require the student to select the correct answer from a set of options. There are several assessment tools that use closed-ended questions:

- True/false questionnaire: These present a series of statements, and the student must record whether s/he thinks the statement is true or false, for example, on ways that HIV can be transmitted. A variation on this is to add the option “not sure”; when students are encouraged not to guess, but to respond honestly if they are not sure, this variation can provide the teacher with feedback about topics that may need to be taught more thoroughly.

- Multiple-choice questionnaire: When used to assess knowledge, multiple-choice questionnaires present a question, and a list of three to five possible answers, only one of which is correct; the student must select the correct one. An example might be:

*“Which of the following methods of birth control is also effective in preventing HIV?”*

- A) Birth control pills;*
- B) Withdrawal;*
- C) Condom;*
- D) Diaphragm.”*

Multiple-choice items are often used in self-report surveys to assess attitudes, skills and behavioural objectives.

An example of a multiple-choice item that assesses attitudes might be:

*“How serious a problem do you think harassment of girls is in your school?”*

- A) very serious;*
- B) somewhat serious;*
- C) not very serious;*
- D) not serious at all;*
- E) No opinion.”*

An example of a multiple-choice item that assesses skills (by proxy; in other words, through students’ own assessment of their skill level) might be:

*“Which of the following statements best describes how you would react if a someone in your school was harassing a female student?”*

- A) I would not get involved.*
- B) I would want to stop it, but I don’t know how.*
- C) I would get someone else to intervene.*
- D) I would intervene myself*

**Note:** Where the goal is to select the single "right" answer, care must be taken in development of choices such that the right answer does not overlap and is distinct from the others; or alternatively, in some cases more than one answer may be allowed with explanations.

An example of a multiple-choice item that assesses behavioural objectives might be:

*“How frequently have you consumed alcoholic beverages in the past WEEK?”*

- A) not at all*
- B) once or twice per week*
- C) three or four times per week*
- D) every day*
- E) once a day*

- **Matching items:** These usually present two lists, for example, a list of words and a list of definitions. The student must correctly match the words and definitions. An example might be matching technical terms for birth control methods with a definition of each method.

*Advantages:* Closed-ended questions elicit uniform responses, making them easy to score. They test a large amount of information in a short time. When used in self-report surveys, closed-ended questions allow the teacher to generate quantifiable results, making comparison with other students or other classes easier.

*Disadvantages:* These questions must be carefully structured, and this can take time and skill. The question writer needs considerable knowledge of the subject matter. When used to assess knowledge objectives, they do not provide information on the student's ability to actually use that knowledge. Some students will answer certain questions by guessing among the options, rather than demonstrating recall. The usefulness of closed-ended questions in self-report surveys depends on the degree of honesty with which students respond.

Open-ended questions are useful for assessing **knowledge** objectives. They can also be used for assessing **attitude** objectives. They can be used as a "proxy" for assessing skills (in other words, students may be asked what they would do in a certain situation; this will indicate their perspective on their skills, though not necessarily whether they could perform that skill in real life).

Open-ended questions are ones in which the teacher does not provide a list of possible responses. Rather, the student provides his/her own answer. This tool can take the form of a question such as "What is one thing you can do to prevent the spread of HIV?" Or, incomplete sentences that require students to "fill in the blanks" can be used, such as "Abstinence means \_\_\_\_\_". Questions can also be constructed that require the application of knowledge to a new problem, rather than simple recall of information. Open-ended questions should be structured, but not leading.

Essay-writing is another type of open-ended question technique that allows students to demonstrate their knowledge, and reveal their attitudes. For example, they might be asked to write an essay on the topic: "Of the various methods of birth control that are available, which ones would be preferable for teens in this community? Why?"

*Advantages:* Open-ended questions give students opportunity to demonstrate recall, which may not be the case when selecting from a list of pre-determined options. Essays allow students the freedom to express the full range of their knowledge on a subject. They allow for creativity and imagination. They demonstrate the ability to apply knowledge. They can be a good means of finding out about unintended effects of a programme, and for understanding why students hold particular attitudes.

*Disadvantages:* The teacher may have to consider whether certain responses qualify as correct. Where the meaning of the responses must be interpreted by the teacher, the possibility of misunderstanding or bias is raised. This also means that open-ended questions are more difficult to score than closed-ended questions. Essays can take time to grade, and may be difficult for those who are not good writers. It may be necessary to construct guidelines for assessing the essays.

Analysis of an article, video, case study, or fictional scenarios is useful for assessing **knowledge** objectives. It can also be used to assess **attitude** and **skill** objectives.

Articles, videos, case studies, or fictional scenarios can be used in a variety of ways. Student can be asked to read a case study and identify risky behaviours, or degrees of risk (knowledge). They can be asked to describe what a character might have done differently in order to more effectively prevent HIV transmission (skills). They can also be asked to describe how they feel about the actions of a character in a case study (attitudes).

*Advantages:* Analysis activities allow a stimulus material to be used to achieve a full range of objectives. They give students an opportunity to demonstrate thinking skills (such as problem-solving and decision-making), and application of knowledge to new situations.

*Disadvantages:* Instructions for analysis must be clear and specific. Materials for analysis must be carefully chosen to ensure that they are appropriately, but not overly, challenging. Clear assessment criteria must be developed for each article, case study or video used.

Time lines are useful for assessing **knowledge** objectives.

Creating time lines is a useful way to assess students' knowledge of the order of steps in a sequential process, such as correctly applying a condom. Students can be asked to create their own time lines, or they can be given a set of cards with text to place in sequence, or they can sequence a series of pictures.

*Advantages:* Time lines can provide an engaging alternative to traditional assessment methods. They can be created with pictures, which is helpful for those with low literacy skills. If they are set up to have only one correct sequence, they can be easily scored.

*Disadvantages:* Creating text or graphic material for time lines can be time consuming.

Picture sorting is useful for assessing **knowledge** objectives.

Sets of pictures can be developed and students can be asked to sort them according to various criteria. For example, pictures can be sorted according to whether they do or do not depict a way that HIV can be transmitted.

*Advantages:* Picture sorting is fun and engaging, especially for younger students. It can be used with students whose language or literacy skills are low. Correct answers are easy to score.

*Disadvantages:* Pictures must be easily recognizable. They must be carefully chosen so that the criteria for sorting are clear.

Role-plays and simulations are useful for assessing **skill** objectives. They can also be used to assess **knowledge** and **attitude** objectives.

Role-plays and simulations can be an effective ways for students to demonstrate the level to which they have developed their skills, such as the ability to negotiate for less risky behaviour. Attitudes, such as assertive or confidence, can also be inferred from behaviour observed during a role play. Role-plays can be constructed to allow peers or the teacher to assess the level of knowledge demonstrated, for example, on how to handle blood or a wound at the scene of an accident. Role-plays can be assessed by either the teacher or other students.

*Advantages:* Role-plays and simulations allow assessment of skills in a situation that is as near to reality as possible. They allow students to demonstrate their abilities to apply their skills in unpredictable circumstances. They also allow students the opportunity to demonstrate the ability to apply their knowledge in a new situation, rather than simply recall information.

*Disadvantages:* It can be challenging to assess skill level when watching a role-play or simulation. Different observers may interpret what they see in a role-play differently. A clear set of criteria must be developed for assessing the skills to be demonstrated through a role-play. The same is true for assessing knowledge or attitude objectives.

Writing/performing skits or plays can be used to assess **knowledge**, **attitude** and **skill** objectives.

Skits or plays offered more extended opportunities for assessment than role-plays. Students who are asked to write a play about caring for a person living with AIDS, for example, will have to demonstrate a high degree of knowledge on this topic. A drama on the impact of HIV on girls will reveal a great deal about attitudes toward gender roles. During performances, skills in assertiveness or advocacy may be demonstrated.

*Advantages:* Writing and performing skits or plays allow for more in-depth assessment than may be possible in a classroom period. It enables teachers to see how students integrate knowledge, attitudes and skills. The act of producing a drama may also be a powerful learning experience.

*Disadvantages:* The time required to allow students to write and perform a skit or play may be prohibitive. A clear set of criteria must be developed in order to use a drama as an effective assessment tool.

Observations/anecdotal records are useful for assessing **skill** and **behaviour** objectives. They can also be used to indirectly assess **knowledge** and **attitude** objectives.

Teachers can sometimes directly observe students performing skills related to skills-based health education. For example, communication skills can be observed in a role-play. Observations may also be done in more natural settings, such as when students are working in groups, to assess skills or behaviours such as cooperation or problem solving. Knowledge and attitudes may be inferred from observations. Observations are sometimes carried out in a single session; more meaningful information about behaviour change or development can be gathered if observational records are carried out over time. These are sometimes called anecdotal records. They may reveal a pattern of skill or behaviour development.

*Advantages:* Observations allow for the possibility of assessing skills and behaviours in real situations, or in settings that are close to reality.

*Disadvantages:* Many of the life skills relevant to HIV/AIDS prevention cannot be easily simulated in the classroom. While opportunities for observations in real settings can be created, the opportunity to practice particular skills or behaviours may not arise, and the frequency of those opportunities cannot be controlled. Many behaviours that are critical to HIV/AIDS prevention are unlikely to occur in the presence of an observer. Keeping anecdotal records may be too time-consuming for teachers. Assessing knowledge, attitude, and skill objectives from an observation requires the development of clear criteria. Interpretations of behaviour are subjective, and may reflect teacher bias.

Check lists are useful for assessing **skill** objectives.

Check lists allow students to report on skills that they have used, either within a classroom exercise or outside of the classroom. Checklists can be created that allow students to assess their peers; for example, a checklist of certain skills to look for during a role play can be given to those watching, enabling them to assess the skills demonstrated by the actors.

*Advantages:* Checklists can yield a large amount of information in a short period of time, and are relatively easy to administer.

*Disadvantages:* Checklists can be time-consuming to create. As with all assessment tools that ask students to self-report, there is a risk that students will not report information about themselves reliably.



Interviews are useful for assessing **attitude** and **knowledge** objectives. They can also be used for assessing **skill** objectives.

An interview is a face-to-face encounter, carried out either by the teacher or by other students, which allow students to report on their own knowledge, attitudes and skills. Attitude questions might include “How do you feel about HIV-positive students attending our school?” or “What do you think your responsibilities are in preventing the spread of HIV?” An interviewer can ask knowledge-related questions, such as “What are three ways to prevent the spread of HIV?” Interviews can also allow students to self-assess their own skills levels, for example using questions such as “If someone pressured you to share needles used for injecting drugs, and you didn’t want to, what would you do?”

*Advantages:* Interviews allow the possibility of probing for more information, to look more deeply at the reasons why student attitudes have or have not changed, and to determine the types of situations in which students may feel they need more skills. A skillful interviewer can probe to find out more about students’ comprehension than can be revealed by a questionnaire. Interviews allow students to express themselves freely, and are therefore a good way to assess the knowledge of children whose writing skills are poor.

*Disadvantages:* Interviews can be time consuming to carry out. Interviews about certain types of situations may make students feel uncomfortable or pressured. Some types of questions could be perceived as intrusive or inappropriate. Interviews require a level of trust between the student and the teacher in order to yield valid information. There is a risk in interviews that students will say what they think the interviewer wants to hear. The results may require skilled analysis and interpretation.

Stimulus activities are useful for assessing **skill** and **attitude** objectives. They can also be used to assess **knowledge** objectives.

“Stimulus activities” are creative means of eliciting information about the impact of a skills-based health education programme on students. The term refers to a broad range of assessment tools that present some sort of stimulus and ask students to respond to them in a way that demonstrates knowledge, skills, or attitudes. The range of stimulus activities is limited only by the teacher’s imagination. Examples might include:

- Scenarios to which students are asked to react; for example, “What would you do in this situation?”
- Photos that students are asked to write captions for.
- Cartoons with empty speech bubbles; students are asked to fill these in and the responses are analysed.
- Having students design a poster, or create a slogan; these are analysed for the attitudes they indicate.
- Letter writing: students write responses or advice to sample letters from other students about HIV-related issues.

*Advantages:* Stimulus activities are often more engaging to students than traditional paper-and-pencil assessment tools. They help address the needs of students with a range of learning styles. They can be created to use visuals such as photos and pictures, which may be helpful in assessing students with low reading and writing skills. They can be carried out either individually or in focus groups.

*Disadvantages:* Stimulus activities may require time and creativity on the part of the teacher. The results they yield may be difficult to assess unless clear criteria are set for the demonstration of each skill.

Scales are most useful for assessing **attitude** objectives. They can also be used by students to self-assess **skill** objectives.

Scales allow students to self-assess their own attitudes, including confidence in their own ability, or intentions to behave in a certain way. There are a number of types of scales that can be used for assessment in skills-based health education programs.

- Likert scales present a statement, and students are asked to indicate the intensity with which they agree or disagree with that statement. An example of a Likert scale item addressing attitudes might be:

*Circle the number that best indicates your opinion:*

*“It is realistic to expect young people to abstain from sex before marriage.”*

1. *strongly disagree*
2. *agree*
3. *undecided*
4. *agree*
5. *strongly agree*

- Semantic differential scales ask students to express their opinions on an issue. They do this by choosing a point on a continuum between two opposite positions. Semantic differential scales usually contain several dimensions for each issue. The placement of terms that are related to each other are varied in the scale, to discourage students from responding in a patterned way. An example of a semantic differential scale item addressing attitudes might be:

*Choose the response that best represents your opinion:*

*“For young people, abstaining from sex before marriage is...”*

<b>RESPONSIBLE</b>	<i>Very</i>	<i>Somewhat</i>	<i>Neither</i>	<i>Somewhat</i>	<i>Very</i>	<b>IRRESPONSIBLE</b>
<b>PRACTICAL</b>	<i>Very</i>	<i>Somewhat</i>	<i>Neither</i>	<i>Somewhat</i>	<i>Very</i>	<b>IMPRACTICAL</b>
<b>UNHEALTHY</b>	<i>Very</i>	<i>Somewhat</i>	<i>Neither</i>	<i>Somewhat</i>	<i>Very</i>	<b>HEALTHY</b>

*CARING*                      *Very* *Somewhat*    *Neither*    *Somewhat*    *Very*    *UNCARING*

- Bogardus Social Distance Scales ask students to respond to a series of statements regarding association with persons from a particular group. Each possible response represents an increase in intensity of attitude. An example of a Bogardus Social Distance Scale item might be:

*Indicate your response to each statement below:*

1. *I would sit next to a person with HIV on a bus.*    *YES*    *NO*
2. *I would shake hands with a person with HIV.*    *YES*    *NO*
3. *I would hug a person with HIV.*    *YES*    *NO*
4. *I would kiss a person with HIV on the cheek.*    *YES*    *NO*

*Advantages:* Scales produce data that can be scored, allowing for comparisons within the group, and in pre-test/post-test assessment designs.

*Disadvantages:* Scales do not produce information about why the students hold the attitudes that they report.

Unobtrusive techniques or indirect measures are useful for assessing **attitude** and **behaviour** objectives.

The use of unobtrusive techniques, also called indirect measures, involves gathering data from sources other than the classroom or the students themselves, from which one can then make inferences about young people's health-related behaviours or attitudes. For example, an indirect measure of young people's use of condoms during intercourse might be to monitor condom sales to see if they are steadily increasing. An indirect measure of students' willingness to take responsibility for their sexual health might be to monitor visits to youth-friendly health services to see if there are increases. Other sources of information from which attitudes might be inferred could include school records (for example, of attendance at health education classes or workshops), records of numbers of disciplinary actions for harassment or violence, etc.

*Advantages:* Unobtrusive techniques can provide objective, quantifiable data from which attitudes may be inferred. They provide information on actual behaviours that allows the teacher to interpret the results of other tools such as self-report surveys, observations, or "intent to behave" statements.

*Disadvantages:* Collecting data from a number of sources outside the school is generally not practical for the classroom teacher. Some types of data may be hard to obtain, or may be confidential. It cannot be assumed that changes in behaviour suggested by indirect measures are necessarily due to a skills-based health education programme, or that students in the programme were the ones buying condoms or visiting the clinic.

Diaries and journals are useful for assessing **behaviour** objectives. They can also be used to assess **attitude** objectives.

Diaries and journals require students to keep a running record of their own behaviours, and provide a means for students to reflect on those behaviours. They can be analysed for qualitative information on students' attitudes toward life skills and health issues.

*Advantages:* Diaries and journals may provide insight into how patterns of behaviour change or development, as well as reasons for those changes.

*Disadvantages:* Analysing journals may require qualitative assessment techniques that are time-consuming and demand skills that many teachers may not have.

“Intent to behave” statements are most useful for assessing **behaviour** objectives.

“Intent to behave” statements are a form of simple self-report questionnaire that ask students to assess their own likelihood of carrying out certain behaviours. Examples of items that assess intent to behave might include, “Do you plan to wait until you are married before you have sex?”, “If you thought you had a sexually transmitted infection, would you go to your local clinic?”, or “If you thought you were pregnant, would you tell an adult?”

