

IM TOOLKIT

FOR PLANNING SEXUALITY EDUCATION PROGRAMS

**USING INTERVENTION MAPPING IN PLANNING SCHOOL-
BASED SEXUAL AND REPRODUCTIVE HEALTH AND
RIGHTS (SRHR) EDUCATION PROGRAMS**

**WORLD POPULATION FOUNDATION
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This toolkit is based on 'Planning Health Promotion Programs; An Intervention Mapping Approach' (Bartholomew, Parcel, Kok & Gottlieb, 2006)

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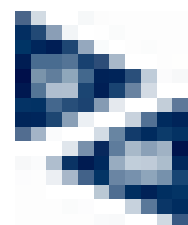
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PREFACE

The idea to develop this practical toolkit to plan school-based sexuality education programmes already came up in 2002. The toolkit is an addition to the handbook *Intervention Mapping* (Bartholomew, et al., 2006). It took a number of years to develop the toolkit with practical information and lessons learned from various projects. We hope that it can actually be a kit with tools, experiences and background information that have proven to be useful in developing programmes that aim to improve young people's life, particularly their sexual and reproductive health, all over the world.

The toolkit is developed by World Population Foundation in close collaboration with Maastricht University. However, this was not possible without the input and experiences of many Dutch, African and Asian planners, researchers and implementers working with young people.

First, we want to thank the useful feedback from Kay Bartholomew and Gerjo Kok. We also like to thank the researchers of the Universities of Dar es Salaam, Cape Town and University of the North in the SATZ project and particularly those who were involved in *Intervention Mapping* in Tanzania and South Africa; Petrus Steijn from Stellenbosch University (South Africa) who co-developed *Today's Choices*; all who were involved in the development and adaptation of the *World Starts With Me* for Uganda, Kenya, Indonesia, Thailand and Vietnam where WPF implements this programme; all involved in developing RHIYA's Behaviour Change Communication Strategy in Vietnam; the organisations that are part of the MAIN-PHASE network in India, including CYSD, Pratham, Lokmitra and URMUL Trust. Valuable contributions were provided by Stop AIDS Now! and all others involved in the development and adaptation of the Planning and Support Tool, a supplement to this manual.

The World Population Foundation (WPF) uses this toolkit in its trainings in various networks and projects in both the Netherlands and developing countries. The primary aim is to build capacity and make useful, but sometimes difficult, information about effectiveness, research and theory more practical and applicable in the day-to-day setting of planners and implementers.

WPF supports any effort in applying and spreading this manual and appreciates any comment and feedback for improvement.

ABBREVIATIONS

AB	Advisory Board
BCC	Behaviour Change Communication
CBO	Community Based Organisation
FGD	Focus Group Discussion
FPA	Family Planning Association
GO	Governmental Organisation
HPB	Health Promoting Behaviour
ICPD	International Conference on Population and Development
IDI	In Depth Interview
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IM	Intervention Mapping
NGO	Non-Governmental Organisation
PCM	Project Cycle Management
PLWHA	People Living With HIV/AIDS
PO	Performance Objective
RTI	Reproductive Tract Infection
SATZ	South Africa - TanZania
SRH	Sexual and Reproductive Health
SRH&R	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UN	United Nations
WG	Working Group
WHO	World Health Organisation
WPF	World Population Foundation
YFC	Youth Friendly Centre

1. INTRODUCTION

Today, young people are the largest proportion of the world's population in history. Nearly half of the world's population is under the age of 25. About 20% of them, a staggering 1.2 billion, are adolescents aged 10-19. Of these adolescents, 87% live in developing countries with approximately 60% in Asia alone.¹ It is expected that by 2020, the proportion of adolescents living in developing countries has grown to about 89%. In 2006, in 57 developing countries, over 40 per cent of the population was under 15 years old.²

These figures and the fact that young people are the future generation, make it even more important to target them today. Especially young people in developing countries deserve attention. Since young people constitute the largest population segments worldwide and since they are deeply affected by underdevelopment, poverty and economic marginalisation, this manual focuses particularly on improving sexual and reproductive health of young people in developing countries.

Evidence shows that interventions that aim at the improvement of young people's sexual and reproductive health, are effective only under particular conditions and can be developed using a number of steps. This manual is about the systematic planning (development, implementation and evaluation) of interventions for young people, aiming at the promotion of their well being, their sexual and reproductive health and rights (SRHR) and the context they live in. It provides a tool for effective promotion of the positive aspects of their sexual development, and to prevent the obstacles they may face.

In the manual we use the Intervention Mapping (IM) model; a stepwise way of developing and implementing health promotion programmes. IM can be used to design interventions targeting various health problems, such as smoking, vascular diseases, cancer, or mental health problems. In this manual we use the experiences of WPF and partner organisations in using IM to plan sexuality education aiming at the promotion of young people's sexual and reproductive health and rights, including prevention of HIV/AIDS, Sexually Transmitted Infections, early pregnancy and sexual harassment. The manual is a practical guide based on the more theoretical book '*Planning Health Promotion Programs; An Intervention Mapping Approach*'.³

1.1 Who can use this manual?

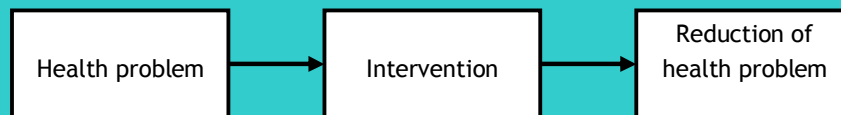
We have designed this manual primarily for project officers and project staff of governmental organisations (GO's) and non-governmental organisations (NGOs), working in developing countries on the topic of young people's sexual and reproductive health and rights (SRHR).

Other users of this manual can be researchers of universities and research institutes, as well as research-consultants who are collaborating with NGOs/ GO's in curriculum development. Ideally, governmental organisations, NGOs and research institutes collaborate on project planning, each contributing with their own expertise.

Governmental organisations, generally responsible for the implementation of school curricula, often have a lot of experience, power and influence with regard to policies and national co-ordination. NGOs can contribute with their practical experience in the field, as well as their specific knowledge and skills concerning the target group, training and implementation. Researchers can contribute

with their specific expertise in underpinning specific aspects of program development and evaluation with research, evidence and scientific theories.

A third group of users consists of participants who attend courses or workshops on (sexual) health promotion. In Chapter 4, we have included a list of characteristics of people who can be involved in intervention planning.



Intervention Mapping is not a new model or theory. It is a comprehensive planning tool, derived from academic knowledge. It maps a step-wise path: from recognition of a need or problem to the identification and application of a solution.⁴ In the context of this manual: from recognition that many young people face sexual health problems, to a situation in which young people receive sexuality education, in order to improve their health (see the figure above).

To promote the well being and sexual health of young people, evidence and theories emphasise that (young) people need to be able to voluntarily take their own decisions. When supporting young people in own decision-making, they should not only be provided with sufficient, up to date information, but they also need adequate skills training, awareness and development of own attitudes, beliefs and perceptions related to their development, sexuality and health risks. In addition to the promotion of healthy behaviour of young people, they need to be supported by their environment (i.e., access to information, health services and facilities; support from parents and community members). This implies that in addition to education for young people, interventions might be required to support or change their environment.

The tools that are provided in this manual can assist in the systematic design of interventions that take the needs and rights of young people into account. It emphasises the use of evidence and theory in intervention development, and its practical approach can assist in the translation of ‘academic knowledge’ into practice.

Involving young people themselves, their educators (i.e., teachers and peer educators) and decision-makers in the educational system during the planning of interventions, contributes to an intervention that is convincing for young people, user-friendly for educators and acceptable to gain commitment of policy-makers and communities.

Experiences with using Intervention Mapping

‘I found Intervention Mapping a very useful tool to develop our intervention for young people in the slums. It was sometimes a lengthy process and it took us more time than we usually spend on intervention planning. But in the long run it was worth spending more time beforehand and developing a programme of which we can expect that it creates change. The most useful aspect of it is that for every decision we took, we had to think ‘why’. Beforehand we did not spend too much time on thinking. We know better now why we are doing what we do. It helps us to explain other stakeholders what we are doing.

Participant of the MAIN PHASE network in India

Many organisations work with models to organise the planning, management and funding of their projects, programmes, and interventions. Intervention Mapping is a model that particularly focuses on the content and intervention development itself, and does not include financial or management planning.

1.2 Manual development

This manual is developed based on various experiences in using Intervention Mapping in projects in Asia and Africa. Intervention Mapping is an academic model, although it is used in various non-academic settings as well. We want to make academic knowledge that is needed for the development and implementation of interventions, accessible and applicable for workers in the field. And we also want to make information available from various projects, so that new initiatives do not have to reinvent the wheel, but can learn from other experiences and make use of work that has already been done in other projects.

The obstacles and lessons learned in applying Intervention Mapping in these projects, generally in a non-academic setting, are included in this manual. Table 1.1 provides an overview of the projects.

The SATZ project (SATZ stands for South Africa, TanZania)^{5;6} combined the input of researchers and fieldworkers in the design of comprehensive sexuality education programs in Africa. South African and Tanzanian project teams were trained and supported in the systematic planning of cultural-specific programs in schools. They were systematically guided through the IM phases during workshops, coaching, and field visits. Lessons learned are incorporated in this manual.⁷ The SATZ project was primarily an academic project, with a high-quality evaluation of the implementation and outcome of the programme on young people's behaviour. The project has resulted in three programmes, one in Dar es Salaam (Tanzania) and two in South Africa (Limpopo and Western Cape), consisting of a student and teacher manual, and a teacher training package.