*Advantages:* “Intent to behave” statements are relatively easy to create and analyse. The results can be easily quantified. Research shows that there is a strong relationship between intentions and behavioural outcomes (Webb and Elliot, 2000, p. 103), so the use of “intent to behave” statements may be a fairly reliable tool.

*Disadvantages:* As with any self-report instrument, there is a risk that students will not accurately report their own intentions, but rather report what they think is the socially desired response.

Student projects are most useful for assessing **skill** and **behaviour** objectives. They can also be used to assess **knowledge** and **attitude** objectives.

Projects carried out in the community – whether as part of the curriculum, an internship, or a work experience – can provide a way to assess skills and behaviour in a real-life setting. For example, students can design and carry out a risk assessment survey, carry out a community service project involving AIDS education, start a campaign to inform more young people about the availability of youth-friendly health service, or volunteer to work with persons living with AIDS. Observation tools can then be designed that will allow the teacher or a third party to assess student behaviours such as willingness to advocate for safer sexual practices, or the ability to provide safe and appropriate social support to those affected by AIDS. Having students take part in a community service can be a useful way to assess a range of life skills, such as communication, decision-making, and problem-solving. Knowledge and attitude changes can

also be inferred through observation of students’ performance during the project, or through their written reflections on the experience.

*Advantages:* The observation of student behaviours during projects, as opposed to classroom activities or role plays, may give a more realistic assessment the extent to which knowledge, attitude, skill and behaviour objectives are being met. Observations and anecdotal records can be used to gather assessment information. Community service projects can also be powerful catalysts for learning, and have been shown to reduce risk behaviour, including reducing teen pregnancy rates (Kirby, 2001).

*Disadvantages:* Student projects can only be used to assess a limited range of behaviours. In the case of HIV prevention, these are generally not behaviours that pertain to personal sexual risk. Community service projects can be time-consuming to set up and run. It can be challenging for the teacher or other third parties to collect assessments of all the students consistently. Clear criteria must be set for the skills that are to be observed during the course of the project.

The table below summarises the appropriateness of various assessment tools for use with knowledge, skill, attitude and behaviour objectives. Normal type indicates that the tool is useful in assessing that objective. Bold type indicates the tool is highly useful for assessing that particular type of objective.

Type of assessment tool	Most useful for assessing:			
	Knowledge	Skills	Attitudes	Behaviours
Closed-ended questions	<b>X</b>	X	X	X
Open-ended questions	<b>X</b>	X	X	
Analysis of article, video, case study, etc.	<b>X</b>	X	X	
Time lines	<b>X</b>			
Picture sorting	<b>X</b>			
Role play/simulation	X	<b>X</b>	X	
Writing/performing skits or plays				
Observations/anecdotal records	X	<b>X</b>	X	<b>X</b>
Checklists		<b>X</b>		
Interviews	<b>X</b>	X	<b>X</b>	
Stimulus activities	X	<b>X</b>	<b>X</b>	
Scales		X	<b>X</b>	
Unobtrusive techniques or indirect measures			<b>X</b>	<b>X</b>
Diaries and journals			X	<b>X</b>
“Intent to behave” statements				<b>X</b>
Student projects	X	<b>X</b>	X	<b>X</b>

### **Can students create assessment tools?**

It is very likely that teachers themselves will devise their own tools for assessing skills-based health education. These tools can draw on the range of approaches described above and adapting them to the content of their own programmes, but will require extensive piloting to ensure that the tools are valid and reliable.

Some teachers may wish to explore involving students in the creation of these tools. Student input can be useful at the level of identifying what should be assessed in a skills-based health education programme. Student feedback on priorities can provide insight into the issues that they find most pertinent in their daily lives: Is lack of information on HIV prevention widespread? What are the local myths and traditions? Is information sufficient, while the ability to effectively communicate, assert oneself, and make decisions is lacking? Is dealing with bias – against girls, against homosexuals, against individuals who are HIV-positive – an issue for students?

Students can also play a role in the creation of specific assessment tools. For example, if the teacher wants to assess students' ability to resist peer pressure, students themselves can suggest, or write, realistic scenarios in which such pressure takes place. If the teacher wants to assess students' attitudes toward gender roles, students themselves can create a list of commonly held assumptions and stereotypes.

Finally, students can help establish criteria for assessment, particularly of attitudes and skills. For example, if a teacher wants to develop a checklist to assess students' ability to negotiate for safer sex in a role-play, students themselves can suggest the types of situations most relevant and the corresponding responses that they feel would be effective. If the teacher wants to develop a questionnaire on attitudes toward teen pregnancy, the students may be able to inform the teacher as to the range of views actually held by young people in the community, which can be helpful in developing scales or multiple-choice items. GREAT!

### **III: Assessing Knowledge Objectives**

#### **A. Knowledge objectives**

The World Health Organization has identified knowledge objectives for skills-based health education, including life skills for HIV prevention (WHO, 1999). These include the following objectives for different age levels<sup>1</sup>:

Pre-adolescents: Students will learn:

- Bodily changes that occur during puberty are natural and healthy events in the lives of young persons, and they should not be considered embarrassing or shameful
- The relevance of social, cultural, and familial values, attitudes and beliefs to health development and the prevention of HIV infection
- What a virus is
- How viruses are transmitted
- The difference between AIDS and HIV
- How HIV is and is not transmitted

Adolescents: Students will learn:

- How the risk of contracting HIV infection can be virtually eliminated
- Which behaviours place individuals at increased risk for contracting HIV infection
- What preventive measures can reduce risk of HIV, STI and unintended pregnancies
- How to obtain testing and counseling to determine HIV status
- How to use a condom appropriately

#### **B. Assessing knowledge objectives: Issues to consider**

Assessing knowledge involves determining what students understand and have learned. Assessing knowledge is essential in skills-based health education. However, caution must be used in interpreting results of knowledge assessments. The ability to recall information is not necessarily the same as comprehension and application, which requires the students to understand how the information can be used in new situations (Hawe, Degeling and Hall, 1990, p. 108). Acquisition of knowledge alone does not guarantee an influence on behaviour, which is the ultimate aim.

For many teachers, assessing knowledge is easier than assessing skills or attitudes. The tools widely used to assess knowledge – true-false tests, multiple choice questionnaires, sentence completions, short answer tests – are familiar to most teachers. Because knowledge is usually assessed according to whether answers are right or wrong, these tools lend themselves to teacher

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<sup>1</sup> For objectives for young children, see WHO, 1999, WHO Information Series on School Health, Document Six: Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools, p. 19.

assessment. Peer or self-assessment is more difficult, as students cannot always assess their own level of knowledge. Parent assessment of students' knowledge, particularly of HIV/AIDS related issues, is generally impractical, as many students who have been exposed to skills-based health education know more about this topic than their parents do.

Knowledge assessment tools lend themselves easily to scoring. This allows for norm-referencing, the comparison of a student's performance with that of other children in the class. However, widely accepted norms for knowledge about HIV/AIDS are still in the process of development, and are affected by local factors. So teacher-designed knowledge assessment tools that are specific to the skills-based health education programme being used are essential.

Despite the relative familiarity of many of the tools used to assess knowledge, the validity of such tools depends on well-constructed questions. Questions must assess what students really know, rather than eliciting the answers that students think the teacher wants to hear. Some criteria for the construction of good questions are summarized in the table below.

<b>Criteria for the construction of good questions</b>		
<b>Criteria</b>	<b>Bad example</b>	<b>Good example</b>
Questions should be clear and unambiguous.	What are safe ways of showing your affection?	What are ways of showing affection to a boyfriend/girlfriend that do not place you at risk of getting an STI?
Ask only questions that the respondents could reasonably know the answer to (information that has been covered in class).	List, in order, the three most common sexually transmitted infections in your country today.	Name an infection that can be sexually transmitted.
Short items are best.	True or False: It is safe to care for a person with AIDS if you take precautions such as not coming into contact with open sores or body fluids, wearing latex gloves if you might come into contact with body fluids, and disposing of gloves and other soiled items properly.	True or False: If you are caring for a person with AIDS who has open sores, wearing latex gloves will prevent the spread of HIV.
Avoid negative items.	Which of the following is not a way that HIV can be spread? A. Eating food prepared by an HIV positive person. B. Sharing needles used for injecting	Which of the following is a way that HIV can be spread? A. Eating food prepared by an HIV positive person. B. Sharing needles used for injecting



	drugs. C. Through breast-feeding. D. Not cleaning syringes	drugs. C. Being bitten by a mosquito that has bitten an HIV positive person.
Avoid biased terms.	People with loose sexual morals have an increased risk of _____.	People who have unprotected sex with multiple partners have an increased risk of _____.
Avoid double-barreled questions (those that ask for a single answer to a combination of questions).	True or False: A girl cannot get pregnant if she is using birth control pills, but she can still get infected with HIV.	True or False: Birth control pills provide protection against HIV.

This section has described some general guidelines for assessing knowledge objectives; the next section gives actual examples of assessment tools that can be adapted for use with the objectives of a specific programme. Some of these are “paper and pencil” assessment tools, such as true false or multiple choice tests. While these are among the most familiar ways of assessing knowledge, this section includes a number of non-traditional strategies as well.

## C. SAMPLE ACTIVITIES FOR ASSESSING KNOWLEDGE OBJECTIVES

### **K-1. Puberty Quiz**

Age level: Pre-adolescents

Purpose: to assess students’ knowledge of “bodily changes that occur during puberty...” (WHO, 1999, p. 20).

Before using this assessment tool: This assessment tool can be used at the end of a learning unit on male and female anatomy, and the bodily changes that take place during puberty.

Type of assessment tool: This tool is a true/false questionnaire. The teacher assesses the students’ responses to the questionnaire.

Assessment criteria: Students will correctly identify which statements about puberty are true and false. The teacher may wish to set a standard, such as 70% correct, as an indication of mastery of this knowledge objective.

Description:

1. Distribute a copy of the “Puberty Quiz” below to each student. Ask them to complete the questionnaire individually, indicating which statements they think are true and which are false.
2. Collect the quizzes and grade them according to the answer key below.

### **Answer Key**

1. True
2. True
3. True
4. False
5. True
6. False
7. True
8. False
9. True
10. True
11. False
12. False
13. False
14. True
15. False

Comments: The teacher may wish to modify this quiz so that there are three options for answers: “True”, “False”, and “Not Sure”. Students should be told that it is acceptable for them to answer honestly if they are “Not Sure” about the correct response to an item. This will provide the teacher with feedback on what topics may need to be given extra instructional time.

As an alternative to taking the quiz individually, students can form teams. The teacher can read one question at a time to each team; the team can consult together before giving the answer. This will provide the teacher with an assessment of the group’s level of knowledge about puberty; it will not provide information on individuals’ level of knowledge.

Source: Adapted from an activity in Happy, Healthy and Safe, 1998, Family Health Trust Zambia – Anti-AIDS Project (page 33).

**Student Material S-1**

**Puberty Quiz**

Read each statement, decide whether you think it is true or false, and circle the correct response.

1. Changes in the body happen to boys and girls at puberty because a gland in our brains makes chemicals called hormones. TRUE    FALSE
2. The hormone that makes the changes in the body at puberty is different in girls and boys.  
TRUE    FALSE
3. As boys' and girls' bodies change during puberty, hormones also cause their feelings to change.  
TRUE    FALSE
4. All girls' bodies begin to change when they are 11 years old. TRUE    FALSE
5. Girls usually start puberty at an earlier age than boys. TRUE    FALSE
6. Girls have monthly periods (menstruation) on the same day every month at the beginning of puberty.  
TRUE    FALSE
7. When monthly periods (menstruation) start, it means that a girl's body is capable of having a baby.  
TRUE    FALSE
8. If a girl has started to menstruate, it means that she is emotionally ready to become a mother.  
TRUE    FALSE
9. Sperm comes out of the body through a boy's penis. TRUE    FALSE
10. It is normal for sperm to sometimes come out of a boy's penis at night. TRUE  
FALSE
11. If sperm is released often, a boy will use up all of his sperm.  
TRUE    FALSE
12. All boys will end up with deep voices. TRUE    FALSE
13. All boys will grow hair on their chests. TRUE    FALSE
14. There is no need to worry about the size of one's sexual organs. TRUE    FALSE
15. Playing with your own sexual organs can make you ill. TRUE    FALSE

## **K-2. Transmission Picture Sort**

Age level: Pre-adolescents

Purpose: To assess students' knowledge of "how HIV is and is not transmitted" (WHO, 1999, p. 20).

Before using this assessment tool: Since this tool assesses students' knowledge of how HIV is transmitted, they should first be exposed to lessons on what a virus is, how viruses are transmitted, and how the HIV virus is transmitted.

Type of assessment tool: This is a "stimulus" activity that requires students to correctly sort a set of 12 pictures into two groups: those that illustrate ways that HIV can be transmitted, and those that illustrate ways that HIV is not transmitted. The teacher assesses whether or not the pictures have been correctly sorted.

Assessment criteria: Students will correctly sort all 12 pictures.

Description:

1. Make a copy of the "HIV Transmission Picture Set" (below) for each student in the class.
2. Have the students cut the pictures into separate cards. Ask them to sort the pictures into two groups: one that shows ways that HIV can be transmitted, and one that shows ways that HIV is not transmitted.
3. Check each student's work according to the answer key below, and record the number of correctly sorted pictures.

### **Answer Key:**

Ways that HIV is transmitted:

Pictures # 1, 2, 4, 5, 8, 10.

Ways that HIV is not transmitted:

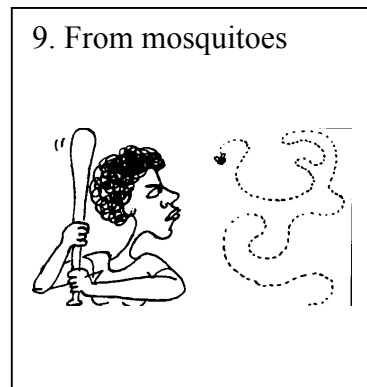
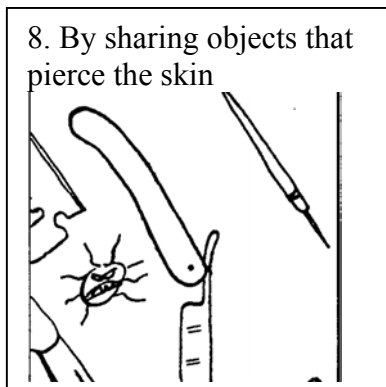
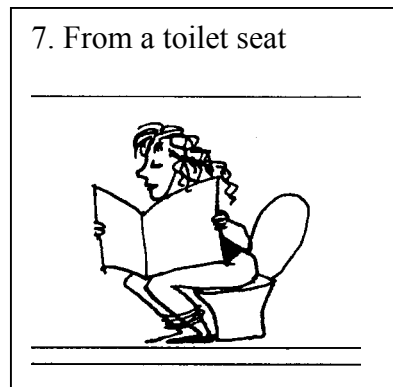
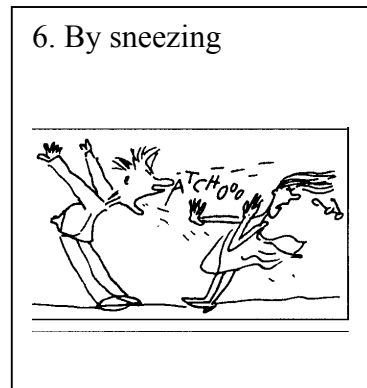
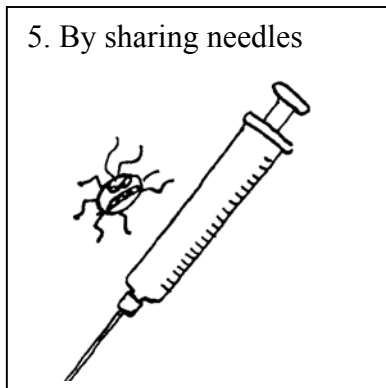
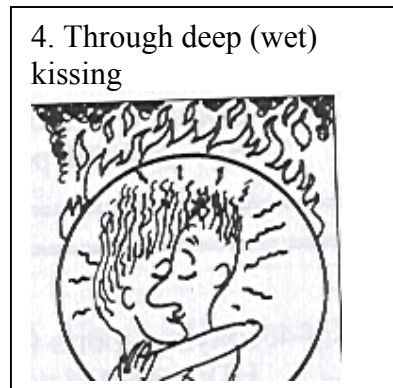
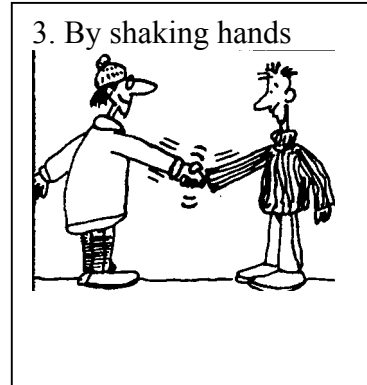
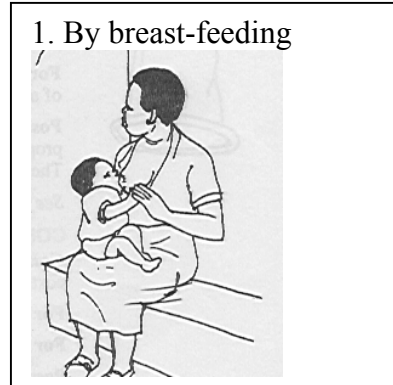
Pictures # 3, 6, 7, 9, 11, 12.