The second project, the World Starts With Me, aimed at the development of a computer-based sexuality education programme for young people in Uganda (in 2003).⁸ The programme is implemented by teachers in schools and to a certain extent self-implemented by the users of the programme. After a successful pilot in Uganda, the programme is adapted to settings in Kenya, Thailand and Indonesia. Today's Choices is a programme that is to a certain extent similar to the World Starts With Me. This programme is taken up by the Department of Education in Western Cape in South Africa and used by many schools and teachers.

Another project was the development of a Behaviour Change Communication (BCC) Strategy in Vietnam (component of the RHIYA project), to assist various organisations in Vietnam in deciding what to communicate with regard to SRHR among young people. Based on a needs assessment/situation analysis, objectives and messages are stated for various segments of youth in Vietnam, to guide intervention development.

The Planning and Support Tool was initiated by Stop AIDS Now! in the Netherlands and developed in collaboration with WPF and South African organisations. It includes a number of characteristics of effective school-based sexuality education programmes, underpinned with evidence and theory. The tool is linked to this manual and is structured according the Intervention Mapping steps.

Finally, in a currently ongoing project in India, MAIN PHASE, four Indian organisations mainstream sexuality education/ HIV/AIDS prevention in their educational programmes. The Intervention

Mapping model is used to plan the design and implementation of programmes for youth and their environment.

Table 1.1 Use of Intervention Mapping in WPF projects

PROJECT	COUNTRY	WHEN	TARGET GROUP	INTERVENTION
1. SATZ	Tanzania (Dar es Salaam), South Africa (Western Cape), South Africa (Limpopo)	2002-2006	School-going youth	3 school-based comprehensive sexuality education/ life skills programmes, facilitated by teachers
2. The World Starts With Me	Uganda, Kenya, Indonesia, Thailand	2003-2007	Young people in school (and out of school)	Comprehensive computer-based programme for school-going youth, facilitated by teachers. 14 lessons.
3. Today's Choices	South Africa	2003-2005	School-going youth	Comprehensive computer-based programme for school-going youth, facilitated by teachers
4. Behaviour Change Strategy	Vietnam	2004	NGOs and GOs in Vietnam	Strategy based on evidence outlining objectives and messages for youth with different backgrounds
5. Planning & Support tool	South Africa Netherlands	2006-2007	NGOs in the Netherlands and in South Africa	Checklist with background information based on evidence about effectiveness of sexuality education programmes for school-going youth
6. MAIN PHASE	4 organisations in India (Orissa, Rajasthan, Gujarat, Uttar Pradesh)	2006-2009	School-going youth	Education programmes for young people, community

1.3 Starting points

Some basic principles of this manual are addressed in this section. These are the starting points when planners use the manual in developing and implementing comprehensive and rights-based sexuality education for school-going youth. Some principles are related to the content and approach of interventions for young people, while others are related to technical aspects of intervention development.

1.3.1 Systematic approach

Systematic intervention planning contributes to the effectiveness of an intervention,⁹ by providing intervention planners insight in the steps and decisions to take during the preparation, design, implementation and evaluation of the intervention.

Intervention Mapping is a tool that assists planners to accomplish these tasks and consists of a number of steps: 1) involvement of relevant stakeholders, 2) needs assessment/situation analysis, 3)

specification of programme objectives, 4) programme design, including the use of theory and pre-testing, 5) planning for adoption and implementation, and 6) planning monitoring & evaluation. The Intervention Mapping model is explained in Chapter 2. These steps are not new and are used in other models as well. One of the unique aspects of Intervention Mapping is that it emphasises the use of evidence and theory in intervention planning.

1.3.2 Use of theory and evidence

IM emphasises that intervention planners ideally should base all their decisions during programme planning on empirical and theoretical evidence about the problem, its causes, and the options to change this.

Interventions that are based on *theory* take into account what is already known about behaviour change and the factors that influence behaviour, or about changing the environment. A theory-based intervention is developed by using theories that a) explain environment, behaviour and determinants, b) change environment, behaviour and determinants, and/or c) guide intervention development and implementation.

There is much support for the proposition that interventions that are guided by these theories are more likely to be effective than interventions that are not.¹⁰ Several reviews of sexuality education and AIDS prevention programs conclude that (psycho)social theories, particularly cognitive behavioural theories, can add understanding about explanation and change of sexual behaviour and its behavioural determinants.^{11;12;13}

Some of the theories that have proven to be useful in the development of comprehensive sexuality education programs for young people, are described in Chapter 7 (Evidence-Based Intervention Design).

By *evidence* we mean information from research studies (in scientific literature), but also opinions and experiences of community members, the target population and planners. Evidence-based interventions are based on information from and about the target group and implementers of an intervention, as well as about the implementation setting.

This information can be obtained prior to programme development in an analysis of existing literature (i.e., reports, articles) and research among the target group and the various stakeholders of the intervention (i.e., through focus group discussions with young people, teachers, and parents). Which information can be collected and how to do this, is described in Chapter 5 (needs assessment/ situation analysis).

Douglas Kirby and his colleagues have reviewed publications about the effectiveness of school based sexuality education programmes worldwide.¹⁴ A number of publications in developing countries were also included in the review.¹⁵ They concluded that programmes that have shown effectiveness, share a number of characteristics. These are displayed in Table 1.2.

Not all evidence is equal and the quality of evidence can vary. Meta-analyses and narrative reviews (for example, Kirby's review of HIV prevention interventions^{16;17}) can be seen as very strong evidence. And usually, the larger and more representative the study population, the better the evidence. Evidence is often relevant to a particular problem or setting (times, settings, contexts, and populations). For example, research studies conducted in South Africa may not be applicable in settings in East Africa.

We suggest planners to be flexible in using evidence, but indicate on what kind of evidence particularly the important decisions are based. In case of contradicting evidence, planners should do more research to explore the actual situation in a particular context. The Internet provides a lot of resources and evidence to plan sexuality education programmes.^{18;19}

Table 1.2 Effectiveness of sexuality education programmes

The Process of Developing the Curriculum	The Contents of the Curriculum Itself	The Implementation of the Curriculum
<ol style="list-style-type: none"> 1. Involved multiple people with different backgrounds in theory, research and sex/HIV education to develop the curriculum 2. Assessed relevant needs and assets of target group 3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviours affecting those health goals, the risk and protective factors affecting those behaviours, and the activities addressing those risk and protective factors 4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, and supplies) 5. Pilot-tested the program 	<p><i>Curriculum Goals and Objectives</i></p> <ol style="list-style-type: none"> 1. Focused on clear health goals - the prevention of STD/HIV and/or pregnancy 2. Focused narrowly on specific behaviours leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviours, and addressed situations that might lead to them and how to avoid them 3. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviours (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy) <p><i>Activities and Teaching Methodologies</i></p> <ol style="list-style-type: none"> 4. Created a safe social environment for youth to participate 5. Included multiple activities to change each of the targeted risk and protective factors 6. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors 7. Employed activities, instructional methods and behavioural messages that were appropriate to the youths' culture, developmental age, and sexual experience 8. Covered topics in a logical sequence 	<ol style="list-style-type: none"> 1. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations 2. Selected educators with desired characteristics (whenever possible), trained them and provided monitoring, supervision and support 3. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement, e.g., publicized the program, offered food, or obtained consent 4. Implemented virtually all activities with reasonable fidelity

1.3.3 Collaborative planning

Participatory, or collaborative planning is a key aspect in the design and implementation of health promoting interventions, including sexuality education. Involvement of stakeholders on different levels adds to a sense of ownership among the implementers of an intervention, to the feasibility of a programme for implementation, to acceptance of a programme by decision makers and other relevant actors, and it increases correspondence with the actual needs and expectations of the target group.

Intervention planners should at any time avoid the situation of developing an intervention 'behind their desk' without the involvement of the target group and relevant stakeholders. This is addressed in Chapter 4, about the involvement of relevant stakeholders.

Apart from increasing effectiveness of interventions, young people also have the right to be involved in the planning, implementation, and evaluation of interventions that aim at the promotion

of their SRHR. Their involvement increases the chance that programmes reflect the actual needs of young people, and not the needs as perceived by (adult) programme developers and policy makers.

1.3.4 Rights-based approach

The rights-based approach is one of the main starting points of this manual. Since 1987 (CRC), it has been internationally agreed that all people, including young people, have sexual and reproductive rights (and choices), which are laid down in UN conventions,²⁰ each signed by more than 200 countries worldwide. According to these conventions, young people should be seen as sexual beings, in and outside a relationship, and as decision makers and social actors in their own right. They have their own values, norms, experiences and voice and by becoming aware of their rights, they can learn to decide and act according to them. For example, young people have a right to self-determination, education and information, youth friendly services, protection and participation.

The rights of young people, according to UN conventions are:

1. *To be oneself* - free to make decisions, to express oneself, to enjoy sex, to be safe, to choose to marry and plan a family
2. *To know* - about sex, contraception, STIs/HIV, and about rights
3. *To protect oneself and be protected* - unintended pregnancies, STIs/HIV, sexual abuse and discrimination
4. *To have health care* - confidential, of good quality, affordable
5. *To be involved* - in planning programmes with/ for youth, attending meetings etc.

One of the underlying assumptions of a rights-based approach is that if people voluntarily take their own decisions, their intention or behaviour will hold longer than when they are forced to behave or think in a prescribed way.²¹ A rights-based approach emphasises young people's assets, empowers and strengthens them and promotes self-reliance. It recognises that young people are diverse and cannot be approached as one homogeneous group, implying that programmes for young people have to offer choices and not just one message or to prescribe particular messages. Evidence shows that sexuality education programmes that provide young people with information about sexuality do not increase sexual activity among young people.²²

In summary, the rights based approach means that

- young people are approached as people who have rights, one of them being that they have the right to make own decisions related to their sexuality
- young people's sexuality is approached in a positive way: sexuality is a positive force in life
- young people all over the world want information about sexuality and growing up as a young person
- young people's health needs and risks related to sexuality have to be addressed

Actors in the environment of young people (such as parents, policy and programme makers, and teachers) have to support the rights young people are entitled to. Governments have to implement the rights of the conventions they have signed.

1.3.5 Comprehensive approach

This manual advocates a comprehensive approach with regard to sexual and reproductive health and rights (SRHR) education programmes for young people. A comprehensive approach intends to integrate the various perspectives in defining who and what young people are, how and what to communicate to them, which role they can play and how their environment can support them.

Various approaches, problems and solutions are integrated into one approach, including a comprehensive view on young people and their sexuality, the integration of HIV/AIDS and SRHR, embedding a problem-based approach in a broader and positive approach towards promotion of quality of life, and the integration of a rights-based approach and the behaviour change approach. As the focus of this manual is to promote SRHR of young people, the prevention of sexual health problems goes beyond an exclusive focus on STIs and HIV/AIDS. It also focuses on teenage pregnancies, unsafe abortions, sexual harassment and abuse, and stigma and discrimination (e.g., with regard to gender, HIV-status and sexual orientation). Comprehensiveness means to link problems that are closely related and of which the solutions can reinforce each other. For example, preventing sexual abuse can result in prevention of HIV/AIDS, STIs and unintended pregnancies.

Comprehensive sexuality education

Education about all matters relating to sexuality and its expression. Comprehensive sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about sexual and reproductive health services. It may also include training in communication and decision-making skills. *(Definition IPPF)*²³

Comprehensiveness also includes the promotion of sexual and reproductive rights of young people, their sexual development, self-esteem and self-reliance. Sexuality education programs are most likely to be effective if education about SRH and sexuality is embedded in a broader perspective of human well being, quality of life, skills, self-awareness and self esteem.²⁴ Programmes are more likely to be effective if an exclusively fear-based or problem-based approach is avoided.

1.3.6 Sustainability

It is evident that the ultimate aim of developing health promoting interventions is to implement these on a wide scale and for a relatively long period of time. This manual therefore promotes to plan ahead for sustainable adoption and implementation of interventions.

This not only includes the commitment and involvement of stakeholders in intervention design and development, right from the start (i.e., the Ministry of Education and community and policy leaders), it also means that the actual implementation of education on SRHR has to be embedded in a policy on sexual health and rights.

In a school setting, such a policy is a tool to structurally include the designed sexuality education into a school work plan. It can also link education in the class with education outside the class and involvement of parents and the wider community in sexuality education. In addition, to effectively implement an interactive curriculum, the school administration has to create a school atmosphere and environment that is in line with the principles of the curriculum, and establish rules that forbid behaviours that are contra productive to learn to make healthy decisions, for example rules that reject discrimination, sexism and bullying. A school policy can also facilitate a structural link with counselling and health services in and outside the school to support individual students who have concerns or a problem, or to get access to condoms and/or contraceptives.

1.3.7 Documentation

Many health promotion interventions have been developed and implemented, but health educators seldom write in depth about the process of intervention development, and complicated interventions are often reduced to some sentences in evaluation articles.²⁵ For various reasons it is

useful to document the decisions that are taken in intervention development, including the underlying evidence, theories and practical reasons that have determined how the intervention appears in the end.

One of the reasons for documentation is to prevent the loss of information and next programme developers making the same kind of mistakes as others have already done. Documentation means therefore learning. Secondly, by documenting the information that is collected, but also the decisions that are taken during Intervention Mapping, all information is structured and on paper, which can assist during meetings with the various stakeholders (i.e., during linkage board meetings, or meetings with decision makers).

Time constraints could hinder documentation: there is always lack of time and the programme needs to be finished within a certain timeframe. It could feel as if it is a waste of time to pay a lot of time and efforts to do that. It is suggested to make (rough) notes at the time planners are working on a certain part and make certain decisions.

Planners have to find a balance in documentation of the decisions. If the information is not used, it would be useless to spend a lot of time on documentation. The most relevant, crucial decisions can be documented.

1.4 Contents

The manual consists of 9 chapters. Chapter 1-3 provide an introduction to the manual, Intervention Mapping and sexual and reproductive health and rights of young people. The remaining chapters provide background information, guidelines and examples for each of the steps. The original IM model is a little bit different, although all IM steps are reflected in the chapters of this manual.

Steps in Intervention Mapping

1. Involvement
2. Needs Assessment/ Situation Analysis
3. Objectives
4. Evidence-Based Intervention Design
5. Adoption & Implementation
6. Monitoring & Evaluation

The Internet provides a lot of information that is relevant for intervention planning. If a document can be downloaded from the Internet, we have indicated the website where the document can be found. To increase the user friendliness of the manual, we have used colours for different themes.

See the overview below.

Background information about theories
Example of applying Intervention Mapping in other projects
Background information about SRHR, young people, sexuality education
Examples to clarify Intervention Mapping
How to use this manual

References

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2. INTERVENTION MAPPING

Intervention development is a complex process, integrating a wealth of information, theories, ideas, and models to develop interventions that are at one hand logical and effective and at the other hand practical and user-friendly. To guide and support planners in intervention design, health promotion scientists¹ developed the Intervention Mapping (IM) model: a protocol, a decision aid for the development of health promotion programs and interventions.

The original Intervention Mapping model describes intervention development in six steps or phases, each of which are further specified in terms of tasks, which health educators can accomplish. The model continuously challenges health educators to back-up their decisions with theory and empirical evidence, and it provides them with a framework for involving all relevant stakeholders.

A challenge for both scientists and field workers is that decisions that are taken, are often not documented. Intervention Mapping provides a tool that can assist planners to document all relevant decisions in a structured way.

Box 2.1 IEC, BCC and IM

The terms 'IEC' (Information, Education and Communication) and 'BCC' (Behaviour Change Communication) are commonly used in discussing adolescent reproductive and sexual health responses. In this manual we add the term 'IM' (Intervention Mapping). How do these concepts relate and what is the difference?

Information, Education and Communication (IEC)

Information, Education and Communication is a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviours which are appropriate to their settings.²

Behaviour Change Communication (BCC)

BCC is a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviours which are appropriate to their settings and provide a supportive environment which will enable people to initiate and sustain positive behaviours.³ Experience has shown that providing people with information and telling them how they should behave ('teaching' them) is not enough to bring about behaviour change. Providing information to help people to make a personal decision is a necessary part of behaviour change. But BCC recognises that behaviour is not only a matter of having information and making a personal choice. Behaviour change also requires a supportive environment. Community and society provide the supportive environment necessary for behaviour change. IEC is thus part of BCC while BCC builds on IEC.

Behaviour change suggests that this approach only focuses on changing behaviour that is seen has not health promoting. However, this approach also incorporates the reinforcement of behaviour that is promoting people's health and rights.

Intervention Mapping (IM)

Both IM and BCC have much in common, with Intervention Mapping being a general protocol for the development of health promotion programmes and Behaviour Change Communication primarily being a tool for designing health messages.⁴ As such, Intervention Mapping incorporates Behaviour Change Communication. Both IM and the Behaviour Change Communication approach acknowledge that behaviour change should be integrated in a broader health promotion perspective including policy and community change, and service provision.

This has some important advantages: at first, if developers resign their job, the knowledge about why the intervention is the way it is, is still available (referred to as ‘knowledge management’); secondly, it encourages intervention planners to take well-informed decisions; and thirdly, clear documentation assists planners when they need to communicate about the production of the intervention with production specialists or when they need to inform stakeholders. The documentation also provides structured information for evaluation of the intervention and its implementation.

Intervention Mapping is not a new model. It describes steps that many intervention planners already accomplish. Its added value is the provision of a framework and a detailed overview of sequential steps and tasks, guidance on the use of theoretical and empirical evidence, and the provision of a tool to document each decision. The model can be used to develop new interventions, to adjust existing interventions, or to document the development and implementation of existing interventions retrospectively.

In this chapter, we address the underlying principles of IM, highlight the logic model that comes back in all steps of IM, and we describe the Intervention Mapping steps.

2.1 Underlying principles

Intervention Mapping (IM) is based on a number of approaches and principles that are elaborated in this section. IM is based on the health promotion approach; encourages the use of theory and evidence; is based on an ecological approach; encourages participation of stakeholders in planning; and it acknowledges that intervention planning is not a static but rather an iterative process.

2.1.1 Health promotion

There are several ways to look at health, health problems, and well being of people. In the history of health promotion science, there has been a shift from an individual to a more ecological and strategic approach. In the latter approach, health is viewed as a function of individuals and their environments, including families, social networks, organisations, and public policy context.