Comments: If it is not possible to cut out all the picture cards individually, students can be given the entire sheet of pictures and asked to write "yes" next to those that show a way that HIV can be transmitted, and "no" next to those that show ways that HIV is not transmitted. If multiple copies of the pictures are not available, they can be displayed, and students can be asked to make two lists on a sheet of paper or a slate: one list should indicate the number of each picture that shows ways that HIV is transmitted, and one list should indicate the number of each picture that shows ways that HIV is not transmitted.

This tool can also be used as a group activity, and in a pre-test/post-test format.

Sources: Pictures are taken from Happy, Healthy and Safe, 1998, Family Health Trust Zambia – Anti-AIDS Project, and School Health Education to Prevent AIDS and STD: Students’ Activities, 1994, WHO and UNESCO.

HIV Transmission Picture Set



10. From a pregnant mother to her baby



11. From food



12. By sharing clothes



### **K-3. Dear Doctor**

Age level: Adolescents/pre-adolescents

Purpose: to assess students' knowledge of "which behaviours place individuals at increased risk of contracting HIV infection" (WHO, 1999, p. 21).

Before using this assessment tool: Because this assessment tool requires knowledge of risk factors for HIV transmission, it can be used after a learning module in which students have been introduced to basic facts about HIV, learned how the virus is transmitted, and explored common myths regarding HIV transmission.

Type of assessment tool: This is a "stimulus" activity that requires students to respond to a stimulus, a letter from a peer who is concerned about having engaged in a potentially risky behaviour, using accurate knowledge to formulate a response. The teacher assesses the accuracy of the students' knowledge.

Assessment criteria: Students will correctly identify which behaviours described in the letters carry a high risk, low risk, or no risk of contracting HIV.

Description:

1. Provide a sheet of letters for each student in the class (Note: one sheet contains sample letters for adolescents, the next contains sample letters for pre-adolescents). Ask them to work individually to write answers to the letter writer. Tell them that as the doctor, they have a responsibility to be honest about how much risk is involved in the behaviour described. This is important if the letter-writer is going to get appropriate help. Ask the students to explain, in their responses, why the behaviour described carries a high risk, low risk, or no risk.
2. Before collecting the letters and assessing the responses, you may wish to have students read selected letters aloud to the group for discussion about the accuracy and appropriateness of the response.
3. Collect the letters and record how many each student answered correctly, using the answer key below.

**Answer key (adolescents):**

A – Low risk  
B – No risk  
C – High risk  
D – High risk  
E – No risk  
F – High risk  
G – No risk



**Answer key (pre-adolescents):**

- A – No risk
- B – Low risk
- C – High risk
- D – No risk
- E – High risk

Comments: The “doctor” can be given a checklist to complete after each letter, with the following responses:

- ✓ High risk
- ✓ Low risk
- ✓ No risk

Younger students, or those with limited writing skills, might be asked to carry out the activity in pairs. One student could read the letter out loud. The partner, playing the role of the doctor, could reply verbally. The teacher could listen to assess the accuracy of the response.

Older students will likely vary in how extensive their responses to the letters might be. Some may choose to make suggestions to the letter-writer. If so, the activity could then be used to assess the skill of: “actively seek[ing] out information and services related to sexuality, health services or substance use that are relevant to their health and well-being.” (WHO, 1999, p. 20)

This tool provides an assessment of each student’s individual progress in acquiring knowledge of behaviours that increase the risk of HIV transmission. Alternatively, the teacher can give out one letter per student, or have students work in small groups on a selection of the letters. This will provide information about the group’s understanding of risk behaviours, as opposed to individual’s understanding.

Source: Adapted from an activity in School Health Education to Prevent AIDS and STD: Students’ Activities, 1994, WHO and UNESCO.

## Student Material K-3

### “Dear Doctor” sample letters (adolescents)

A. Dear Doctor,

I am a 15 year old girl, and I have been going out with a boy for 6 months. He says that it is time that we have sex, but I don't want to. We have been doing some heavy petting, and we have been deep (wet) kissing. My friend told me that I can get AIDS from doing those things. Is this true?

B. Dear Doctor,

I am a 18 year old boy, and I like to play soccer. One of my best friends on my soccer team has started to get sick all the time. He is always tired, doesn't want to eat, and is losing a lot of weight. I'm beginning to think he might have AIDS. There are times when we run into each other on the soccer field. What I want to know is, does this mean that I have been exposed to AIDS too?

C. Dear Doctor,

I went to a party recently where people were drinking alcohol and shooting drugs. They were all using the same needle and passing it around. When it came to me, I didn't want to use it, but everyone was laughing at me and calling me a coward. So I used the needle and shot drugs. Is it possible that I could get infected with HIV? I only did it once.

D. Dear Doctor,

I am a 16 year old girl, and I recently had sex for the first time. I think the boy may have had sex with other women before. I asked him to use a condom, but he said he didn't have one. He also said that I didn't have to worry, that I couldn't get HIV or any other disease if it's the first time I had sex. Is that true? Should I be worried?

E. Dear Doctor,

I ate at my friend's house last week. His mother is infected with HIV. I didn't think anything about it, but someone at school told me that the food that she cooked could be contaminated with HIV. Is this true? Should I get an HIV test?

F. Dear Doctor,

I was having sex with my girlfriend last week. I learned how to use a condom in school, and I always use one every time we have sex. I thought that would always keep me safe, but this time, the condom broke. Am I at risk for getting HIV?

G. Dear Doctor

We have been learning about HIV in health class at school. I have been really scared about what I've been learning and I want to do everything I can to prevent getting infected with HIV. The problem is, now I am getting worried about using public toilets. Can I get HIV from those toilets?

### Student Material K-3

#### “Dear Doctor” sample letters (pre-adolescents)

A. Dear Doctor,

I ate at my friend’s house last week. His mother has HIV. Can I get HIV from the food she cooked?

B. Dear Doctor,

I am a 10-year-old girl. An older boy has been waiting for me after school and making me kiss him. He puts his tongue in my mouth. Can I get AIDS from him?

C. Dear Doctor,

I want to get my ears pierced. One of my friends has needles and she has pierced a lot of other girls’ ears with them. Is it dangerous to let her pierce my ears?

D. Dear Doctor,

I know that there are people in my town who have AIDS. If a mosquito bites them, and then bites me, can I get AIDS too?

E. Dear Doctor,

I am an 11-year-old boy. I had sex with a high school girl. She told me I had to do it to prove that I was a man. I didn’t use a condom. Could I have HIV?

## **K-4. Safe Condom Use**

Age level: Adolescents

Purpose: To assess students' knowledge of "what preventive measures can reduce risk of HIV, STI and unintended pregnancies" (WHO, 1999, p. 21).

Before using this assessment tool: Because this tool assesses whether or not students know the correct sequence of steps to follow in using a condom effectively, it should be used after a learning activity on condom use, preferably one that includes practice.

Type of assessment tool: This is a "stimulus" activity that requires students to place cards describing a sequence of steps to using a condom in the correct order. The teacher assesses whether or not the order of steps is correct.

Assessment criteria: Students will identify the sequence of steps to be taken to use a condom correctly (see answer key below).

Description:

1. Make a copy of the "Steps for Using a Condom" cards (below) for each student. Cut the cards out separately, and mix them up. Give one set of cards to each student.
2. Ask students to work individually to place the cards in sequence, starting with the first thing they should do when using a condom. When they have determined what they think is the correct order, students may glue the cards onto another sheet of paper in sequence. Suggest to students that there may be more than one way to sequence the cards.
3. Correct the students' papers according to the answer key below.

### **Answer Key:**

The following is the correct sequence for the "Steps" cards.

1. Check the expiry date on the condom. If old, don't use it.
2. Check that the condom package is not open. If open, don't use it.
3. Open the package with your fingers. Remember to push the condom down to make space to tear the plastic. Do not use your teeth or a sharp object to open the package.
4. Hold the condom at the tip. Make sure it is like a hat, with the tip coming through the rolled up edges.
5. The penis should be erect before the condom is put on.
6. Keep the tip squeezed as you put the condom on. This keeps air out of the end of the condom and creates a space for the semen.
7. Roll the condom down on the erect penis.
8. You are now ready to have sexual intercourse.

9. After intercourse, the male should hold on to the rim of the condom while the penis is still erect, and withdraw the penis from the vagina. Then he can take it off, being careful not to spill any semen.
10. Tie a knot in the condom, wrap it in toilet paper, and put it into the dustbin (do not flush it down the toilet).

Comments: Steps 1 and 2 are interchangeable, as are Steps 4 and 5. This tool can be done by small groups, rather than individuals. If it is done in a group, let students know that some steps may be interchangeable. Allow discussion about the sequence, but encourage them not to waste time debating over the one correct way to sequence the cards.

Students can also be asked to number the cards in the correct sequence from 1 to 10, rather than cutting them out and pasting them on another sheet of paper.

Source: Adapted from an activity in My Future is My Choice, March 1999, Youth Health and Development Programme, Government of the Republic of Namibia and UNICEF (page 35).

## Student Material K-4

### Steps for Using a Condom

Open the package with your fingers. Remember to push the condom down to make space to tear the plastic. Do not use your teeth or a sharp object to open the package.	Tie a knot in the condom, wrap it in toilet paper, and put it into the dustbin (do not flush it down the toilet).
Keep the tip squeezed as you put the condom on. This keeps air out of the end of the condom and creates a space for the semen.	Hold the condom at the tip. Make sure it is like a hat, with the tip coming through the rolled up edges.
Check the expiry date on the condom. If old, don't use it.	You are now ready to have sexual intercourse.
After intercourse, the male should hold on to the rim of the condom while the penis is still erect, and withdraw the penis from the vagina. Then he can take it off, being careful not to spill any semen.	Check that the condom package is not open. If open, don't use it.
The penis should be erect before the condom is put on.	Roll the condom down on the erect penis.

## **K-5. Birth Control: Advantages and Disadvantages**

Age level: Adolescents

Purpose: To assess students' knowledge of "what preventive measures can reduce risk of HIV, STI and unintended pregnancies" (WHO, 1999, p. 21).

Before using this assessment tool: Students should have received instruction about the various methods of birth control, their correct use, their effectiveness in preventing pregnancy, their effectiveness (if any) in preventing STI's, and other advantages and disadvantages.

Type of assessment tool: This is an "item matching" tool, in which students match the names of different birth control methods with descriptions of both the advantages and disadvantages of each method. The teacher assesses the number of correct answers.

Assessment criteria: Students will correctly match the names of birth control methods with their advantages and disadvantages. The teacher may wish to set a standard, such as 70% correct, as an indication of mastery of this knowledge objective.

Description:

1. Make a copy of the "Birth Control: Advantages and Disadvantages" sheet (below) for each student.
2. Ask students to draw a line to connect one advantage, and one disadvantage, to each form of birth control. Each advantage and disadvantage can be used only once.
3. Collect the students papers and record the number of correct answers according to the answer key (below).

### **Answer Key**

1. Withdrawal	Advantage: B	Disadvantage: J
2. Condom	Advantage: E	Disadvantage: L
3. Foam, creams, jellies	Advantage: C	Disadvantage: G
4. Diaphragm	Advantage: A	Disadvantage: K
5. IUD	Advantage: F	Disadvantage: H
6. Birth control pill	Advantage: D	Disadvantage: I

Comments: The "Birth Control: Advantages and Disadvantages" sheet can be cut into sections, and students can match the individual cards.

One card can also be given to each student. They can be asked to move around the room and form groups of three, with one birth control method, one advantage, and one disadvantage in each group. This will assess the group's level of knowledge, as opposed to individual's.

Sources: Adapted from activities in Life Skills and HIV/AIDS Education: A manual and resource guide for secondary school teachers, Planned Parenthood Association of South Africa (pp. 87-91), and My Future is My Choice, March 1999, Youth Health and Development Programme, Government of the Republic of Namibia and UNICEF (pp 22-24).



## Student Material K-5

### Birth Control: Advantages and Disadvantages

Advantages	Birth Control Method	Disadvantages
A. It can be put in ahead of time, so as to not interrupt lovemaking. It cannot be felt by either partner if it is inserted correctly. There are no health risks, and it is highly effective in preventing pregnancy.	1. Withdrawal	G. They must be used every time you have sex. They provide only short lasting protection. They are better if used with another form of birth control. Some users find them messy or irritating.
B. It requires no supplies or equipment.	2. Condom	H. It may cause discomfort to the woman. It increases the risk of getting a sexually transmitted disease. It does not protect against STD's or HIV.
C. They are easy to use, have very few health risks, and provide lubrication. Some may provide slight protection against sexually transmitted diseases.	3. Foams, creams, jellies	I. The woman has to remember to take them every day. They may cause side effects such as headaches or bleeding. Occasionally, side effects can be serious, such as high blood pressure or blood clots.
D. They give continuous protection. They are highly effective in preventing pregnancy. They make the woman's menstrual period lighter.	4. Diaphragm	J. It requires perfect timing and self-control. And some sperm can be released into the vagina before ejaculation.
E. Not expensive and widely available. Protects against sexually transmitted diseases, as well as pregnancy.	5. IUD (intrauterine device)	K. It must be used every time a couple has sex. Some women do not like inserting it. It must be checked for small holes through which sperm could pass.
F. It gives long lasting, continuous protection and does not interrupt sex. It requires little maintenance – the woman just has to check that it is in place.	6. Birth control pill	L. Must be used every time. Some men don't like to use them because they are afraid they will take away the pleasure of having sex.

### **K-6. A Visit to the Clinic**

Age level: Adolescents

Purpose: to assess students' knowledge of "how to obtain testing and counseling to determine HIV status" (WHO, 1999, p. 21).

Before using this assessment tool: Students should have completed lessons on what HIV and AIDS are, symptoms of AIDS, and how HIV/AIDS testing is carried out, before using this assessment tool.

Type of assessment tool: This is a "stimulus" activity involving short role-plays. It requires students to take on the role of a doctor in a clinic who is counseling a young person seeking

information on HIV/AIDS testing. Students watching the role-play use a checklist to assess whether or not the peer who is playing the role of the doctor answers the questions adequately.

Assessment criteria: Students playing the role of the doctor will demonstrate basic knowledge of facts about HIV and testing. Each correct answer will be given one point. The following five-point criterion-referenced scale will indicate the student's level of achievement:

Level 1: Very low achievement: 0-1 points

Level 2: Low achievement: 2-3 points

Level 3: Satisfactory achievement: 4-6 points

Level 4: High achievement: 7-11 points

Level 5: Very high achievement: 12 points or above

Description:

1. Make copies of the "Role Play Scenarios" and the "Student Assessment Checklist" (below).
2. Explain to the students that they will work in pairs to role-play a scenario in which a young person comes to a clinic to speak to a doctor (or other health care worker) about HIV/AIDS and how to get tested. The person playing the role of the doctor will have to correctly answer the young person's question.
3. Divide the class into pairs. Distribute the student materials to the pairs, so that one partner has "Role Play Scenarios" 1-4, and "Student Assessment Checklists" 1-4. The other partner should have "Role Play Scenarios" 5-8, and "Student Assessment Checklists" 5-8. Students should write the name of their partner following the line "Doctor's Name" on the checklists.
4. Ask the student with scenarios 1-4 to read the "young person's" line to their partner. The partner should respond to the question as if s/he were a doctor in a clinic. The person playing the role of the "young person" should use the checklist to record each response that the "doctor" makes. If the "doctor" gives a correct response that is not on the checklist, the "young person" should record that with an additional check.
5. When the first four scenarios and checklists have been completed, have the partners reverse roles. The person who was the "doctor" should now take on the role of the "young person", read scenarios 5-8, and record the new "doctor's" responses on the appropriate checklist.
6. Collect the checklists and record the results, giving one point for each correct answer noted on the checklist. The "pass point" for this activity is Level 3, a total of 4-6 points.

Comments: Depending on the group, it may be appropriate to carry out the role-plays in front of the class. If the "doctor" is unable to answer a question, another person in the class may

volunteer a response; the teacher should record the level of knowledge demonstrated on a checklist for the person responding.