This change in perspectives is generally pointed at as a change from *health education* (interventions focused on change of individuals; disease prevention) to *health promotion* (interventions focused on the individual as well as his/her environment; promotion of the broader scope of health and well-being). Health promotion includes health education.

Box 2.2 Categories of prevention

The concept of prevention is a major component of both health promotion and health education. Prevention is generally divided into three categories:⁵

Primary prevention includes activities to avoid the onset of a disease (e.g., AIDS education; provision of information, education and counselling for responsible sexual behaviour and ensuring a reliable supply of condoms in the case of preventing unintended pregnancy and STI's, including HIV/AIDS)

Secondary prevention includes early detection, screening, maintenance of health and well-being in case of a disease and to minimise its progress (e.g., HIV-testing; counselling in the case of sexual harassment or abuse)

Tertiary prevention includes activities to maintain optimal health status if the disease is in its later stages (e.g., pain control), prevent relapse and complications, promote rehabilitation, and assist in adjustment to a terminal condition (e.g., ARV treatment of people living with HIV/AIDS)

2.1.2 Theory and evidence

Secondly, IM emphasises the use of theory and evidence, as health promotion interventions are more likely to be effective when they are based on theory and on evidence.⁶ See section 1.3.2 (Chapter 1) for more elaboration on the use of theory and evidence.

2.1.3 Ecological approach

Intervention Mapping is based on a social ecological approach. In this approach, health is viewed as a function of individuals and of the environments in which individuals are embedded.

We can distinguish people at various levels who take health-related decisions (see Figure 2.1):⁷

- *Individual level* (people who are at risk, patients)
- *Interpersonal/ group level* (parents, health care providers)
- *Organisational level* (school director, managers in companies)
- *Local/ community level* (community leaders, religious leaders, writers in local newspapers)
- *Society level* (politicians, people working at the ministries or provincial government)
- *Nation/ region/ world level* (national government, international organisations)

HIV/AIDS is not a result of the (sexual) behaviour of individuals, but also by the environment they live in, such as the influence of communities, availability of health services, testing facilities and cultural norms and attitudes. (National) policies or regulations can directly or indirectly contribute to a restrictive or supportive environment. According the ecological approach, interventions aiming at HIV-risk reduction should therefore be targeted at behaviour change of the people at risk, but also at relevant environmental agents.^{8;9}

For example, in the scope of HIV/AIDS prevention, condom accessibility may depend on individual knowledge, motivation and skills, but is also determined by the actions of legislators, health authorities, and schools.

If condom availability has to be increased among sexually active young people, interventions may be required at each of these levels.

Such a programme may combine interventions for different actors:

1. classical education by teachers;
2. support for (sexual active) students by counsellors;
3. condom provision by the school administration or health service providers; and,
4. advocacy to generate community support among community leaders.

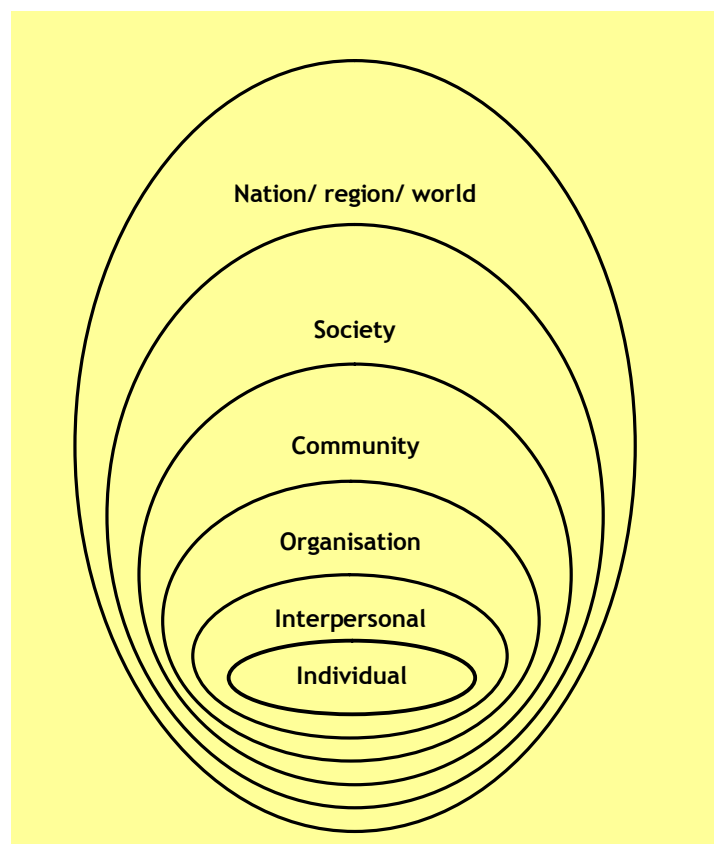


Figure 2.1 Schematic of the ecological approach

2.1.4 Collaborative planning

Intervention Mapping emphasises the involvement of and collaboration with all relevant stakeholders. See section 1.3.3 in Chapter 1. In the original IM model, this aspect comes back in every step of Intervention Mapping. In projects in Africa and Asia, we have seen that having the right people on board is crucial for the successfulness of interventions and particularly its implementation. We have therefore included a specific chapter on collaborative planning and involvement in this manual (see Chapter 4).

2.1.5 Iterative process

Although Intervention Mapping describes the process of intervention planning as a series of steps, tasks, and procedures, the process is iterative: planners move back and forth. It is however also a cumulative process: each step is based upon previous steps.

This implies, for instance, that while thinking about intervention development, planners may have to reconsider decisions regarding their objectives. Or they may find out that due to implementation restrictions, objectives have to be adapted and as a result also the intervention. Or planners discover that they lack information to base their decisions on, and have to get back to the field to conduct additional research.

2.2 From health to determinants, a logic model

One of the cornerstones of Intervention Mapping is a logic model that comes back in all steps of the model. The logic model is a combination of the PRECEDE-PROCEED model and the Theory of Planned Behaviour. These two models are described in this section and help to explore and change the most specific details of the problem. The logic model aims at making the problem and the solutions as specific as possible, ending up at the level of determinants, i.e., the factors that shape people's behaviour, such as knowledge, attitudes, confidence and skills.

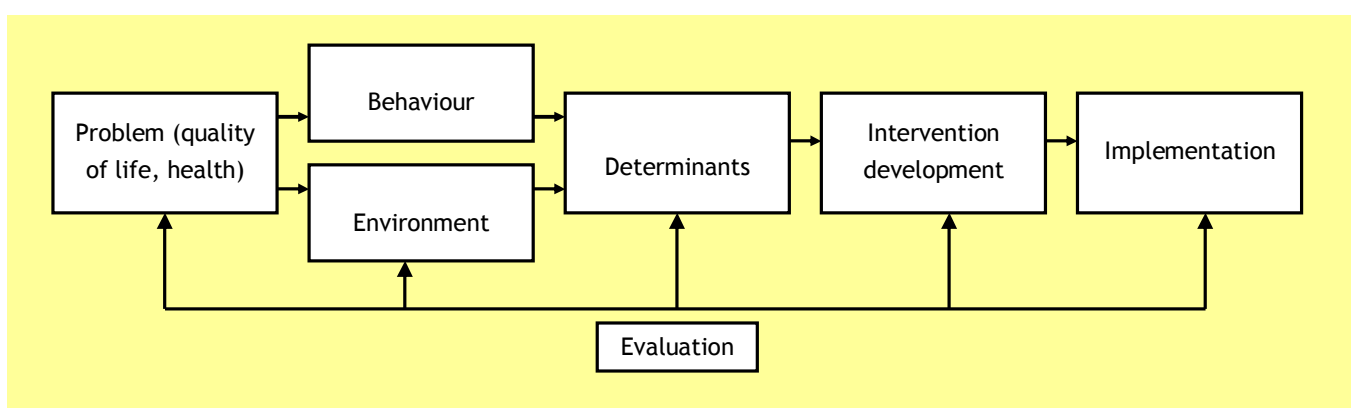


Figure 2.2 Model of systematic health promotion

2.2.1 PRECEDE-PROCEED model

Health promotion is a systematic exercise: planners think before they start doing. One of the most important and most often used planning models in health promotion is the PRECEDE-PROCEED model.¹⁰ A simplified version of this model is provided in Figure 2.2.

Intervention Mapping builds on this model, and particularly explores the phase of ‘intervention development’. PRECEDE-PROCEED also builds upon the principles of self-determination and participatory planning to ensure active involvement of target populations and communities.

Problem (quality of life, health)

The model starts with the question ‘what is the quality of life of a particular population?’ Health is just one of the factors that shape people’s quality of life. Other factors can be, for example, the consequences of war, poverty, discrimination, or unemployment. Health is often described in terms of prevalence and incidence of diseases, and mortality figures, for example, STI prevalence or HIV prevalence. In the needs assessment, planners assess the health of the target population, and can also explore other factors that influence people’s quality of life.

Behaviour and environment

According to the model, health problems are influenced by two factors: behaviour of the people who face the health problems, and by the environment they live in. For example, people can get HIV/AIDS because of unprotected sexual *behaviour*, but they can also get infected through infected blood during blood transfusions (*environment*). Indirectly, the environment can also shape people’s risk behaviours. For example, if condoms are not available or too expensive, people do not protect themselves during sexual intercourse.

In IM, the environmental factors are made concrete by translating them into behaviour of other actors. For example, ‘getting infected blood in a blood transfusion’, can be translated into ‘medical doctors do not check viral status of blood and provide infected blood to their patients’.

In the needs assessment, planners analyse how people get their health problems, by looking at their behaviour as well as the behaviour of actors in their environment. In the step of objectives, planners state desired outcomes on the level of these behaviours. If possible, they evaluate whether these behaviours have actually changed at the end of implementation of the programme.

Determinants

Both behaviour and environment are influenced by determinants. Determinants are all the reasons why people behave in a particular way. Another word for determinants is ‘correlates’.

Determinants can be divided into two categories:

- Internal/ personal determinants; for example, knowledge, risk perceptions, attitudes, values, perceived norms, skills
- External/ environmental determinants; for example, social pressure, environmental barriers or constraints

Another distinction can be made between risk and protective determinants. For example, social influence (*determinant*) can either be a risk factor (social pressure from peers) or protective (support from friends). See section 2.2.2 for more elaborate explanation about behavioural determinants.

The determinants are the focal point of the needs assessment. Planners analyse why people behave the way they do. These determinants are translated into objectives in the next step: what do

planners expect to change during implementation. In the evaluation, planners assess whether the determinants have changed in the positive direction.

Intervention development

Based on the needs assessment, planners develop an intervention that particularly addresses the behavioural determinants of people at risk, but also the behavioural determinants of people in their environment. If the logic model is very ‘strong’ (based on evidence), a change in determinants should result in a change of behaviours, which in turn should result in improved health status of the target population. In intervention development, planners use evidence and theory to identify the most effective ways of changing or reinforcing determinants.

An important aspect of intervention development is the pre-test of materials and the intervention on a small scale, in order to improve the quality of the intervention.

Implementation

After intervention development, the intervention is implemented. It often occurs that carefully designed interventions are not implemented, because planners do not take into account the needs and wishes of the people who are supposed to use the intervention (e.g., teachers, health care providers). It is advisable to involve the ‘users’ (facilitators, educators) from the start of intervention development, and to take into account their needs and suggestions.

Generally, an intervention is first piloted on a small scale (e.g., 4 schools). After careful monitoring and evaluation of the implementation, interventions can be upscaled. This prevents the implementation of an intervention that may have no or even negative effects.

Monitoring & Evaluation

During and after implementation the intervention is monitored and evaluated. By monitoring (which we call process evaluation), planners explore the quality of the implementation of the intervention. In addition, planners can do an evaluation of the effect of the intervention on behaviour of young people, or on the teaching behaviour of teachers.

2.2.2 Determinants of behaviour

Although each behaviour is unique, there is only a limited number of factors (determinants) that influence behaviour in general,^{11;12;13} or health-related behaviour in particular.^{14;15;16} Understanding these factors and their role in behavioural prediction can guide the development of effective behaviour change interventions.

To understand and structure the determinants of behaviour, scientists have developed a lot of models and frameworks. Box 2.3 provides an overview of models that have proven to be useful in sexual health promotion, and particularly promotion of condom use.

We have selected one model, the Theory of Planned Behaviour. According this model, people’s intention or motivation to engage in a behaviour is influenced by various determinants. See Figure 2.3 for an integrative model. In this section, we apply the model to understand sexual behaviour: ‘why is one person sexually active, whereas the other abstains from it?’ and ‘why do some people use condoms, and others don’t?’

Box 2.3 Use of theory in sexual health promotion

Experts in applying psychological theories in the field of sexual health promotion, conclude that heterosexual condom use can be better understood, and therefore more effectively promoted, through the application of psychological theory.¹⁷ There is empirical support for conceptualising condom use in terms of an extended Theory of Reasoned Action, similar in many respects to the Information Motivation Behavior Model.¹⁸ These conclusions were confirmed by a meta-analysis of studies applying the Theories of Reasoned Action¹⁹ and Planned Behaviour²⁰ to condom use. Again, findings demonstrated the utility of these theories as models of the cognitive antecedents of condom use.²¹

This analysis²² adds to a considerable body of evidence indicating that cognitions specified by social cognitive theories, including the ASE-model, Theory of Planned Behavior and Bandura's Social Cognitive Theory²³ provide useful change targets for sexual health promotion.²⁴

It has to be stated here that the model does not assume that all determinants are relevant for all behaviours under all circumstances. The model does claim that each behaviour is determined by at least one or a combination of more determinants. This, however, may vary for different populations in different contexts. For instance, whereas condom use among Western youth is primarily determined by attitudes, condom use among non-Western adolescents might be more strongly determined by what people think that other people think (perceived social influence).

The box below makes the various components of the theoretical model more practical.

Box 2.4 Components of the model

Behaviour	I do
Intention	I plan
<i>Determinants</i>	
Knowledge	I know
Risk perception	I risk
Attitude	I find
Social influence	I think that others think/do
Self-efficacy	I am confident
Skills	I can

Intention (I plan)

People do or do not have an intention to behave in a particular way. For example, someone may have the intention to use a condom during every sexual encounter, or to abstain from sexual intercourse until he or she is in a steady relationship. This intention towards behaviour sometimes is a conscious decision, but in many situations it is not. Generally, people are not completely aware of their intentions. If someone

When people plan to perform in a particular way (e.g., always use a condom during sexual intercourse), they are motivated to maintain or change this behaviour. People's intentions are influenced by knowledge, risk perception, attitudes, social influence, and self-efficacy. These components are described below.

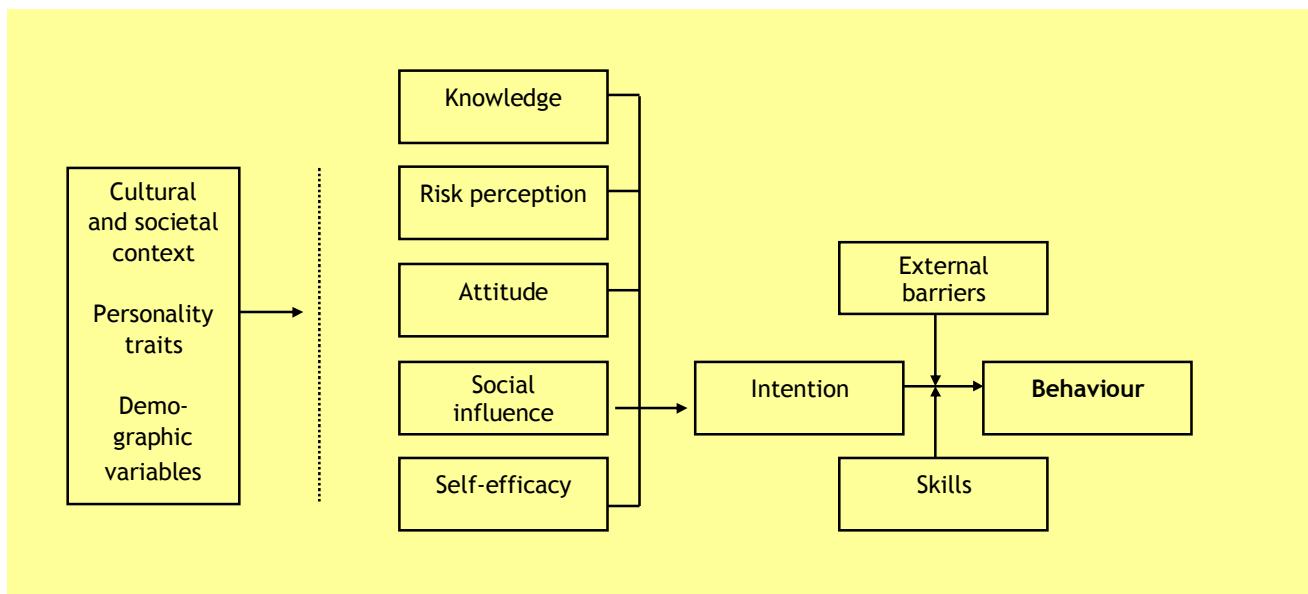


Figure 2.3 Integrated Theory of Planned Behaviour

Knowledge (I know)

Many health promotion planners are aware that behaviour change starts with giving information to people. However, not all educators are aware that this is hardly ever sufficient to actually change behaviour. The Theory of Planned Behaviour shows that in addition to knowledge quite a number of other factors play a role.

In the context of this manual, we refer to knowledge about the transmission of HIV, differences between HIV and AIDS, and ways to prevent HIV and other STI's; about other consequences of behaviour, about what others think and do, and self-awareness about skills and abilities.

Risk perception (I risk)

Risk perception refers to people's idea about the prevalence and severity of a health problem ('Is there a problem, and is it a serious problem?'), and their ideas about their personal risk ('Am I at risk of the health problem? Do others think that I am at risk?').

Risk perception is also a prerequisite for preventive behaviour: when people do not perceive a threat or risk, they will not be motivated to reduce their risks. Accurate perceptions of personal health risks, however, are usually insufficient to motivate people to preventive action. The Health Belief Model pays particular attention to explanation of risk perception.^{25;26} See the internet for more information about the Health Belief Model.²⁷

Attitude (I find)

Attitudes refer to people's expectations and evaluations about advantages and disadvantages of the behaviour. It is a general evaluation of an object (a person, behaviour, situation or idea).²⁸

The more one believes that performing the behaviour in question will lead to 'good' outcomes and will prevent 'bad' outcomes, the more favourable one's attitude towards performing the behaviour.