Sources: Scenarios are adapted from questions in UNICEF's *Voices of Youth* on-line HIV/AIDS quiz, available at [www.unicef.org/voy/](http://www.unicef.org/voy/)

**Student Material K-6**

**A Visit to the Clinic: Role Play Scenarios**

1. Young person: What is the difference between HIV and AIDS? Doctor:
2. Young person: What does the immune system do? Doctor:
3. Young person: What is AIDS? Doctor:
4. Young person: What are the symptoms of AIDS? Doctor:
5. Young person: How can I find out if I am infected with HIV? Doctor:
6. Young person: So if the test is negative, that means I don't have HIV, right? Doctor:
7. Young person: I look healthy, and feel healthy, so that means I can't be infected with HIV, right? Doctor:
8. Young person: If I am infected with HIV, how long will it take for me to develop AIDS? Doctor:

**Student Material K-6**

**A Visit to the Clinic: Student Assessment Checklist**

<p>“Doctor’s” name:</p> <p>1. Young person: What is the difference between HIV and AIDS? Doctor:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> HIV stands for “human immunodeficiency virus”.</li><li><input type="checkbox"/> HIV is a virus that causes AIDS.</li><li><input type="checkbox"/> HIV destroys the immune system.</li></ul>
<p>“Doctor’s” name:</p> <p>2. Young person: What does the immune system do? Doctor:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> It helps the body to fight illnesses, like colds, the flu, or pneumonia.</li><li><input type="checkbox"/> When you get an infection, your immune system produces cells called "antibodies" that fight the infection.</li><li><input type="checkbox"/> A person who has AIDS has a very weak immune system.</li></ul>
<p>“Doctor’s” name:</p> <p>3. Young person: What is AIDS? Doctor:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> AIDS stands for "acquired immunodeficiency syndrome".</li><li><input type="checkbox"/> A person with AIDS has a weak immune system.</li><li><input type="checkbox"/> A person with AIDS cannot fight off infections.</li></ul>
<p>“Doctor’s” name:</p> <p>4. Young person: What are the symptoms of AIDS? Doctor:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> People with AIDS may have symptoms of many different kinds of infections.</li><li><input type="checkbox"/> Possible signs of these infections might be (a) loss of more than 10% of body weight, (b) diarrhea, fever, or a cough that last for more than a month, (c) severe tiredness, (d) painful skin rash, (e) swollen glands.</li><li><input type="checkbox"/> However, all of these can be symptoms of illnesses other than AIDS.</li></ul>
<p>“Doctor’s” name:</p> <p>5. Young person: How can I find out if I am infected with HIV? Doctor:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> The only way to know if you are infected with HIV is to go to a clinic for a blood test.</li><li><input type="checkbox"/> The blood test for HIV/AIDS shows whether or not there are antibodies (cells that fight infection) to the virus in your blood.</li><li><input type="checkbox"/> A positive blood test means that you are infected with HIV.</li></ul>
<p>“Doctor’s” name:</p> <p>6. Young person: So if the test is negative, that means I don’t have HIV, right?</p>

Doctor:

- Wrong.
- Sometimes the antibodies that are a sign of HIV infection do not show up for 2 to 12 weeks after being infected with HIV.
- If you think you may have been exposed to HIV, but your test was negative, you should get tested again in 12 weeks.

“Doctor’s” name:

7. Young person: I look healthy, and feel healthy, so that means I can’t be infected with HIV, right?

Doctor:

- Wrong.
- A person may be infected with HIV, but have no signs of infection for many years.
- Even if you have no signs of infection, if you are HIV positive you can transmit HIV to another person.

“Doctor’s” name:

8. Young person: If I am infected with HIV, how long will it take for me to develop AIDS?

Doctor:

- Once a person is infected with HIV, he or she may become sick within 6 months, or not for up to 10 years or more.
- Taking good care of your health and nutrition may slow the development of AIDS.
- There are drugs that may slow the development of AIDS, but they are very expensive, and they cannot cure AIDS.

## **IV. Assessing Attitude Objectives**

### **A. Attitude objectives**

The World Health Organization has identified attitude objectives for skills-based health education, including life skills for HIV prevention (WHO, 1999). These include the following objectives for different age levels<sup>2</sup>:

Pre-adolescents: Students will demonstrate:

- Commitment to setting ethical, moral and behavioural standards for oneself
- Positive self-image by defining positive personal qualities and accepting positively the bodily changes that occur during puberty
- Confidence to change unhealthy habits
- Willingness to take responsibility for behaviour
- A desire to learn and practice the skills for everyday living
- An understanding of their own values and standards
- An understanding of how their family values support behaviours or beliefs that can prevent HIV infection
- Concern for social issues and their relevance to social, cultural, familial and personal ideals
- A sense of care and social support for those in their community or nation who need assistance, including persons infected with and affected by HIV
- Honour for the knowledge, attitudes, beliefs and values of their society, culture, family and peers.

Adolescents: Students will demonstrate:

- Understanding of discrepancies in moral code
- A realistic risk perception
- Positive attitude towards alternatives to intercourse
- Conviction that condoms are beneficial in protecting against HIV/STI
- Willingness to use sterile needles, if using intravenous drugs
- Responsibility for personal, family and community health
- Support for school and community resources that will convey information about HIV prevention interventions
- Encouragement of peers, siblings and family members to take part in HIV prevention activities
- Encouragement of others to change unhealthy habits
- A leadership role to support the HIV prevention programme
- Willingness to help start similar interventions in the community

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<sup>2</sup> For objectives for young children, see WHO, 1999, WHO Information Series on School Health, Document Six: Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools, p. 19.

## **B. Assessing attitude objectives: Issues to consider**

Attitudes, or how students feel about issues related to the prevention of HIV/AIDS, are one factor that affects behaviour. Learning that addresses knowledge alone, without affecting attitudes, emotions, perceptions, intentions, and motivations is unlikely to influence behaviour (UNESCO PROAP Regional Clearing House on Population Education and Communication, 1998, p. 28).

Directly assessing attitudes is notoriously difficult. Often the presence or absence of certain attitudes is inferred through observing behaviour (Babbie, 1986, p. 98). For example, if a young person consistently uses a condom every time he has sex, it can be inferred that he has a positive attitude toward condom use, and toward taking responsibility for his personal health and that of his partner. Obviously, in the case of HIV/AIDS prevention, such relevant behaviours are unlikely to be observed by the teacher.

However, there are “proxy” measures that may be especially important for assessing the domain of attitudes. For example, tools that assess intentions can reveal student attitudes, and are one of the best predictors of future behaviour. Tools that assess students perceptions of social norms – for example, what friends are doing with regard to sexual behaviour, condom use, smoking, alcohol use – also reveal attitudes, and may be predictive of future behaviour (as most adolescents want to “fit in” with their peer group, what students think friends are doing affects their behavioural choices).

Self-reporting questionnaires on self-esteem are often used as part of attitude assessment. Positive self-esteem is important in itself, but is not necessarily a predictor of positive social behaviour; for example, students who bully others have been found to have high self-esteem (Olweus, 1993).

Self-reporting measures – Likert scales, sentence completion tasks, interviews – are commonly used tools for assessing attitudes. Educators should be aware that students may respond on self-reporting measures in a way that reflects what they think the teacher wants to hear, rather than what they really feel. And care must be taken in interpreting results of self-reporting measures, as the indication of a given attitude (for example, a positive attitude towards alternatives to intercourse) does not automatically insure that a particular behaviour (for example, use of those alternatives) will follow (Education Department of Western Australia, 1985, p. 49).

When assessing attitudes, triangulation – the use of more than one method of assessing the achievement of an objective – is particularly important. Consider using not only teacher assessment tools, but also those that call for self, peer, or even parent assessment, in order to gather information on attitudes from as many sources as possible.

This section has described some general guidelines for assessing attitude objectives; the next section gives actual examples of assessment tools that can be adapted for use with the objectives of a specific programme.



## C. SAMPLE ACTIVITIES FOR ASSESSING ATTITUDE OBJECTIVES

### **A-1. How Do I See Myself?**

Age level: Pre-adolescents

Purpose: to assess the degree to which students demonstrate “positive self-image by defining positive personal qualities and accepting positively the bodily changes that occur during puberty” (WHO, 1999, p. 20).

Before using this assessment tool: Because this tool assesses self-image, it should be used after students have had some skills-based health education on topics such as self-esteem, feelings and friendship. Students should also have been exposed to information about the normal bodily changes that occur during puberty.

Type of assessment tool: This is an open-ended questionnaire. The teacher assesses the degree to which students express attitudes indicating a positive self-image.

Assessment criteria: The students will respond to the majority of items in the questionnaire with answers that indicate positive self-image. Interpretation of student responses will necessarily be somewhat subjective; however, guidelines for an assessment rubric which helps to determine what are indications of positive self-image are suggested at the end of the questionnaire.

Description:

1. Distribute a copy of the “How Do I See Myself” questionnaire to each student.
2. Ask the students to read each question and write their response in the space provided.
3. Collect the papers and read the student responses, making a notation as to whether or not each response is indicative of a positive self-image. Guidelines for how to interpret the responses are provided below.

Comments: If students’ skill levels do not permit them to read the questions and write answers for themselves, the questionnaire can be given in an interview format. The teacher or other interviewer can record students’ verbal responses.

A self-report questionnaire such as this one can be useful to give to students both at the beginning and the end of a skills-based health education programme. This can provide valuable information to the teacher about how students’ attitudes toward themselves might be changing. It will not, by itself, constitute a formal “grading” of self-esteem, but rather will yield information about students’ progress toward achieving greater self-esteem.

Sources: Adapted from activities in Life Skills and HIV/AIDS Education: A manual and resource guide for secondary school teachers, Planned Parenthood Association of South Africa (pp. 9-14).

**Student Material A-1**

**How Do I See Myself?  
Student Questionnaire**

1. Three words I would use to describe myself are:
2. One way that I am special is:
3. Something I've done that I am proud of is:
4. A goal I have for the future is:
5. When I meet new people, I feel:
6. Being a good friend means:
7. When I have a conflict with a friend, I usually:
8. When I look at my body in the mirror, I feel:
9. One thing I like about my body is:
10. If I could change something about myself, it would be:

**Teacher Material A-1**

**How Do I See Myself?**

**Guidelines (or rubric) for interpreting student responses**

<u>Question</u>	<b>Possible indications of positive self-image</b>	<b>Possible indications of poor self-image</b>
1. Three words I would use to describe myself are:	Words that have a positive connotation: strong, kind, smart, brave, etc.	Words that have a negative connotation: stupid, fat, lonely, etc.  No response.
2. One way that I am special is:	Descriptions of differences in positive terms, such as “I am a good singer”.  Descriptions that are personal, such as “My family loves me.”	Descriptions of differences in negative terms, such as “I get the worst grades in the class”.  Descriptions of possessions, rather than personal qualities, such as “I have a new jacket.”  No response.
3. Something I’ve done that I am proud of is:	Descriptions of positive personal achievements: “I passed my science test”, “I read a book last week.”	Descriptions of negative personal achievements: “I beat up John when he called me a name”.  No response.
4. A goal I have for the future is:	Descriptions of academic achievement, career goals, goals involving developing a skill, interest, or personal quality.	Descriptions of activities that are anti-social.  No response.
5. When I meet new people, I feel:	Feeling words that indicate liking, connection, curiosity, interest.	Feelings words that indicate fear, withdrawal, lack of confidence.
6. Being a good friend means:	Descriptions of behaviours such as kindness, loyalty, honesty, communication, etc.	Descriptions of behaviours that suggest passivity or compliance, or going along with anti-social behaviours.
7. When I have a conflict with a friend, I usually:	Descriptions of behaviours such as talking about it, compromising, problem-solving, etc.	Descriptions of behaviours such as fighting or avoiding.
8. When I look at my body in the mirror, I feel:	Feeling words that indicate positive emotions, liking, pride.	Feeling words that indicate negative emotions or judgments.
9. One thing I like about my body is:	Descriptions of positive qualities, such as strength, or abilities, such as “I am a good swimmer.”	Descriptions of abilities to do anti-social things (fight, drink alcohol, etc.).  No response.
10. If I could change something about myself, it would be:	Descriptions of things that one can realistically change, such as abilities, learning new things, developing better interpersonal skills, etc.	Descriptions of things that cannot realistically be changed.  Responses that suggest negative self-judgment.



## **A-2. Would You Be Willing?**

Age level: Pre-adolescents

Purpose: to assess the degree to which students demonstrate “a sense of caring and social support for those in their community or nation who need assistance, including persons infected with and affected by HIV” (WHO, 1999, p. 20).

Before using this assessment tool: Students should be familiar with the ways that HIV/AIDS is and is not transmitted. They should also have received information about safe ways of caring for a person who is living with HIV/AIDS.

Type of assessment tool: This is a Bogardus social distance scale. The teacher collects the scales and analyses the students’ responses to assess their attitudes toward persons living with HIV/AIDS.

Assessment criteria (or rubric): An attitude of caring and support for people infected with HIV is indicated by positive responses to the fourth statement on each item of the scale.

Description:

1. Make a copy of the “Would you be willing?” sheet (below) for each student in the class.
2. Ask students to read each item on the sheet. Next to each question, students should circle either “yes” or “no” to indicate whether the item describes something they would be willing to do.
3. Collect student papers. For each question, record the number of the last question to receive a positive response. This indicates the student’s level of willingness to show care and support to persons infected with HIV.
4. Class averages can also be calculated for each question, to indicate which issues the group as a whole might benefit from addressing further.

Comments: The Bogardus social distance scale is an excellent tool to use both before and after lessons on dealing with people who are HIV positive, to assess changes in students’ attitudes.

Sources: Adapted from an example in HIV and AIDS in Africa, 1997, Douglas Webb.

**Student material A-2**

**Would you be willing?**

A. Would you be willing to:

- |  |     |    |
|--|-----|----|
| 1. ... have someone with AIDS live in your town?     | YES | NO |
| 2. ... have someone with AIDS live on your street?   | YES | NO |
| 3. ... have someone with AIDS live next door to you? | YES | NO |
| 4. ... have someone with AIDS visit in your home?    | YES | NO |

B. Would you be willing to:

- |  |     |    |
|--|-----|----|
| 1. ... have someone who is HIV positive go to your school?       | YES | NO |
| 2. ... have someone who is HIV positive in your class?           | YES | NO |
| 3. ... let someone who is HIV positive sit next to you in class? | YES | NO |
| 4. ... work on a project with someone who is HIV positive?       | YES | NO |

C. Would you be willing to:

- |   |     |    |
|---|-----|----|
| 1. ... sit next to an HIV-positive person on a bus? | YES | NO |
| 2. ... shake hands with an HIV-positive person?     | YES | NO |
| 3. ... hug an HIV-positive person?                  | YES | NO |
| 4. ... kiss an HIV-positive person on the cheek?    | YES | NO |

D. Would you be willing to:

- |   |     |    |
|---|-----|----|
| 1. ... talk with a person who is sick with AIDS on the telephone? | YES | NO |
| 2. ... go shopping for a person who is sick with AIDS?            | YES | NO |
| 3. ... wash the clothes of a person who is sick with AIDS?        | YES | NO |
| 4. ... help a person who is sick with AIDS wash him/herself?      | YES | NO |

E. Would you be willing to:

- |   |     |     |
|---|-----|-----|
| 1. ... walk away from someone who says unkind things about people with HIV/AIDS?                  |     | YES |
|   | NO  |     |
| 2. ... ask a person who is making jokes about people with HIV/AIDS to stop?                       | YES | NO  |
| 3. ... explain to someone who thinks people with HIV/AIDS shouldn't go to school that it is safe? |     | YES |
|   | NO  |     |
| 4. ... stop someone from treating a person with HIV/AIDS unfairly?                                | YES | NO  |

### **A-3. Attitudes toward gender roles**

Age level: Adolescents.

Purpose: To assess the degree to which students demonstrate “understanding of discrepancies in moral code” (WHO, 1999, p. 21). This assessment tool focuses specifically on discrepancies in social expectations between girls and boys.

Before using this assessment tool: This tool can be used after class activities on differences in gender roles, differing social expectations for girls and boys, and the impact of gender on susceptibility to HIV (with emphasis on the special risks faced by girls).

Type of assessment tool: This is a Likert scale, which allows students to self-report the intensity of their attitudes regarding gender roles. Either the teacher or the students themselves can develop an attitude score based on the responses to the scale.

Assessment criteria: Students will demonstrate attitudes favoring equality in gender roles and moral codes for girls and boys. This will be demonstrated by disagreement with statements supporting unequal gender roles, as indicated by a score of 10 or less on the odd-numbered items. It will also be demonstrated by support for statements that reflect attitudes of equality in gender roles, as indicated by a score of 20 or higher on the even-numbered items.