The development of an attitude is determined by various factors. People can have different reasons to either behave healthy or not. These considerations can be based on *health* motives (e.g., 'being pregnant when 14 can cause severe health problems'), but also on other motives, such as *economic*

reasons ('condoms are too expensive'), *social* reasons ('all my friends have girlfriends'), *personal* motives ('I like to be intimate with a boy/girl') or *cultural* beliefs ('men should have more than one wife (polygamy)'). Many motives and beliefs can play a role in shaping an attitude.

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS.²⁹



Figure 2.4 Health Belief Model

Our attitudes are generally shaped by different kinds of considerations. First, we have particular feelings or emotions concerning something (*affective*), often based on our values, such as religious or moral beliefs. For example, attitudes towards premarital sex are often based more on our values and how we feel about it, than on a cold examination of facts. Values underpin the right and wrong, the good and bad dimensions of people's outlook on specific behaviours. Values are more deeply seated and are therefore often difficult to change. Secondly, our attitudes are shaped by our thoughts and beliefs about something (*cognitive*), particularly based on facts and knowledge. In the context of promotion of SRHR, behaviour is influenced by people's attitudes towards sexuality and family planning, condom use, negotiation of sexual risk reduction.

Social influence (I think that others think)

Social influence is an important determinant of many behaviours. Other people may inform us about social reality, especially when we are unsure about what to think and what to do. And, generally, we like it when other people share our values and opinions about important issues.³⁰

We distinguish three types of social influence:

- *Subjective norms* (or 'injunctive social norms'); these are social norms as they are perceived by someone. For example, a young person in school thinks that the norm among his peers is that to

be accepted, he has to have sex. This is not necessarily the norm among his peers, but the way he perceives this.

- *Social support* or *social pressure*; direct influence of others. Social support often has a positive influence on the desired behaviour (e.g., support of others when one wants to stop smoking). Social pressure often has a negative influence on the desired behaviour (e.g., the pressure of friends to drink alcohol).
- *Observation of the behaviour of others* (modelling or descriptive social norms); when many young people do drink alcohol, a person can be influenced to also use it, especially when it seems to have many advantages such as being popular among peers.

The more one believes that significant others think one should perform the behaviour in question, and the more one observes others performing the behaviour, the more social pressure one will feel with respect to performing the behaviour.

Self-efficacy (I am confident)

Self-efficacy refers to the extent people feel confident that they can perform the behaviour. Whether they think that they have control over the performance of the behaviour. When the behaviour is difficult to perform, people generally have a lower self-efficacy than with easier behaviours. For example, people may have a low self-efficacy (confidence) with regard to negotiating use of condom with their sexual partner. This may result in not bringing up the subject with the partner.

Self-efficacy expectations can vary with regard to *magnitude*, how difficult the skills are that needed to perform the behaviour; *generality*, the extent to which the same behaviour will cause problems in different situations; and *strength*, the extent to which one has self-confidence about performing the behaviour.³¹

Skills (I can)

Self-efficacy and skills are closely related. If someone has particular skills, self-efficacy most likely increases. Different categories of skills can be distinguished, related to sexual and reproductive health and rights, and are often referred to as life skills.

Life skills fall into three basic categories, which complement and reinforce each other: a. *Social or interpersonal skills*, including communication, negotiation/refusal skills, assertiveness, cooperation, empathy; b. *Cognitive skills*, including problem solving, understanding consequences, decision making, critical thinking, self-evaluation; and c. *Emotional coping skills*, including managing stress, managing feelings, self-management, and self monitoring.³²

External barriers

Even if a person has sufficient knowledge, positive attitudes towards the behaviour, skills and the confidence that he can perform the behaviour, there may be external barriers that hinder him or her from the actual behaviour. For example, someone may have the plan to visit a health centre to get tested for HIV or an STI, but if the centre does not provide testing facilities, he or she cannot perform the behaviour.

Cultural and societal context

The model in Figure 2.3 describes the indirect relation between behaviour and the so-called external or background variables, such as the traditional demographic, personality, attitudinal and other individual difference variables. These variables only indirectly affect behaviour through attitudes, social influence and self-efficacy.

Men and women, rich and poor, Muslims and Christians, old and young, those from developing and developed countries, those who do and do not perceive they are at risk for a given illness, may hold different beliefs with respect to one behaviour but may hold similar beliefs with respect to another. Nevertheless, external variables such as cultural differences and differences in a wide range of values should be reflected in the underlying belief structure of attitudes, social influences and self-efficacy.

2.2.3 How important are the determinants?

How important each determinant is, depends on the behaviour and the context and population. For example, one behaviour may be primarily determined by attitudes, while another may be primarily influenced by feelings of control (e.g., use of condoms). Similarly, a behaviour that is driven by attitudes in one population or culture may be driven by social norms in another. The model is therefore not 'holy' but can help to structure the various factors that determine behaviour. One should rather perceive it as a tool than a model that has to be rigidly used.

Before developing interventions, it is therefore important to determine the degree to which the behaviour is particularly determined by attitudes, social norms and/or self-efficacy of the population in question. This will enable health promoters to select and specify the objectives for their campaigns and programmes. For instance, when behaviour is primarily driven by attitudes, programmes should focus on attitude change.

When the behaviour is also driven by perceptions of control, health promotion programmes should also focus on the enhancement of people's self-efficacy. And when barriers make it impossible for people to perform the behaviour, health promotion should also focus on the reduction of these barriers. See Box 2.5 how this can be applied to HIV prevention.

Box 2.5 Determinants and behaviour in HIV prevention

In HIV prevention, the likelihood of preventive action, such as delay of sexual debut or condom use, depends on:

- 1) **Knowledge** about AIDS: if people have never heard about HIV/AIDS, they will not feel a need to change their behaviour
- 2) **Risk perceptions**: if people think that they are not at risk, again they will not feel a need to change their behaviour
- 3) **Attitude** (beliefs, expectations about preventive action): if people are not convinced that changing their behaviour will reduce the risk of HIV infection, or if risk reduction has serious disadvantages, they may decide not to change their behaviour
- 4) **Social influence and support** (what others think or do): if relevant others in the social environment (e.g., friends, partners or parents) do not feel a need for risk-reducing behaviour, people may decide that it does not make any sense to change their own behaviour
- 5) **Self-efficacy** (behavioural control): if people assume that they are not able to change their behaviour, they may decide not to try at all
- 6) **External barriers**: if people have the intention to maintain or change their (health) behaviour and use condoms during every sexual encounter, but do not have a condom, they may fail
- 7) **Skills**: if people have the intention to use condoms, have a condom available, but do not have the skills to negotiate its use with the sexual partner, they may fail to perform health behaviour^{33;34}

2.3 Steps in Intervention Mapping

The original Intervention Mapping model describes health promotion planning in six steps: 1) needs assessment, 2) specifying program objectives, 3) selecting theory-based intervention methods and practical intervention strategies, 4) designing and organising of the program, 5) specifying adoption and implementation plans, and 6) generating an evaluation plan (see Figure 2.5).³⁵

The model guides planners through each of the steps by means of specific tasks that in turn provides the basis for subsequent steps. Intervention Mapping steps provide a framework for asking *why* and *how* questions in every stage of intervention planning.



Figure 2.5 Intervention Mapping³⁶

In the needs assessment for example, a question can be ‘Why do adolescents fail to use condoms?’ Other questions include: ‘How can we promote positive attitudes towards condoms?’, ‘How can teachers’ confidence in participatory teaching increase?’, ‘How can we convince school administrators that they should include comprehensive sexuality education in their curriculum?’. IM empowers planners to answer these questions by a) searching and using empirical findings from the literature, b) by accessing and using theory, and by c) collecting and using new data.

The original IM model and the steps as described in this manual are to a large extent the same, but do differ on particular points. In the manual we have added another step before conducting the needs assessment/ situation analysis. In the projects we have been involved in so far, the involvement of relevant stakeholders from the start has been proven to be conditional for successful programme planning. This includes the involvement of young people, implementers, decision makers, but also the composition of the planning team. We highlight involvement in Chapter 4 as step 1. Another difference is that we have included the original step 3 (methods & strategies) and 4 (intervention design) into one step, called ‘evidence-based intervention design’.

2.3.1 Step 1. Needs assessment/ situation analysis

IM starts with an analysis of the needs, problems, capacities and opportunities among the target population, and the wider community (IM Step 1). This analysis addresses people’s quality of life, health concerns, behavioural and environmental factors and determinants. And it also explores the capacity within a community and among the target population that are potentially useful in improving people’s health. In this manual, this step is addressed in Chapter 5.

2.3.2 Step 2. Matrices of objectives

Step 2 in IM addresses the specification of the general program objectives into specific change objectives that explicate who and what will change as a result of the intervention. Change objectives specify what individuals need to learn or what must be changed in the organisational or community environment. They may refer to individual level change (e.g., ‘adolescents express confidence regarding negotiating condom use with a sexual partners’), organisational level change (e.g., ‘school administrators acknowledge the advantages of condom distribution in school’), or community level change (e.g., ‘community leaders approve of the sale of inexpensive condoms in schools and meeting places’). In this manual the objectives are highlighted in Chapter 6.