#### Description:

1. Give each student the “Gender Roles” page, which contains opinions regarding the roles of girls and boys, and women and men. Ask them to indicate the extent to which they agree or disagree with each statement by checking a point along the continuum, from “strongly disagree” to “strongly agree”.
2. Collect the responses and analyse the attitudes indicated. This may be done by assigning a score to each response. For example, score of 1 could be given to all “strongly disagree” responses; 2=disagree, 3=unsure, 4= agree, and 5=strongly agree. The scores for the odd-numbered items should be added together. The scores for the even-numbered items should be added together separately from the odd-numbered items. The teacher, or the students themselves, can tally their scores on the odd- and even-numbered items, and determine the extent to which the criteria has been met, according to the chart below:

#### **Assessment criteria or rubric: Demonstration of attitudes favoring equality in gender roles**

	Criteria met	Criteria not yet met	Criteria not met
Score on odd-numbered items	10 or below	11-19	20 or above
Score on even-numbered items	20 or above	11-19	10 or below

Comments:



3. Class averages can also be developed for each item; this will indicate group trends in attitudes toward gender roles.

Comments: If this tool is used in a pre-test/post-test design (both before and after lessons on gender roles), students can be asked to compare the responses they gave each time. They can then be asked to write a short paragraph assessing how their attitudes have changed, and why.

Sources: Adapted from activities in Facing the challenges of HIV, AIDS and STDs: A gender-based response, Royal Tropical Institute, Southern Africa AIDS Information Dissemination Service, and WHO, 1995, and Gender and relationships, Commonwealth Secretariat, 2001.

**Student Material A-3**

**Gender Roles**

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1. Education is more important for boys than for girls.					
2. Men are just as able to take care of sick family members as women are.					
3. Girls are not as strong as boys.					
4. Both women and men can share in caring for children.					
5. Real men are not sensitive like women (double barrel and also has a negative? Could make it two questions. Could flip the negative? - women are more sensitive than men)					
6. Girls have a right to refuse sex, even if a boy has given her gifts or paid for a night out.					
7. Girls who are knowledgeable about sex are not respectable.					
8. A relationship is best when each person respects the other's needs.					
9. Girls who carry condoms are "loose".					
10. Females should take responsibility for birth control not males (double barrel - could be two questions) I think the question will work better this way -					

#### **A-4. Poster Design**

Age level: Adolescents

Purpose: To assess the degree to which students demonstrate “conviction that condoms are beneficial in protecting against HIV/STI” (WHO, 1999, p. 21).

Before using this assessment tool: As this tool assesses students’ attitudes toward condom use, it should be used after they have received instruction on transmission of HIV, and ways of preventing transmission.

Type of assessment tool: This is a “stimulus” activity in which students are asked to design a poster that advocates for correct condom use among students who have made the decision to be sexually active. Peers assess the effectiveness of the posters.

Assessment criteria or rubric: Students will design a poster that other students consider "not effective", "somewhat effective", “effective” or “highly effective” in convincing young people of their age group to use condoms. The ability to design a highly effective poster can be interpreted as indicating a strong level of conviction about the benefits of condom use.

Description:

1. Gather together an assortment of drawing materials that might be used for making a poster, such as large sheets of paper, pencils, crayons, felt tip pens, paint, magazines. Other materials that might be incorporated into a poster could include newspaper or magazine pictures or headlines; if using these, scissors and glue should also be available.
2. Distribute materials to students and ask them to work individually to create a poster on condom use. Have them imagine that this poster will be seen by young people of their age group who have already decided to become sexually active, or who may be considering becoming sexually active. The poster should use words and images to convince these young people that condom use is a good idea.
3. Allow students time to create their posters. This may take more than one class period. This could also be a project completed outside school hours
4. Display the posters around the room. Ask students to circulate, view all the posters, assessing them using the suggested criteria or rubric (Student Material A4) and give an overall rating using the numbers 1-4, according to whether they are:
  - 1) not effective,
  - 2) somewhat effective,
  - 3) effective, or
  - 4) highly effective.

This can be done by:

- Numbering each poster, and giving each student a sheet of paper with the numbers listed (keep it anonymous); as they view the posters, they place a number from 1-4 (or a letter: a,b,c,d) that indicates their assessment of the poster next to each name. The teacher then collects the rating sheets;
- Placing a sheet of paper next to each poster; students can write a number 1-4 on this sheet to indicate their assessment of the poster.

Guidelines for assessing the effectiveness of the posters may be helpful, and the “Criteria or Rubric for assessing posters” sheet can be discussed or distributed. Students may want to add their own criteria to this list.

Comments: Instead of working individually, students can work in pairs or small groups to design their poster. This will provide the teacher with information about the group’s attitudes, as opposed to individual attitudes. It may also provide the opportunity to assess other interpersonal skills such as cooperation, advocacy, negotiation, conflict management, or effective listening.

Assessment should not rely on artistic ability, but rather the content of the poster. This assessment tool can be used with a variety of topics, not only condom use. For example, it can be used with younger children on topics such as “encouraging healthy habits” or “caring for a person living with AIDS”. With older students, the topic could be “reasons for abstinence” or “caring for your partner”.

This tool can be varied by having students design a radio, television, or print advertisement that tries to persuade others to adopt healthy behaviour, such as getting a voluntary HIV test, becoming familiar with reliable sources of information on healthy behaviour, or using counseling services for questions on HIV and STI’s.

Sources: Adapted from activities in Think About It! Form 2 Students Book, 1994, Ministry of Education and Culture, Zimbabwe (p. 19), and Happy, Healthy and Safe, 1998, Family Health Trust Zambia – Anti-AIDS Project (page 279).

**Student Material A-4**

**Assessment Question:** How well do students use posters to convey a message?

**Possible Criteria (or Rubric) for assessing posters**

Note - tally the score on these items for each poster to help you decide on the effectiveness of each

1) How accurate is the information?	1	2	3	4
2) How easy are the images to understand?	1	2	3	4
3) How appealing is the poster to the target group?	1	2	3	4
4) How catchy, or sharp is the message/s?	1	2	3	4
5) How persuasive is the poster?	1	2	3	4
6) How well does it convey important message/s about the benefits of condom use (prevent the spread of HIV and other STI's, preventing pregnancy)?	1	2	3	4

- Eg. - Does it emphasise the importance of using a condom every time if sexually active?
- Does it help inform about where to get condoms?
- Does it challenge myths about condom use (that it is not manly to use a condom, that they interfere with sexual pleasure?)
- Does it promote the idea that talking about and using condoms is part of a healthy, loving relationship?

Other?.....

**Overall Level of Proficiency:**

**Areas for Improvement:**

## **A-5. Interviews**

Age level: Adolescents

Purpose: To assess the degree to which students demonstrate “encouragement of others to change unhealthy habits” (WHO, 1999, p. 21).

Before using this assessment tool: Students should have completed a skills-based health education programme that provides information about staying healthy and reducing risk, allows for discussion of attitudes and values such as caring, compassion, and responsible behaviour, and encourages the development of skills for advocating for healthy choices.

Type of assessment tool: This tool combines a set of scenarios for students to react to with a series of interview questions about the scenario. Students ask the interview questions of other students and determine the degree to which their responses indicate a willingness to encourage others to change unhealthy habits.

Assessment criteria: Students will respond to the scenarios by correctly identifying health-related behaviours that are unhealthy, and describing ways of encouraging others to act in a more healthy and responsible way. Peer interviewers decide if the interviewee’s responses indicate that they are "willing" to encourage others to change unhealthy habits, "somewhat willing", or "not willing".

Description:

1. Make copies of the four scenarios and the interview questions below. Divide the group into pairs. Give each person in the pair two scenarios.
2. Each person reads her/his scenarios aloud to the other person. The reader then asks their partner the interview questions. Possible responses are included in parentheses after the interview question.
3. Based on the responses, the interviewer rates the interviewee’s level of willingness to encourage others to change unhealthy habits, and to advocate for more healthy behaviour. Two example rubrics are provided below. One is for assessing interviewing skills (interviewer), and the other is for assessing willingness to change (interviewee).

Comments: Students can be asked to write responses to the scenarios, rather than answer questions about them in an interview context. The teacher can then collect and assess the attitudes indicated by the responses.

Sources: Scenarios are adapted from material in Flirting or Hurting?, Stein and Sjostrom (p. 37); Gender and Relationships, Commonwealth Secretariat (p. 109); Life Skills and HIV/AIDS Education: A manual and resource guide for secondary school teachers, Planned Parenthood Association of South Africa (p. 144); and School Health Education to Prevent AIDS and STD: Students’ Activities, 1994, WHO and UNESCO (p. 73).

**Student Material A-5**

**“Interviews” Scenario #1**

"A" is a secondary school student. He is very popular and has a lot of friends. "A" has recently begun harassing girls while they are walking home from school, calling them names and trying to touch them. "A" tells the girls he will hurt them if they report him. "A" is trying to get other boys to join him in this harassment. He says it is fun, and that the other boys are not real men if they are too scared to chase girls. "B" is a friend of "A's" who wants to get him to stop the harassment.

**Interview questions for Scenario #1:**

What is "A" doing that indicates “unhealthy habits”? (*Harassing girls, threatening girls, treating girls as objects or as less than equals; pressuring boys to join him, ridiculing boys who refuse.*)

What could "B" do to encourage "A" to change this behaviour? (*Refuse to be pressured by "A"; explain to A why harassing girls is wrong; explain that harassment violates girls' rights; encourage and support girls who want to stand up to A; tell A that if he can't change his behaviour, B will consider reporting him to school authorities; explain to A that his actions could cause others to not want to associate with him.*)

**Example Assessment Rubric for Interviewing Skills**

**Assessment Question:** How proficient are students in interviewing *skills*?  
 (This is actually a *skills* rubric, which could be used in tandem with the *attitudes* rubric below to assess two aspects of learning through one performance task)

**Rubric for Interviewing Skills**

<p><b>1. Content of interview</b>                  1.1 Ask questions that are relevant                   1.2 Clarifies concepts</p>	<ul style="list-style-type: none"> <li>• Questions are of little or no relevance</li> <li>• Interviewer does not ask questions that lead to further clarification of concepts</li> </ul>	<ul style="list-style-type: none"> <li>• Questions are mostly relevant</li> <li>• Interviewer may ask some questions that lead to further clarification of concepts, but not in all cases deemed applicable</li> </ul>	<ul style="list-style-type: none"> <li>• Questions are very relevant</li> <li>• Interviewer asks questions that lead to further clarification of concepts</li> </ul>
<p><b>2. Process of interview</b>                  2.1 Maintains focus of ideas</p>	<ul style="list-style-type: none"> <li>• Is not able to maintain focus or train of thought</li> </ul>	<ul style="list-style-type: none"> <li>• Is somewhat able to maintain focus or train</li> </ul>	<ul style="list-style-type: none"> <li>• Is very able to maintain focus or train of thought</li> </ul>





**2) Example Assessment Rubric for Expressing Willingness to Change Behaviour**

**Assessment Question:** How willing are students to change?

Based on this interview, \_\_\_\_\_ (name):

- ❑ appears willing to encourage others to change unhealthy habits (gave two or more of the suggested responses or related responses to question 1, and two or more of the suggested responses to question 2; seemed confident about responding)
- ❑ appears somewhat willing to encourage others, but could improve (gave one of the suggested responses to question 1 and one response to question 2)
- ❑ does not appear willing to encourage others to change unhealthy habits (gave no reasonable response or one response to question 1 only; did not give a reasonable response to question

	<b>Not met</b>	<b>Not yet Met</b>	<b>Met</b>
1. Basis for attitude	<ul style="list-style-type: none"> <li>● Is not very able to provide facts and perspectives to support their attitude</li> </ul>	<ul style="list-style-type: none"> <li>● Is somewhat able to provide facts and perspectives to support their attitude; or in a limited away</li> </ul>	<ul style="list-style-type: none"> <li>● Is very able to provide accurate facts and perspectives to support their attitude</li> </ul>
2. Use of body language	<ul style="list-style-type: none"> <li>● Body language does little to support the attitude being portrayed</li> </ul>	<ul style="list-style-type: none"> <li>● Body language is somewhat consistent with attitude eg. use of voice, body, and eye contact show some confidence</li> </ul>	<ul style="list-style-type: none"> <li>● Body language is consistent and convincing eg. use of voice, body, and eye contact, suggest confidence</li> </ul>

Overall Performance:

Areas for Improvement:

## Student Material A-5

### “Interviews” Scenario #2

"C" is a 16-year-old girl who has a steady boyfriend. C and her boyfriend do not use condoms, and C does not use birth control. C says she always washes immediately after sex, and she believes that this will keep her from getting pregnant. However, she has recently heard that this may not be true, and she is beginning to worry about getting pregnant. She thinks that if she asks her boyfriend to use condoms, he will refuse. She is not sure what to do. B is a friend of C's who wants to help her.

#### **Interview questions for Scenario #2:**

What is C doing that indicates “risks”? (*having sex without using any form of birth control; relying on washing to prevent pregnancy; being afraid to talk to her boyfriend about her concerns; assuming that her boyfriend is not willing to help prevent an unwanted pregnancy.*)

If you were B would you encourage C to change this behaviour? If so, how? (*explain to C that washing will not prevent pregnancy; tell C about methods of birth control that work; encouraging C to talk to her boyfriend about her concerns; encouraging C to get medical advice and counseling from a local clinic.*)

## Student Material A-5

### “Interviews” Scenario #3

D is a boy who has had several casual relationships in the past, and never used condoms. Now D is dating a girl that he feels he is really in love with. He has talked with her about wanting to have sex. D doesn't want her to know about his past relationships. But he is wondering if he should get tested for HIV and other STI's. He wants to know whether she has had other sexual partners too, and would like her to get tested as well. He is afraid that if he asks her to do this, she will think he doesn't trust her. B is a friend of D's who wants to help him make healthy decisions about this relationship.

#### **Interview questions for Scenario #3**

What is D doing that indicates risks? (*having casual sexual relationships; having sex without using condoms; not talking with his girlfriend about safer sex; not getting tested for HIV or other STI's.*)

If you were B would you encourage D to change this behaviour? If so, how? (*encourage him to not have sex with his girlfriend until he gets tested for HIV and other STI's; try to get him to understand that getting tested is a way of showing that you really care for your partner; remind him that even if his HIV test is negative, he should wait three months and get re-tested before having sex with his girlfriend; help him find youth-friendly health services in his community; encourage him to get counseling about how to talk with his girlfriend about safer sex.*)

## Student Material A-5

### “Interviews” Scenario #4

E is a girl who dropped out of school after her mother died of AIDS, to care for her father who is also ill with AIDS. E is afraid of having too much contact with her father, because she is afraid that she will become ill too. She has been preparing food for him, but is afraid to wash his clothes or bedding for fear of getting AIDS. She is feeling very lonely because she wants to see her friends, but thinks that they will not want to come visit her. She is feeling ashamed that people in her family have this illness. B is a friend of E's who wants to help her cope with this situation.

#### **Interview questions for Scenario #4**

What is E doing that might make it hard to cope or that is not healthy for her? (*dropping out of school; limiting contact with her father; cutting off contact with her friends; feeling ashamed because her parents have AIDS*)

If you were B would you encourage E to change this behaviour? If so, how? (*reassure her that it is safe to have contact with her father, as long as she avoids contact with his bodily fluids; explain to her how HIV is and is not transmitted; encourage her to continue her education; encourage her to spend time with her friends; reassure her that B is still her friend; explain to her that it is safe to have friends visit the house; reassure her that she does not have to be ashamed just because her parents are ill.*)

## **A-6. Captions**

Age level: Adolescents

Purpose: To assess the degree to which students demonstrate “encouragement of others to change unhealthy habits” (WHO, 1999, p. 21).

Before using this assessment tool: Students should have received lessons on a range of topics relating to health education (smoking, drinking), as well as HIV prevention.

Type of assessment tool: This is a “stimulus” activity that asks students to look at a set of pictures, and develop captions for them that promote healthy behaviour and changing of unhealthy habits. The teacher assesses the effectiveness of the captions.

Assessment criteria: When presented with a stimulus picture, students will write a caption that effectively advocates for healthy behaviour or the changing of unhealthy habits. An effective caption will include one or more of the possible responses suggested in the “Teacher’s guidelines for assessing ‘Captions’”.

Description:

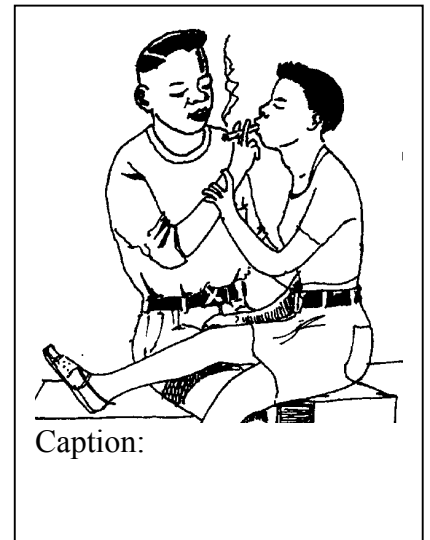
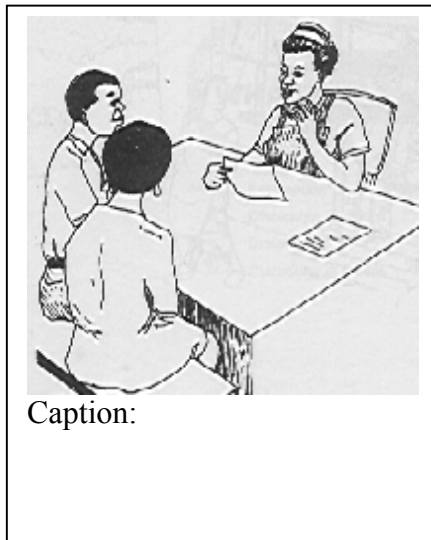
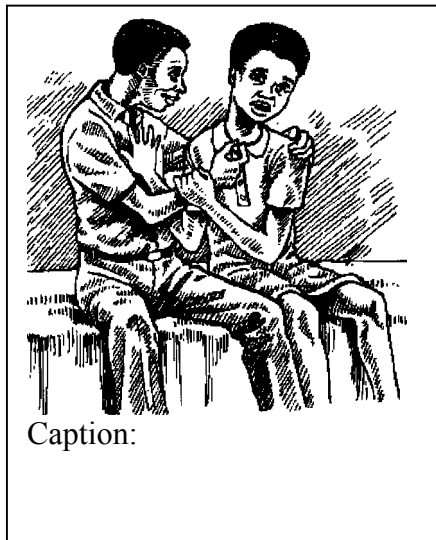
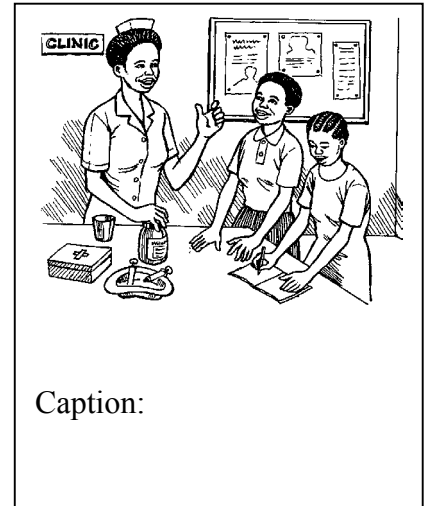
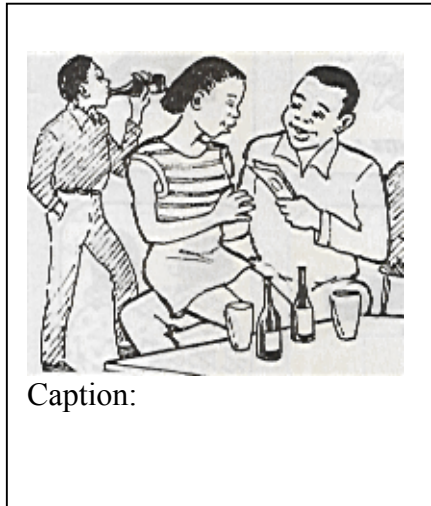
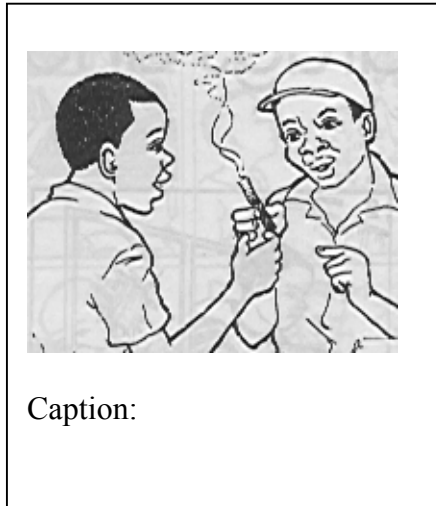
1. Make copies of the pictures below. Give one picture to each student (depending on the age of the students, and the time available, students may be given multiple pictures).
2. Ask students to imagine that they will use these pictures as part of a health education campaign in their community. Ask them to create a caption for each picture that will encourage others to practice healthy habits and behaviours.
3. Collect the pictures and captions and assess whether or not the caption reflects an attitude of encouragement for healthy habits. “Teacher’s guidelines for assessing ‘Captions’” are included below.

Comments: The activity can be used with younger students by selecting age-appropriate pictures or photos.

Sources: Pictures are taken from Think About It! Form 2 Students Book, 1994, Ministry of Education and Culture, Zimbabwe, and Happy, Healthy and Safe, 1998, Family Health Trust Zambia – Anti-AIDS Project.

Student Material A-6

Possible pictures for "Captions"



## Teacher Material A-6

### Teacher's guidelines for assessing "Captions"

These are possible messages that captions might convey. An effective caption should include one or more of these messages. Use "not met", "not yet met", or "met" to suggest level of success. Alternatively a score of 1,2, or 3.

1. Two boys smoking drugs: Caption might emphasise that using drugs is bad for the body; specify health impacts of drug use; drug use impairs judgment and causes you to make bad decisions; drug use may increase risky sexual behaviour; using drugs may be illegal; drug use may feel good in the short term, but has negative long-term consequences; don't be pressured to use drugs just because you think everybody is doing it and you want to "fit in"; there are other ways to have fun and feel good about yourself besides using drugs.

Overall Rating:

Areas for Improvement:

2. Man paying girl for sexual favors, drinking: Caption might emphasise that someone who pays you for sex does not really love you; having sex with someone you don't know very well can lead to STI, HIV, or unwanted pregnancy; sexual relations should be reserved for a person you really love, and who loves you; drinking alcohol impairs judgment and causes you to make bad decisions; alcohol use may increase risky sexual behaviour.

Overall Rating:

Areas for Improvement:

3. Two girls visiting a clinic for information: Caption might emphasise that it is important to know where to get health care; that young people should ask qualified adults when they have questions about health; that taking care of your health is the responsible and mature thing to do; that taking care of your health is a way to show you care about yourself and others.

Overall Rating:

Areas for Improvement:

4. Boy pressuring girl to have sex: Caption might emphasise that no one has the right to force you to have sex; no one should pressure you to have sex to prove your love for them; sex should be part of a loving relationship; forced sex is rape; forced sex is not a proof of manhood; forced sex can lead to STI, HIV, or unwanted pregnancy; if touching doesn't feel good, you have the right to say "no".

Overall Rating:

Areas for Improvement:

5. Man and woman visiting a clinic together for HIV test: Caption might emphasise that getting an HIV test is responsible behaviour; going for voluntary HIV testing and counseling shows that your partner cares about you; that it is important for both partners to be involved in protecting each others' health; that it is important to know where to get information about HIV and STI's; sharing responsibility for healthy behaviour is a sign of real love.

Overall Rating:

Areas for Improvement:

6. Teenaged boy and girl smoking cigarettes: Caption might emphasise that smoking is dangerous for your health; specify health impacts of smoking; smoking costs money; the odor can be unappealing to others; tobacco company ads try to make smoking look sophisticated in order to manipulate young people to buy more cigarettes; smoking can harm a pregnant woman's baby; don't give in to pressure to smoke just because you think it will help you "fit in" with others.

Overall Rating:

Areas for Improvement:

## **V. Assessing Skill Objectives**

### **A. Skill objectives**

The World Health Organization has identified skill objectives for skills-based health education (including life skills) on HIV prevention (WHO, 1999). These include the following objectives for different age levels<sup>3</sup>:

Pre-adolescents: Students will be able to:

- Communicate messages about HIV prevention to families, peers and members of the community
- Actively seek out information and services related to sexuality, health services or substance use that are relevant to their health and well-being
- Build a personal value system independent of peer influence
- Communicate about sexuality with peers and adults
- Use critical thinking skills to analyse complex situations that require decisions from a variety of alternatives
- Use problem-solving skills to identify a range of decisions and their consequences in relation to health issues that are experienced by young persons
- Discuss sexual behaviour and other personal issues with confidence and positive self esteem
- Communicate clearly and effectively a desire to delay initiation of intercourse (e.g., negotiation, assertiveness)
- Express empathy toward persons who may be infected with HIV

Adolescents: Students will be able to:

- Refuse to have sexual intercourse
- Assess risk and negotiate for less risky alternatives
- Seek out and identify sources from which condoms can be obtained
- Appropriately use health products (e.g. condoms)
- Seek out and identify sources of help with substance use problems, including source of clean needles or needle exchange

### **B. Assessing skill objectives: Issues to consider**

Skills refer to student abilities which can support behaviours. It is essential to evaluate skills in skills-based health education programmes because skills act as a link between knowledge, attitudes and behaviour (Education Department of Western Australia, 1985). Students who have

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<sup>3</sup> For objectives for young children, see WHO, 1999, WHO Information Series on School Health, Document Six: Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools, p. 19.



developed and performed specific skills in the classroom are more likely to behave outside that classroom in ways that are conducive to health and well-being.

There is a range of different skills that should be assessed in life skills education programmes with a focus on HIV/AIDS prevention. Some are specific programme skills, such as the ability to safely care for a person living with AIDS, or the ability to accurately assess risk. Others are psychosocial skills such as the ability to solve problems, communicate assertively, or use critical thinking skills to analyse situations. Certain assessment tools described below may be most appropriate for different types of skills.

Skills are often assessed through demonstration or observation. But in assessing skill development for HIV/AIDS prevention, the critical skills needed often can't be observed in the artificiality of the classroom setting. While students may use skills effectively in a lesson, there is no guarantee that those skills will be used in actual situations where peer pressure, threats, or other factors may influence their use. Self-report instruments are another commonly used means of assessing skills, but students using them may over- or under-estimate their skills, or report what they think the teacher wants to hear. As is the case in assessing other domains of learning such as knowledge and attitudes, it is important to triangulate, or use more than one type of instrument to gather information on students' skill levels.

The use of peer assessment strategies may be particularly effective for skill assessment. An adult's evaluation of a student's abilities to negotiate for less risky behaviour, for example, may be based on what adults consider important criteria. This may have little relationship to what actually works when young people must make decision about sexual behaviour. Students themselves are more likely to be able to determine whether or not a particular strategy will really work, and under what circumstances.

This section has described some general guidelines for assessing skill objectives; the next section gives actual examples of assessment tools that can be adapted for use with the objectives of a specific programme.

## **C. SAMPLE ACTIVITIES FOR ASSESSING SKILL OBJECTIVES**

### **S-1. Peer Influence**

Age level: Pre adolescents

Purpose: to assess the degree to which students are able to “build a personal value system independent of peer influence” (WHO, 1999, p. 20).

Before using this assessment tool: Students should have been exposed to lessons on risk prevention. They should have had frequent opportunities for interactive practice of skills such as negotiation, assertiveness, and refusal. They should also have had discussions on personal, family, and community values, and the role that values play in developing healthy behaviours.

Type of assessment tool: This is a variation of a self-report checklist, which asks students to assess their own abilities using a simple semantic differential scale.

Assessment criteria: Students' responses to the situations in which they encounter peer pressure should indicate that they consider themselves knowledgeable about what to say, able to refuse, and confident that they can resist continued pressure. This is indicated by average scores of 4 or above on each of the three dimensions: "not knowledgeable – knowledgeable", "unable – able", and "unsure – confident".

Description:

1. Copy the "Peer Influence Checklist" (below) for each student.
2. Distribute the checklist, have the students to read each scenario, and ask them to rate themselves on their knowledge of how to resist peer pressure, ability to refuse, and confidence in resisting continued pressure
3. Collect the students' checklists and record each students' assessment of their abilities. A number can be assigned to each response to allow for scoring. For example:

Very <b>knowledgeable</b>	5
somewhat knowledgeable	4
neither	3
not very knowledgeable	2
not at all knowledgeable	1

Very **able**=5, somewhat able=4, neither=3, somewhat unable=2, very unable=1.

Very **confident**=5, somewhat confident=4, neither =3, somewhat unsure=2, very unsure=1

(Note that the above can be organised as a horizontal or vertical scale, and that the order of responses can be reversed to discourage students from responding in a patterned way.)

An average score can be developed for each question, or across each dimension.

Comments: This activity can be used with older students by adapting scenarios for their age group.

If students cannot read the scenarios and the scale, the scenarios can be read aloud to them. They can be asked to pick a number from 1 to 5 (for example, with 1 representing "not able", and 5 representing "very able") that indicates their assessment of their own skill level.

Sources: Based on an activity in School Health Education to Prevent AIDS and STD: Handbook for Curriculum Planners, 1994, WHO/UNESCO (p. 71).

**Student Material S-1**

**Peer Influence Checklist**

1. You are at a party where some of your friends are drinking alcohol. They want you to join them and are pressuring you to do so. If you do NOT want to join your friends in drinking...

... How knowledgeable are you about what to say?

	Very	Somewhat	Neither	Somewhat	Very	
<b>Knowledge-able</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Not knowledge-able</b>

... How able to refuse are you?

	Very	Somewhat	Neither	Somewhat	Very	
<b>Unable</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Able</b>

... How confident are you that you could resist if your friends kept pressuring you?

	Very	Somewhat	Neither	Somewhat	Very	
<b>Confident</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Unsure</b>

2. Your parents have forbidden you to go to a part of town that they think is dangerous, because there is crime and drug use in that area. Some of your friends want you to go there with them. They say it is not that bad and that you can have a good time there. They say you are a coward if you don't go. If you do NOT want to go with your friends...

... How knowledgeable are you about what to say?

	Very	Somewhat	Neither	Somewhat	Very	
<b>Knowledge-able</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Not knowledge-able</b>

... How able to refuse are you?

	Very	Somewhat	Neither	Somewhat	Very	
<b>Unable</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Able</b>

... How confident are you that you could resist if your friends kept pressuring you?

	Very	Somewhat	Neither	Somewhat	Very	
<b>Confident</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Unsure</b>

3. You are with a group of friends. One friend brings glue to sniff. Some of your friends join in and seem to be having a great time. They urge you to join them. You know that sniffing glue can be dangerous to your health. If you did NOT want to join your friends in sniffing glue...

... How knowledgeable are you about what to say?

**Knowledgeable**    Very    Somewhat    Neither    Somewhat    Very    **Not knowledgeable**  
                   

... How able to refuse are you?

**Unable**    Very    Somewhat    Neither    Somewhat    Very    **Able**  
                   

... How confident are you that you could resist if your friends kept pressuring you?

**Confident**    Very    Somewhat    Neither    Somewhat    Very    **Unsure**  
                   

4. It is a Sunday afternoon, and you have been putting off your chores and homework all weekend. You have got enough work to fill the rest of the day. Your best friend calls to invite you to go to a movie. S/he says the chores and homework can wait. If you did NOT want to go with your friend...

... How knowledgeable are you about what to say?

**Knowledgeable**    Very    Somewhat    Neither    Somewhat    Very    **Not knowledgeable**  
                   

... How able to refuse are you?

**Unable**    Very    Somewhat    Neither    Somewhat    Very    **Able**  
                   

... How confident are you that you could resist if your friend keeps pressuring you?

**Confident**    Very    Somewhat    Neither    Somewhat    Very    **Unsure**

## **S-2. Parent Observations**

Age level: Pre-adolescents

Purpose: to assess the degree to which students are able to “communicate about sexuality with peers and adults ” and “discuss sexual behaviour and other personal issues with confidence and positive self esteem” (WHO, 1999, p. 20).

Before using this assessment tool: This tool assesses students’ ability to communicate about a range of issues pertaining to sexuality. It is best used at the end of a comprehensive skills-based health education programme. It could also be used both before and after the programme, to assess the extent to which students have improved in their ability to communicate about sexuality issues over time. Prior to using this tool, it may be helpful to send home a note to parents, or hold a parent meeting, to discuss the nature or the programme, the topics it addresses (HIV prevention, risky behaviour, relationships, etc.), and to ask that they maintain on-going communication about the programme.

Type of assessment tool: This is an observation tool for collecting anecdotal records on students’ abilities to raise issues about sexuality with their parents. Parents are asked to keep a record of when their children discuss issues of sexuality with them, what issues they raise, and how confident they seem in doing so.

Assessment criteria: Anecdotal records will show that children are raising issues about sexuality with their parents, and that they appear confident in raising these issues. If the records are kept over a period of time, or if they are kept at the beginning and at the end of a skills-based health education programme, records will show an increase in either the number of issues raised, or the children’s confidence (as assessed by the parent).

Caution should be used in interpreting the results of these anecdotal records. For example, if the records are kept over time, the number of questions that children ask their parents may decrease, as children acquire more information in school.

Also, some parents may actively discourage their children from raising issues about sexuality. These records may show no incidence of children discussing these issues or asking questions. Or, the parents may refuse to keep records on this subject at all.

Description:

1. Decide how you want to use parent observations: at the end of a skills-based health education course, at the beginning and the end, or continuously over several months.
2. Make copies of the “Parent Observation Sheet” below. Distribute one to a parent or guardian of each child in the class.