2.3.3 Step 3. Methods and strategies

The next step in IM is to select theoretically based intervention methods that may be effective in achieving the objectives and to decide upon practical strategies to operationalise these methods. For instance, a theoretical method that describes how to enhance self-efficacy is modelling.

A practical strategy for this method could be role-playing and/or watching models on a video. Theoretical intervention methods can be derived from the scientific literature and information about the feasibility and effectiveness of practical strategies can be derived from needs assessments, contacts with other health promoters, collaboration with program implementers and users, and from small-scale pilots.

An important task at this step is to identify the conditions that may limit the effectiveness of intervention methods and strategies. A method or strategy that has proven to be effective among a particular target group in a particular context will not necessarily be effective among other populations or in other contexts.

From our experience in various projects we have learnt that this is often a difficult step to take for programme planners in the field. And in practice, the use of theories goes hand in hand with the design of intervention materials (the original step 4 in IM). In this manual, we have provided many examples of methods and strategies and we have combined these with intervention design in Chapter 7 of this manual.

2.3.4 Step 4. Program design

In IM step 4 programme developers design a plan for the production and delivery of the program. This involves organising the strategies into a deliverable program with components that are comprehensible and acceptable to program implementers and participants. IM can help developers to specify the scope and sequence of program components, the channels of delivery of intervention strategies, and how each program component will reach program participants (e.g., public service announcements on radio, magazines or, lessons delivered by classroom teachers). This step also involves transfer of programme specification to a production (e.g., health educators, designers, artists), and testing of pilot materials.

2.3.5 Step 5. Adoption and implementation plan

The production of the programme must be closely linked to adoption and implementation planning and reliable diffusion procedures are essential to program impact. IM step 5 describes how programme planners can set objectives for programme adoption, implementation and maintenance and link these objectives to theoretical methods and practical strategies for promoting adoption and implementation. Thus interventions are required, not only to change individual behaviour, but also to facilitate program adoption and implementation. In addition, programme planning can address the sustainability of the program to encourage institutionalisation of the program to ensure programme impact over an extended period of time. In this manual we describe adoption and implementation in Chapter 8 and distinguish between a pilot phase (in which the programme is implemented on a small scale to test whether it works) and the sustainability phase (in which the programme is implemented on a wider scale, and if possible integrated in ongoing programmes).

2.3.6 Step 6. Evaluation plan

Finally, IM step 6 focuses on evaluation. Programme planners develop instruments to evaluate the impact of the intervention on behavioural determinants and behaviour. They also specify the time frame appropriate for expected outcomes. These tasks generate a monitoring and evaluation plan. How to develop a plan for monitoring and evaluation is described in Chapter 9 of this manual.

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3. Young People's Sexual and Reproductive Health and Rights

This chapter describes who young people are, particularly focusing on their sexuality, their sexual and reproductive health and young people's rights. Annex 3.1 provides an overview of definitions related to sexuality and sexual and reproductive health.

3.1 Young people and sexuality

Today, young people are the largest proportion of the world's population in history. Nearly half of the world's population is under the age of 25. About 20% of them, a staggering 1.2 billion, are adolescents aged 10-19. Of these adolescents, 87% live in developing countries with approximately 60% in Asia alone.¹ It is expected that by 2020, the proportion of adolescents living in developing countries has grown to about 89%. In 2006, in 57 developing countries, over 40 per cent of the population was under 15 years old.²

These figures and the fact that young people are the future generation, make it even more important to target them today. Especially young people in developing countries deserve attention. Since young people constitute the largest population segments worldwide and since they are deeply affected by underdevelopment, poverty and economic marginalisation, this manual focuses particularly on improving sexual and reproductive health of young people in developing countries. This section provides an introduction about young people and distinguishes some categories and addresses the heterogeneity of young people.

Youth, as a concept, varies from culture to culture and from one society to another. Defining youth globally according to some exact age range or developmental stage is a difficult task. For example, some traditional cultures use rites of passages, particularly for boys, to confer on them a new status and position in society in their growth to adulthood. These rites have symbolic significance and are usually given during ceremonies by the whole community.

Increasing globalisation also influences youth cultures and life-phase transitions and relations between generations. As a result, definitions of youth are not as predictably as in the past. One can classify young people from different perspectives: by defining them according age groups, developmental stages, or from a 'social' perspective, taking the cultural context into account.

3.1.1 Age groups

A definition of young people based on age, can be helpful in dividing the whole group of young people into smaller entities. The age segmentation is often used for statistics in demographic classification or for indication of legislative ages (i.e., age of access to levels of education, or age of being allowed to get married).

The World Health Organization (WHO) and other UN organisations define *young people* as all young men and women aged 10-24, *youth* as all people between 15-24 years old, and *adolescents* (or teenagers) as people in the age range of 10-19, with young people 10-14 years old (early adolescents), and those aged 15-19 in their late adolescence.³ However, in many developing countries, people aged up to 35 years old, are defined as young people, using steady employment as a criterion of young people's social position.

3.1.2 Stages of development

Defining young people according to development stages incorporates the phases in which young people mature physically, psycho-socially, emotionally and mentally from childhood to adulthood. These phases encompass concepts such as ‘puberty’ and ‘adolescence’.

Puberty is used as the marker of transition from child to young person. It is often perceived as a biological transition, a fundamental and drastic life span full of rapid changes, starting in childhood. The processes that mark puberty (i.e., development of secondary sex characteristics, a growth spurt and emotional, psycho-social and cognitive maturation) vary greatly among young people of the same age.

This variety is determined by the time of onset of puberty, the pace of development and the time of termination. Today, young people experience puberty earlier than youth of previous generations. In some cultures, girls enter puberty as early as 8 years old, and boys being 9 years old. In general, the puberty of girls ends at their 13th and of boys at their 14th birthday.

Box 3.1 Definitions of adolescence

Early, middle and late adolescence

In *early adolescence* (ages 9-13 for girls and 11-15 for boys), experimenting with sexual behaviour is common, although sexual intercourse (vaginal, anal, or oral) is usually limited. During this stage, young adolescents start the process of separating from the family and become increasingly influenced by their peers. Young adolescents primarily engage in concrete thinking, and as it is difficult for them to imagine future consequences, they continue to value their parents' guidance, especially on important life issues.

In *middle adolescence* (ages 13-16 for girls and young women and ages 14-17 for boys and young men), the ability to think abstractly begins to develop. Separation from the family increases, and the desire to be accepted by one's peers can exert a strong influence on behaviour. Sexual experimentation is common, and many adolescents have first intercourse during this stage of life.

In *late adolescence* (young women aged 16 and older and young men aged 17 and older) the process of physical maturation is completed. The ability to understand abstract concepts is achieved by many adolescents at this stage, and many of them understand what the results and consequences of their actions and behaviours may be. There is an increased ability to empathise with others, give and receive intimacy, and define adult roles. There also is greater autonomy from the family as well as from the peer group, and sexuality may become more associated with commitment and planning for the future.

The broader concept of *adolescence* includes puberty. Between the ages of 10-19, young people go through adolescence, gradually preparing themselves for tasks and roles that mark adulthood. Adolescence starts with physical changes during puberty and ends with having an own identity and adult responsibilities and roles (i.e., economically, socially, legally and politically). It also leads to ‘sexual independence’ at the end of adolescence. In other words, adolescence ‘starts in biology and ends in culture’.

Today, all cultures recognise and mark the transition from childhood to adulthood. The concept of this transition as a life stage, however, did not exist in developed countries until the late 1800's and early 1900's. In many developing countries the concept arose, as recently as 30 years ago, and in some regions the idea is still new today.⁴

Adolescence can be categorised into three stages of development: early, middle, and late adolescence. Although an individual adolescent will develop at her or his unique pace, there are

recognisable patterns of change in behaviour and sexuality that occur from one stage of development to the next.⁵

Box 1 provides an overview of main characteristics of early, middle and late adolescents.⁶ However, the duration and characteristics of these periods vary across time, cultures, and socio-economic situations. For example, a recent survey on reproductive health showed that the lowest median age at first sexual experience was in Niger, at age 15.7, whereas the average age for 29 sub-Saharan African countries was approximately 17 years old. In Latin America and the Caribbean the median age at first intercourse was between 18 and 19 among women, and 20 years in Eastern Europe and Central Asia.⁷ These findings show that behaviour and characteristics vary among cultures and countries.

Looking at young people from the perspective of development is often used in educational programs for young people. This perspective is also called the ‘developmental approach’.⁸ For example, promoting self-identity of younger adolescents requires recognition of how many of them have already explored alternative values, beliefs, or behaviours compared with the ones they had in childhood and how many are already exploring peer relations, friendships, sex roles, and relationships with the opposite sex.⁹

According to the developmental approach, adults play an important role in the process of young people’s identity building during adolescence, taking into account the many changes young people have to cope with within a short period of time. Adults are expected to act as role models. Their knowledge, protection and support can help young people to understand their lives, to meet societal expectations and to help them overcome the problems they face.

The developmental approach gains value for effective policies, programs and interventions if young people’s social position and roles as well as their potential, views, preferences and voice are taken into account as well.

3.1.3 Young people’s position in society

In addition to categorising young people into age groups, or according to developmental stages, we can also look at young people from the perspective of their position in society. Developmental stages and ritualised events are losing their intended significance, as an individual’s status and position in society have become more important from a social, political and economic perspective. This perspective takes their class, career and employment opportunities, gender and race, as well as their entitlements into account.¹⁰

This so-called ‘social-based definition’ categorises young people according to their position in society and recognises that the lives of young people are inherently connected to and dependent on their surrounding environment.