3. Hold a meeting, or send home a letter, to explain to parents the purpose of the sheets. Ask parents to keep a record for a month of whether or not their child raises any of the issues pertaining to sexuality that are listed on the sheet. Ask them to note the date that their child initiated a discussion about relationships or sexuality, and what they asked or discussed. Ask them also to assess whether they thought their child seemed confident and comfortable in having this discussion, or whether the child seemed hesitant or uncomfortable.
4. Collect the record sheets at the end of the month, and make notes on the number of times each student raised issues of sexuality with their parents.

Comments: If parents are not able to read the observation record sheet, a teacher or other adult may interview them about the extent to which children have discussed issues pertaining to sexuality.

Sources: Adapted from an idea in My Future is My Choice, March 1999, Youth Health and Development Programme, Government of the Republic of Namibia and UNICEF (pp. 49-51).

**Parent Material S-2**

**Parent Observation Sheet**

As part of our skills-based health education class, the school is gathering information on whether talk with their parents about issues raised in the class. This will help us to strengthen communication and partnership between students, parents and the school.

Please help us by filling out this sheet for one month:

- If your child talks to you about relationships, health or related issues listed below, please write down the date. You may write down more than one date for each topic.
- Write down what your child said or asked, if you can remember.
- How confident did your child seem in talking about this issue? Check the box to indicate.

Thank you for your help!

<b>Topic</b>	<b>Date</b>	<b>What did s/he say?</b>	<b>Was s/he ...?</b> 5: Very confident 4: Somewhat confident 3: Neither 2: Somewhat unsure 1: Very unsure
Menstruation			
Pregnancy			
Childbirth			

Condoms			
Sexual intercourse			
Abstinence			
HIV/AIDS			
Sexually transmitted infections			
Other topics?			



### **S-3. Speech Bubbles**

Age level: Pre-adolescents

Purpose: to assess the degree to which students are able to “communicate clearly and effectively a desire to delay initiation of intercourse (e.g., negotiation, assertiveness)” (WHO, 1999, p. 20).

Before using this assessment tool: Students should have received instruction on how HIV is transmitted. They should also have had the opportunity to practice skills such as negotiation and assertiveness.

Type of assessment tool: This is a “stimulus” activity, in which students look at cartoons having to do with pressure to have intercourse. They fill in an empty speech bubble with a response that demonstrates the ability to delay or avoid intercourse. Peers (who are most likely to know what sort of responses would work in real life) assess the effectiveness of each other’s responses.

Assessment criteria: In response to a cartoon in which one character is being encouraged to have sex, students will be either “effective” or “very effective” in delaying or refusing intercourse, according to the judgment of other students in the class.

Description:

1. Give one set of the “Speech Bubbles” cartoons (below) to each student. Ask them to read what the first person in each cartoon says. They should then fill in the blank speech bubble with a response that they think would be effective in delaying or refusing intercourse.
2. When all students have completed all four speech bubbles, have them exchange papers with another student. Ask each student to rate how effective they think their partner’s responses would be on a scale of 1-4:
3. Allow the students to negotiate for a change in their rating, if necessary. The peer assessor should be prepared to give reasons for the rating, or to change it if presented with a reasonable argument as to why a particular response would be effective.
4. Collect all the papers and keep a record of how students have rated each other’s responses.

Comments: The activity can be adapted for older students by substituting age-appropriate graphics and text.

The student responses may be rated by more than one student, and can be given out anonymously, to prevent bias on the part of the student assessor.

Student responses can also be rated by the teacher, as opposed to peers.

Sources: Adapted from an activity in School Health Education to Prevent AIDS and STD: Students' Activities, 1994, WHO and UNESCO. Pictures taken from School Health Education to Prevent AIDS and STD: Students' Activities, 1994, WHO and UNESCO (p. 32) and Think About It! Form 2 Students Book, 1994, Ministry of Education and Culture, Zimbabwe (p. 12).

**Example Rubric**

**Assessment Question:** How effective are students in communicating a desire to delay initiation of intercourse?

Beginner (1) = not effective

Novice (2) = somewhat effective

Proficient (3) = effective

Expert (4) = very effective

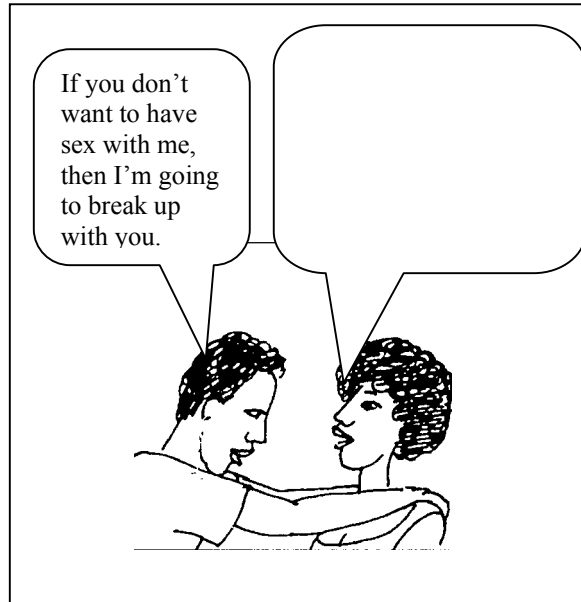
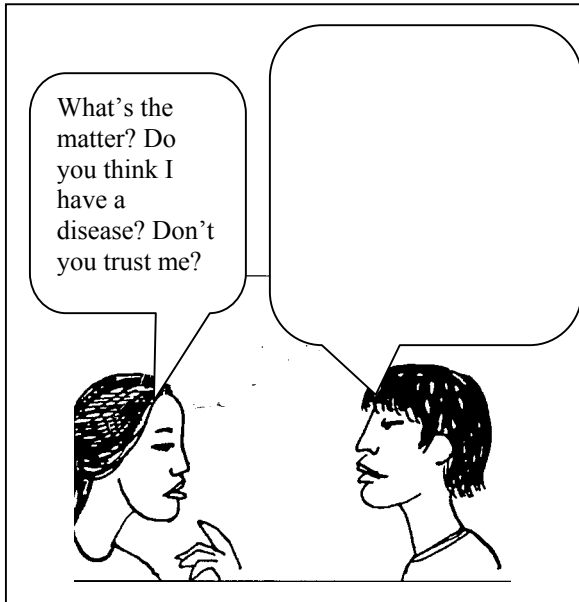
Criteria	Level of proficiency			
	1	2	3	4
<b>1. The content of the speech bubbles</b> 1.1 The main idea is clear 1.2 The content is accurate (where applicable) 1.3 The example is sufficient for the task				
<b>2. Strategy</b> 2.1 The vocabulary is appropriate to the task 2.2 The language/main idea takes a convincing or useful perspective				
<b>3. Presentation</b> 3.1 The speech bubbles are clearly presented 3.2 The response is feasible to the task and audience				

Overall level of proficiency:

Areas for improvement:

Student Material S-3

Speech Bubbles



#### **S-4. Assessing Risk**

Age level: Adolescents

Purpose: to assess the degree to which students are able to “assess risk and negotiate for less risky alternatives” (WHO, 1999, p. 21).

Before using this assessment tool: Students should have completed lessons on how HIV is transmitted, and behaviours that reduce the risk of transmission. They should also be aware of other behaviours that pose risks of unwanted pregnancy, contracting and STI, etc.

Type of assessment tool: This tool consists of scenarios that students react to. They write endings for the scenarios so that the character described uses less risky behaviours. The teacher assesses the skill level shown in the written responses.

Assessment criteria: Students will accurately assess potential risks described in a scenario, and will write an ending to the scenario in which less risky behaviours are effectively negotiated. See example assessment rubric below.

Description:

1. Distribute one of the “Assessing Risk” scenarios (below) to each student (depending on the time available, students may work on both scenarios). Ask the students to read the scenario, and answer the questions that follow it. Then, they should write an ending for the scenario in which the main character negotiates less risky behaviour.
2. Collect all the student papers. Record whether or not the each student has accurately identified potential risks. Guidelines for assessing the student responses are provided after the scenarios.

Comments: This assessment tool can be adapted for use with younger children by writing simpler scenarios. Different scenarios can be generated to address local issues. If students are unable to write responses, a scenario can be read aloud to individuals, and they can be asked for their responses in an interview, or through a role-play.

Sources: Scenarios are adapted from ideas in Think About It! Form 2 Students Book, 1994, Ministry of Education and Culture, Zimbabwe (p. 27), and Life Skills and HIV/AIDS Education: A manual and resource guide for secondary school teachers, Planned Parenthood Association of South Africa (p.127).

## Sample Rubric for Assessing Ability to Identify and Negotiate Risks

Met: Students identify a comprehensive list of risks (Question 1), and both verbal alternatives and physical actions which reduce potential risk (Question 2)

Not yet met: Students provide a limited list of risks, and limited alternatives

Not met: Students are unable to identify potential risks, and are unable to negotiate for less risky alternatives

**Assessment question:** 1. How proficient are students at identifying risks?  
2. How proficient are students at negotiating risks?

### Criteria

### Level of Proficiency

Not met (wrong)

Not yet met (superficial)

Met (indepth)

	Not met (wrong)	Not yet met (superficial)	Met (indepth)
<b>1. Identifying risks</b> 1.3 Knowledge of risks  1.4 Ability to show perspective of Lena (empathy)	<ul style="list-style-type: none"> <li>Incorrect or illogical information provided; little or no evidence of knowledge of risks</li> <li>Not able to view situation from perspective of Lena</li> </ul>	<ul style="list-style-type: none"> <li>Identifies some direct/obvious risks accurately, for Lena, but not a comprehensive list</li> <li>Able to provide some insight into the perspective and situation of Lena</li> </ul>	<ul style="list-style-type: none"> <li>Identifies direct and indirect risks from the perspective of accurate knowledge, from how Lena feels, and including consequences that may eventuate; able to provide a comprehensive list of risks for Lena that are accurate and feasible</li> <li>Provides direct insight into the perspective of Lena directly and indirectly</li> </ul>
<b>2. Negotiating risks</b> 2.1 Knowing what to say (complete the scenario)  2.2 Knowing what to do (complete the scenario)  2.3 Being able to show how	<ul style="list-style-type: none"> <li>Little or no evidence of feasible/convincing excuses or reasons Lena could give to avoid or limit risk</li> <li>Little or no evidence of feasible actions Lena could take to avoid to limit risk</li> <li>Body language does not match the purpose of the role play</li> </ul>	<ul style="list-style-type: none"> <li>Able to provide limited reasons/excuses; not all alternatives are equally feasible/convincing</li> <li>Able to describe an alternative action Lena could take; but does not provide a backup plan in case she meets resistance</li> <li>Body language matches somewhat (but perhaps not consistently) with purpose of role play</li> </ul>	(provides both verbal alternatives and physical actions) <ul style="list-style-type: none"> <li>Able to provide ways/reasons for reducing risks - a comprehensive list of things to say</li> <li>Able to describe an alternative action Lena could take; AND also provides a backup plan in case she meets resistance</li> <li>Body language matches with purpose of role play consistently and convincingly reinforcing</li> </ul>

		purpose of role play - eg. use of voice tone, body, and eye contact to reinforce message	the message eg. use of voice tone, body, and eye contact to reinforce message
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**Student Material S-4**

**Assessing Risk Scenarios**

Scenario #1

Lena is 15 years old. She has been invited to a party by a man who is 20 years old. She has only known him for a week, but she really likes him. The day before the party, Lena finds out that she doesn't know anyone else who is going to the party, and this makes her feel uncomfortable. Her friend has told her that there will be alcohol at the party. Lena knows that many of the people there will be over the legal drinking age, but she is not. She has heard from a friend that sometimes people get drunk at these parties and end up having sex. Lena thinks this young man is interested in her, but she does not feel ready for sex with him.

1. What are the potential risks for Lena in this scenario?
2. Write an ending for this scenario. In your ending, have Lena negotiate with the young man for ways to reduce the risks.

Scenario #2

Juan has recently met a girl he likes. They have gone out together several times. Juan is interested in having sex with her. He thinks that she may have had sex before and he does not know if she used any protection such as condoms. One day, she tells him that her family has gone out of town to visit relatives. She invites Juan to come over and spend the day with her, and suggests that they can have sex. She says that she is taking some herbs her grandmother gave her, and those will keep her from getting pregnant. Juan is feeling uneasy about this, and is not sure what to do.

1. What are the potential risks for Juan in this scenario?
2. Write an ending for this scenario. In your ending, have Juan negotiate with this girl for a way to reduce the risks.

## Teacher Material S-4

### Guidelines for assessing the effectiveness of the student responses

#### Scenario #1

1. What are the risks for Lena in this scenario?

*Possible responses:*

- *going to a party with someone she doesn't know well,*
- *going to a party where all the people are older than she is,*
- *going to a party where alcohol is being served,*
- *socialising with people who get drunk and have casual sex.*

2. Write an ending for this scenario. In your ending, have Lena negotiate with her boyfriend for a way to reduce the risks.

*Possible responses:*

- *Lena tells her boyfriend she has decided not to go to the party;*
- *Lena goes to the party, but tells her boyfriend beforehand that she would like to bring a friend with her;*
- *Lena tells her boyfriend that she would like to go to the party, but that she does not want to drink;*
- *Lena tells her boyfriend that she would like to go to the party, but wants to leave early if there is a lot of drinking;*
- *Lena tells her boyfriend that she likes him and wants to get to know him better, but that she is not ready to have sex yet;*
- *Lena suggests to her boyfriend that they find something else to do together that night, like go to a movie;*
- *Lena decides to stop seeing her boyfriend if he pressures her to do things she does not feel ready for.*

#### Scenario #2:

1. What are the risks for Juan in this scenario?

*Possible responses:*

- *Having sex with the girl without knowing her sexual history;*
- *Having sex without a reliable method of birth control could result in the girl getting pregnant;*
- *He could get HIV or another STI if he has unprotected sex.*

2. Write an ending for this scenario. In your ending, have Juan negotiate with his girlfriend for a way to reduce the risks.

*Possible responses:*

- *Juan refuses to spend the day at her house, but suggests they go out somewhere together instead;*
- *Juan suggests that they delay having sex until they get to know each other better;*
- *Juan tells her that he thinks they should talk to each other about their sexual histories;*
- *Juan agrees to spend the day with her, but insists they need to use condoms, and buys the condoms;*
- *Juan suggests that they spend the day together, but that they agree not to have sex; they can do other things such as touching, kissing, or giving each other backrubs.*

## **S-5. Mapping**

Age level: Adolescents

Purpose: to assess the degree to which students are able to “seek out and identify sources from which condoms can be obtained” and “seek out and identify sources of help with substance use problems, including sources of clean needles or needle exchange” (WHO, 1999, p. 21).

Before using this assessment tool: Students should have received lessons on how HIV transmission is prevented, and behaviours that reduce the risk of contracting HIV. They should also have discussed how to obtain condoms, clean needles, etc. in their community, or carried field trips or visits to places that provide health services.

Type of assessment tool: This is a mapping tool, in which students draw a map of their community and plot on the map sources of condoms, or sources of help with substance use problems. The teacher assesses the degree to which the maps indicate skill in identifying these sources.

Assessment criteria: Each student’s map will identify at actual places where condoms can be obtained, and actual places where students may obtain help with substance use problems. (The numbers of places may be adjusted according to more accurately reflect the availability of resources in the community.)

Description:

1. Distribute a large sheet of paper and drawing materials to each student. Ask them to draw a map of their community, labeling major landmarks and significant buildings: shops, community centers, schools, places of worship, health centers or clinics, recreational areas, etc.
2. Ask students to label on their maps all the places they can think of where they would be able to obtain condoms.
3. Then, ask students to label on their maps all the places they can think of where they would be able to obtain help if they, or someone they know, had a substance use problem (smoking, alcohol, inhalants, marijuana, injecting drugs).
4. Collect the maps and record the number of places students have labeled as sources for condoms, or sources for help with substance use problems. Possible student responses are suggested below.

Comments: Maps can be created in small groups, instead of individually. This will give the teacher information about the group’s skill level, as opposed to that of individuals.

If drawing materials are in short supply, maps can be drawn on slates. They can also be created as models, using scrap materials to represent different buildings in the community.



Mapping is a tool that can also be used with other skill objectives, such as students' abilities to assess risk. The group can be asked to draw a map that indicates where high risk areas are in their community, in terms of likelihood of harassment, bullying, crime, unsafe sexual behaviour, use of alcohol, or prevalence of drug use.

Sources: Based on an activity described in Happy, Healthy and Safe, 1998, Family Health Trust Zambia – Anti-AIDS Project (page 250).

## Teacher Material S-5

### Possible student responses to “Mapping”

Possible sources of condoms (actual responses will vary depending on the community):

- Shops (students should specify which ones)
- Health center or clinic
- Youth centre
- Community centre
- Vending machines in bars, recreational areas
- Some NGO’s
- Friends

Possible sources of help with substance use problems (actual responses will vary depending on the community):

- Health center or clinic
- Some NGO’s
- Some places of worship
- Counselling center
- Youth center
- School
- Family
- Friends

## **S-6. Saying No**

Age level: Adolescents.

Purpose: To assess students' abilities to "refuse to have sexual intercourse" (WHO, 1999, p. 21).

Before using this assessment tool: This tool can be used after students have acquired knowledge of risky behaviours for HIV transmission. They should also have been introduced to concepts such as assertiveness and refusal skills. Depending on the skills-based health education curriculum being used, those concepts might include:

- Distinguishing between passive, assertive and aggressive responses;
- Steps to creating assertive messages (explaining your feelings and the problem, making your request, and asking how the other person feels about your request);
- Constructing "I-messages": "When..." (specific description of the action), "I feel..." (your response) "because..." (the reason for your response), "And what I'd like is..." (suggestion for the change you would like).
- Using non-confrontational strategies such as refusal, delay, and bargaining to respond to pressure to engage in risky behaviours.

In addition to being introduced to these concepts, students should have had multiple opportunities to practice those skills before being assessed on their skill development.

Type of assessment tool: This is a peer-assessment tool based on role-play scenarios. Students role-play various situations in which they may be pressured to have sex or engage in high-risk behaviours. They are asked to role-play assertive responses that will enable them to avoid risk. Peers then assess whether the response would be effective, somewhat effective, or not effective. Peer assessment, rather than teacher assessment, is appropriate for use with this tool, because students themselves are more likely than adults to be able to accurately determine what refusal behaviours are most likely to work in situations of peer pressure.

Assessment criteria: In a role play situation, students will demonstrate refusal skills that are effective in enabling them to resist pressure to engage in risky behaviour.

Description:

1. Divide students into pairs or small groups. Give each pair or small group one of the role-play scenarios listed below. Ask them to work together to develop a role play in which one person pressures the other to engage in a risky behaviour, and the other refuses assertively or negotiates an alternative.
2. Students perform the role plays in front of the class. During each role play, students in the audience rate how effective they think the assertive response demonstrated would be, using an assessment checklist (below).

3. Collect the assessment checklists and record the results. Students can work together (with the teacher) to develop an assessment rubric, and use it to act as student/assessors - Students could work in pairs or small groups to also give verbal feedback and coaching to fellow students.

**Comments:** To more rigorously assess individual skills, students can be asked to prepare their role-play responses without consultation with a partner. Another alternative would be to present students with a scenario without advance preparation. They must then develop a response “on the spot”. This may give a more realistic view of the degree to which students will be able to use those skills in an actual situation of pressure, when they have no time to prepare. However, this alternative may involve stress for the students, which the teacher may decide is not appropriate.

It is not necessary for girls to only play the part of girls, and boys to only play the part of boys, in the role-plays.

**Source:** Adapted from an activity in *My Future is My Choice*, March 1999, Youth Health and Development Programme, Government of the Republic of Namibia and UNICEF.

**Sample Rubric for Assessing Resistance Skills**

Met: Students identify a comprehensive list of risks (Question 1), and both verbal alternatives and physical actions which reduce potential risk (Question 2)

Not yet met: Students provide a limited list of risks, and limited alternatives

Not met: Students are unable to identify potential risks, and are unable to negotiate for less risky alternatives

**Assessment question:** How proficient are students at demonstrating resistance skills?

Criteria	Level of Proficiency		
	Beginning	Novice	Expert
<b>1. Knowledge of what to say</b> 1.1 Knowledge of arguments/excuses or actions to resist	<ul style="list-style-type: none"> <li>• Incorrect or illogical information provided; little or no evidence of arguments/excuses or actions provided</li> </ul>	<ul style="list-style-type: none"> <li>• What is said provides evidence of some knowledge of arguments/excuses, OR actions, but not a comprehensive list</li> </ul>	<ul style="list-style-type: none"> <li>• What is said demonstrates broad knowledge of arguments, excuses, AND actions that can be taken to refuse to have sex</li> </ul>
<b>2. Able to refuse</b>	<ul style="list-style-type: none"> <li>• Little or no evidence of feasible/convincing arguments nor actions to resist having sex</li> </ul>	<ul style="list-style-type: none"> <li>• Able to provide limited arguments/excuses, or actions; not able to maintain confidence; not all alternatives are equally feasible/convincing</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrates confidently (easily) arguments, excuses, and actions to resist having sex</li> </ul>
<b>3. Confidence in resisting if</b>	<ul style="list-style-type: none"> <li>• is not able to continue to resist ongoing pressure</li> </ul>	<ul style="list-style-type: none"> <li>• is not able to <i>consistently</i> resist</li> </ul>	<ul style="list-style-type: none"> <li>• Able to continue to resist with confidence, when</li> </ul>

pressure continues		ongoing pressure with <i>confidence</i>	pressure from peer persists
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Overall level of Proficiency:

Areas for improvement:

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Student material S-6

**“Saying No”: possible role-play scenarios**

A boy tries to convince a girl to have sexual intercourse, accusing her of being afraid.

A girl thinks that because a boy wants to use a condom, he thinks she has a disease.

A boy is sexually excited and therefore expects the girl to have sexual intercourse. He doesn't want to consider anything less.

A girl/boy argues that because everyone else is using drugs at a party, you should too.

A girl argues that her boyfriend should have sex with her, to prove that he really loves her and plans to marry her.

A girl/boy argues that if you do not want to drink alcohol, you are a boring person.

A boy/girl suggests that this is your only chance to have sex with him/her, so you should take the chance, even though neither of you have condoms.

A boy tries to convince a girl that he can't use a condom because he feels no pleasure.

## **VI. Assessing Behaviour Objectives**

### **A. Behaviour objectives**

Influencing behaviour is a complex process, and is therefore a medium- to long-term objective of skills-based health education, including life skills for HIV prevention. While behavioural objectives vary in different programmes, the following are objectives that are widely used (UNICEF/WHO, 2001):

#### Medium term:

- Decrease in intravenous drug use
- Reduced number of sexual partners
- More use of health services
- Increased frequency of condom use
- Fewer intravenous drug users sharing needles
- More intravenous drug users cleaning needles
- Increasing age of onset of sexual activity

#### Long term:

- Fewer HIV infections
- Fewer STDs
- Fewer alcohol- and drug-related accidents
- Increasing age of first pregnancy
- Increasing age of first marriage
- Persons affected by HIV/AIDS are healthier, living longer
- More children affected by HIV/AIDS staying in school
- Improved mental health (self-esteem, self-confidence, etc.)

### **B. Assessing behaviour objectives: Issues to consider**

Changes in knowledge, attitudes and skills as a result of skills-based health education can be assessed by the classroom teacher in the short-term, as described in previous chapters. And changes in knowledge, attitudes and skills are assumed to contribute to the behaviour change or development that is the ultimate goal of skills-based health education. But the extent to which behaviour itself has been influenced can generally only be assessed in the medium- to long-term. The development and maintenance of new behaviours takes time, and behavioural outcomes in life skills education for HIV prevention generally will not take place where they can be witnessed and measured by the classroom teacher.

Measures of the extent to which behaviour has been influenced therefore are generally not a major component of classroom-based assessment. Behaviour change or development measures are more likely to be used in programme evaluation, as an indicator of the success of a skills-

based health education programme. However, approaches to assessing the degree to which behaviour has been influenced are discussed below to provide a picture of the larger goals of evaluating life skills education.

A few cautions about interpreting results of behaviour change or development assessments are worth mentioning. Many tools for assessing the extent to which behaviour has been influenced ask young people to self-report about their own behaviour. However, it should be borne in mind that self-reporting is not always reliable; if the behaviour being assessed is perceived by students as being socially desirable, they are likely to report that they do it, whether or not they actually do (Hawe et. al., 1990, p.110).

Additionally, the fact that assessment tools indicate that behaviour has been influenced does not prove that it is the skills-based health education programme that has brought about the change. Education is but one factor that contributes to change. Social policies, the media, practices of health care systems, peer pressure, and parents are a few of the other contributors.

This section has described some general guidelines for assessing behaviour objectives; the next section gives actual examples of assessment tools that can be adapted for use with the objectives of a specific programme.

## **C. SAMPLE ACTIVITIES FOR ASSESSING BEHAVIOUR OBJECTIVES**

### **B-1. My Intentions**

Age level: Adolescents

Purpose: to assess students' intentions to act in ways that will prevent the spread of HIV.

Before using this assessment tool: The use of this tool presumes that students have been through a skills-based health education programme with a focus on HIV prevention; that they will have acquired knowledge about how HIV is transmitted, skills in refusing to take part in risky behaviours, and attitudes of responsibility for their personal health.

Type of assessment tool: This tool is an "intent to behave" statement, in which students are asked to self-report their intentions to engage/not engage in certain types of behaviours.

Assessment criteria: Students will indicate an intention to not engage in behaviours that place them at risk of contracting HIV, as indicated by a score of at least 4 on the "intent to behave" questionnaire.

Description:

1. Make copies of the "My Intentions" sheet (below) for each student.
2. Distribute the sheets and ask each student to complete them according to the directions.

3. If you wish to score the “My Intentions” assessment, use the following key to assign points to each response:

- Question 1: A=2, B=1, C=0
- Question 2: A=2, B=1, C=1, D=0
- Question 3: A=0, B=1, C=2
- Question 4: A=2, B=1, C=0

Higher scores reflect safer behavioural intentions.

Comments: “Intent to behave” statements can be adapted for younger age levels by modifying the content to reflect choices that younger students would be likely to make.

It can be useful to give students an “intent to behave” questionnaire at both the beginning and the end of a skills-based health education programme, to assess whether or not there have been changes in the likelihood of certain behaviours occurring. “Intent to behave” questionnaires can also be used to promote reflect, and to encourage students to enter into “contracts” regarding future behaviours.

Sources: Taken from School Health Education to Prevent AIDS and STD: Handbook for Curriculum Planners, WHO/UNESCO, p. 66.



## Student Material B-1

### My Intentions

Instructions: Read each statement and circle the one that is most true for you.

- 1) In the next six months...
  - A. I do not intend to be tested for HIV
  - B. I might get tested for HIV.
  - C. I will probably get tested for HIV.
  
- 2) In the next six months...
  - A. I do not intend to have sex.
  - B. I might have sex.
  - C. I will definitely have sex with one person.
  - D. I will definitely have sex with two or more people.

If you circled B or C in statement 2, please answer the following:

- 3) In the next six months
  - A. I will definitely use condoms with my sexual partners.
  - B. I might use condoms with my sexual partners.
  - C. I will probably not use condoms when having sex.
  
- 4) In the next six months
  - A. I will definitely talk to my sexual partner/s about using condoms.
  - B. I might talk to my sexual partner/s about using condoms.
  - C. I will probably not talk to my sexual partner/s about using condoms.

## **B-2. Behaviour Survey**

Age level: Adolescents

Purpose: to assess the extent to which adolescents are engaging in safe and unsafe sexual practices.

Before using this assessment tool: This is an assessment tool that can effectively be used both before and after a life skills education programme with a focus on HIV prevention. When used after such a programme, it is assumed that the programme will have addressed knowledge, attitudes and skills related to sexual transmission of HIV.

Type of assessment tool: This tool is a self-reporting multiple-choice questionnaire that asks students for information on past sexual behaviours.

Assessment criteria: This type of assessment is *unlikely to be used as a formal individual assessment piece*, but rather, the responses might be aggregated and fed back to the group/class so that they could monitor their own behaviour, and perhaps set group goals to reduce risk behaviour.

Description:

1. Make copies of the “Behaviour Survey” (below) for each student in the class.
2. Distribute copies of the survey and ask students to complete it according to the directions. Stress that they should not write their name on the survey, and that the results will be kept confidential.
3. Collect the surveys and tabulate the results. Compare the group’s results both before and after completing the life skills education programme.

Comments: Surveys can be used with younger children by modifying the content to deal with topics that are appropriate for their age group. Many examples of such surveys are available covering a wide range of issues which can be adapted to local situations.

Sources: Adapted from the 2001 Youth Risk Behavior Survey, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, <http://www.cdc.gov/nccdphp/dash/yrbs/2001survey.htm>

## Student Material B-2

### Behaviour Survey

This survey is about health behaviour. The information you give will be used to develop better health education for young people like yourself.

Do not write your name on this survey. The answers you give will be kept private. Answer the questions based on what you really do.

Completing the survey is voluntary. Circle the letter of the response that best describes your answer to the question. If you are not comfortable answering a question, just leave it blank.

1. Have you ever had sexual intercourse?
  - A. Yes
  - B. No
  
2. How old were you when you had sexual intercourse for the first time?
  - A. I have never had sexual intercourse.
  - B. 11 years old or younger
  - C. 12 years old
  - D. 13 years old
  - E. 14 years old
  - F. 15 years old
  - G. 16 years old
  - H. 17 years old or older
  
3. During your life, with how many people have you had sexual intercourse?
  - A. I have never had sexual intercourse.
  - B. 1 person
  - C. 2 people
  - D. 3 people
  - E. 4 people
  - F. 5 people
  - G. 6 or more people
  
4. During the past 3 months, with how many people did you have sexual intercourse?
  - A. I have never had sexual intercourse.
  - B. I have had sexual intercourse, but not during the past 3 months.
  - C. 1 person
  - D. 2 people
  - E. 3 people
  - F. 4 people
  - G. 5 people
  - H. 6 or more people
  
5. Did you drink alcohol or use drugs before you had sexual intercourse the last time?
  - A. I have never had sexual intercourse.
  - B. Yes
  - C. No
  
6. The last time you had sexual intercourse, did you or your partner use a condom?
  - A. I have never had sexual intercourse.
  - B. Yes
  - C. No

7. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response.)
- A. I have never had sexual intercourse.
  - B. No method was used to prevent pregnancy
  - C. Birth control pills
  - D. Condoms
  - E. Depo-Provera (injectable birth control)
  - F. Withdrawal
  - G. Some other method
  - H. Not sure
8. How many times have you been pregnant or gotten someone pregnant?
- A. 0 times
  - B. 1 time
  - C. 2 or more times
  - D. Not sure

### **B-3. Community Service Project**

Age level: Adolescents

Purpose: To assess the extent to which students are able to put selected behaviours relating to HIV/AIDS awareness into practice in their communities.

Before using this assessment tool: Students should have completed a skills-based health education programme with a focus on HIV prevention. This method of assessment is not appropriate for use in a “pre-test” context.

Type of assessment tool: This tool involves observation by a third party of student behaviour while involved in a community service project in their community.

Assessment criteria: Assessment criteria will vary depending on the nature of the project. For the project described below, which involves volunteer work in an HIV clinic, criteria might be that students will demonstrate caring and supportive behaviour toward persons infected with HIV, and will demonstrate behaviours that protect themselves from contracting HIV.

Description:

1. Discuss with students the types of community service projects related to HIV/AIDS that they might carry out in their community. These could include such projects as:
  - Volunteering in an HIV clinic
  - Caring for persons with AIDS in their homes (for example, by cooking, cleaning, or shopping)
  - Doing peer counseling on HIV/AIDS
  - Doing community theatre productions on HIV prevention
  - Running an information campaign in the community
  - Teaching lessons on HIV to younger students
2. With students, choose one project and make the necessary contacts in the community to actually carry out the project.
3. Identify a person in the community who can act as a liaison or resource person for the project, and who would be willing to assess student behaviours, either at the end of the project, or at both the beginning and end.
4. Create a “Student Observation Sheet” that will allow the liaison person to assess the targeted student behaviours. Give the sheets to the liaison person to complete, one per student. If possible, these should be done in the early stages of the project, and again at the end of the project, to allow for assessment of behavioural changes. Minimally, they should be completed at the end of the project. A sample “Student Observation Sheet” for a project in which students work in an HIV clinic is included below (actual questions would depend on what types of tasks students carry out).

Comments: Types of community service projects can be varied according to the needs, interests and age levels of the students.

The “Student Observation Sheets” given to those who assess the students must be modified according to the project.

**Student Material B-3**

**Student Observation Sheet**

**Student's name:**

**Does this student demonstrate caring for persons living with HIV/AIDS?**

Never            Rarely            Sometimes            Often            Always

How? Please explain.

**Does this student work with persons with HIV/AIDS in ways that protect her/his own health?**

Never            Rarely            Sometimes            Often            Always

How? Please explain.

**Does this student take initiative to provide information on HIV to users of the clinic?**

Never            Rarely            Sometimes            Often            Always

How? Please explain.

**Does this student discuss HIV positive patients with respect when talking to other clinic staff?**

Never            Rarely            Sometimes            Often            Always

How? Please explain.

**Does this student demonstrate support for the families of persons living with HIV/AIDS?**

Never            Rarely            Sometimes            Often            Always

How? Please explain.

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