3.1.4 Heterogeneity

Whatever definition is used to define young people, it is not a homogenous group. Young people are diverse. To reach young people effectively with programs and policies, their diversity in needs should be acknowledged.

Young people differ in needs related to their developmental stage, social class and position, ethnicity, abilities and disabilities, lifestyle, as well as the developmental state of their residential country. They may be illiterate, educated, still studying, working or unemployed. They may be religious or not, either having a lifestyle and value system congruent with the community they live in, or linking up with a certain youth culture, especially when they live in urbanised regions. They may already be sexually active before marriage, or married, have children of their own, or they may have a sexual relationship but postponing their marriage until they have enough economic security. They may have a hetero-, bi- or homosexual orientation.

A special subgroup of young people consists of HIV-positive youth. This worldwide, rapidly increasing group of young people has specific needs, being vulnerable to discrimination, isolation and exclusion of the community. Irrational fear of infection and blaming them for spreading HIV, stigmatises this group, often leading to rejection instead of giving them the support they need and meeting their right to protection.

Today, reducing the stigma of people living with HIV/AIDS (PLHA) has to be an integrated goal for most target groups of young people, particularly in high-endemic countries. In addition, in these countries young people living with HIV/AIDS (YPLHA) may be a separate target group for policies, programs and interventions, while people surrounding them have to be educated how to meet their needs and right to support.

3.2 Young people's sexuality

Figures on sexual health show that a great part of young people worldwide in most cultures and societies are sexually active, starting at an increasingly earlier age and practicing pre-marital sex in spite of traditional and religious norms of the communities they live in.¹¹

This section shows the need to acknowledge young people's sexuality and sexual development in policies and programs for young people. It starts with a definition of sexuality and sex, explains sexual development of young people, acknowledges young people as sexual beings, and describes the implications of these facts and perspectives for the development of programs and policies concerning young people.

Box 3.2 Definition 'Sexuality'

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.¹²

3.2.1 Sexuality and sex

The meaning of sexuality and sex varies between and within cultures, from person to person and also between men and women. Sexuality is a broad concept and thus not equal to sex, representing the acts through which sexuality is expressed. These acts cover a broad range of practices, varying from kissing and petting to mutual masturbation, including sexual intercourse. In contrast to particularly young men's views on sex being equal to sexual intercourse, pleasurable and safer alternatives than only intercourse could be practised and negotiated by girls. Some people regard sexuality as related to reproduction, expression of intimacy, love or pleasure. Others however, associate it with taboo, sin, shame and sickness.

According to the WHO, *sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.*¹³ Sexuality can be experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and within or outside a relationship.

This definition shows that sexuality is more than reproduction only: it is a fundamental aspect of human nature, and can be a positive and powerful force and a source of energy, creativity, motivation and interaction. This contradicts the view of many cultures and religions, which associate sexuality exclusively with the ability to have children.

3.2.2 Sexual development

Sexual development starts even before a child is born: sex organs develop, by which the sex of the child can be defined. After birth, the sexual development of children continues, influenced by both heredity and by the environment they grow up, for example the influence of parents, culture, and peers.

Sexual development is a complex process. The most dynamic part occurs during adolescence. In this period, rapid changes occur related to body shape, size of genital organs and maturing capacities to reproduction. Adolescents also discover the potential of their sexuality, start to experience sexual attraction and discover that others find them sexually attractive. These are all new, surprising, often confusing and exiting emotions.

Sexual development during adolescence includes learning about own sexuality, excitement, attraction and intimacy, as well as personal values and boundaries. This mainly occurs through interaction with peers, friends and often also a partner. In addition, young people develop an understanding of reproductive processes, personal (gender) roles in relationships and adjusting to erotic feelings and experiences. Learning about societal standards and practices with regard to sexual expression, is also part of this developmental process.

When young people explore their own identity, cultural, religious and social influences of parents, family, schools, peers and community give meaning to the exploration of their own body, feelings and social roles. The way people around the adolescent behave, touch each other as well as their children, the gender-roles they model and the communication they have or do not have about sexuality, provide the foundation for the decisions the adolescent will make and how it will form his or her own sexuality.¹⁴ Learning about sexuality continues until the end of life.

During adolescence, many young people have their first sexual experience, either with themselves, with a partner or with more than one partner. Others decide to abstain from sex at all, or practise only alternatives of intercourse, 'saving' sexual intercourse for one special person or for marriage. However, curiosity about sexuality and experimentation with sex and relationships is an evident part of adolescence.

3.2.3 Sexual values, norms and morality

Figures show that the majority of young people worldwide are sexually experienced when they are 20 years old.¹⁵ Prevalence of young people's sexual health problems and particularly the evidence of HIV figures, with half of those infected being young people, reflect this practice.

Most young people start their sexual life while they are uninformed and unprepared. Norms and values (sexual morality) on sexuality may influence policy makers, public opinion leaders, teachers and parents to believe that withholding information about sexuality and reproduction from young people will dissuade them from becoming sexually active.

Views on sexual morality are derived from religious and cultural beliefs, as well as social, economic and environmental conditions. Sexuality is so powerful and universal that every culture surrounds its expression and exploration with customs, taboos, laws, rituals, legends and strong values. Sexual morality refers to the beliefs and practices by which a culture, group or faith regulates their members' sexual behaviour.

Examples of these beliefs are: 'sexuality is only for reproduction', 'sexuality is only part of marriage', 'sexuality should be controlled' and 'sexuality is only for adults'. Particularly if it

concerns young people, these beliefs are often imposed on them, assuming that young people are 'empty boxes', without norms and values.

Sexual morality differs from culture to culture, but also from person to person. Some people may believe that sexuality and reproduction are strongly linked and that biological reproduction is the primary aim of sexual intercourse. Others may perceive sexuality with sexual intercourse aiming at pleasure. The extent to which people openly communicate about sexuality, reproduction, sex before marriage, polygamy and homosexuality is also linked to sexual morality.

The taboo on sexuality in many cultures hinders adults to openly discuss sexuality, norms and values with young people. Young people can experience resistance or even hostility from adults when they try to obtain the information and services they need and deserve.

3.2.4 Healthy sexuality

For most people, healthy sexuality is first and foremost about enjoying one's sexuality. It means that they themselves and their partner have to feel ready for it and that their sexuality is consensual and safe and not harming others. This is in line with definitions of the WHO on sexual rights. Among today's young people, this view on sexuality is becoming more prevalent.

Some global developments result in a changing context for young people. As we have seen before, more young people become sexually active at a younger age. The current onset of puberty is earlier than in the past, while the average age of marriage is later. Consequently, young people tend to already explore their sexuality and do not want to wait until marriage. Secondly, many young people lack parental guidance, because of increased mobility of young people themselves and their families, and because of increased absence of parents due to economic reasons, HIV/AIDS or broken families. This lack of guidance can lead to less solid norms. Peers can more easily pressure them to become sexually active. Thirdly, many of today's young people adjust to a lifestyle, which is financially demanding. Poverty or economic requirements can be a reason to use sex as an object to exchange or source of income, pushing the onset of sexuality to an early age. Finally, globalisation, Internet and international youth media trigger a newly emerging, global youth culture with, in general, liberal attitudes towards pre-marital sex.

These developments have caused a rapid change in the way young people today deal with sexuality, and figures show that over 50% of young people worldwide are sexually active at their 18th birthday. Often, they are not prepared for a sexual life and get confronted with not only positive aspects of sexuality. The lives of millions of adolescents worldwide are at risk, because they do not or insufficiently have the information, skills, health services and support they need to stay healthy through their sexual development. It is difficult for them to decide on postponing sex until they are physically, socially and emotionally mature, or to take preventive measures if they are sexually active.

Sexual health problems disproportionately affect adolescents, while girls face higher risks than boys. Besides teenage pregnancy, unsafe abortions and infections with STI's and HIV, for many of them (especially girls) sex is linked with coercion and abuse, often by adults and sometimes even by family members. In many societies, women are conditioned to be submissive to men. It is then difficult or even impossible for them to refuse sex or unprotected sex with a partner, particularly when it concerns an unfaithful spouse. In addition, decisions about (early) marriage, planning a family and spacing births are often taken by the man, while he does not take the needs of his partner into account or shares his decision making with her.

3.2.5 Gender and sexuality

Worldwide, the meaning of sexuality that is given by the social environment to girls is generally not the same as the one given to boys, having its origins in both socio-cultural and biological factors. These differences have a tremendous impact on the sexual behaviour of young people and results in young women's vulnerability to sexual health problems.

Cultural, religious and social factors not only influence a child's exploration of his/her own sexuality, identity and behaviour, but also its gender role. Both boys and girls can experience these factors and the world in different ways. Often, the world gets 'bigger' for boys, but contracts for girls.

Boys enjoy new privileges reserved for men; girls endure new restrictions reserved for women. Boys gain autonomy, mobility, opportunity, and power (often including power over girls' sexual and reproductive lives), while girls are systematically deprived of these assets.¹⁶ Girls are often expected to be submissive, charming and elegant, while boys are expected to take initiative, to be resolute and go straight to the point, and to be allowed to show dominance and aggression in the case of problems.

Related to these general attachments of gender characteristics and social roles of boys and girls, their sexual activities are also valued differently by adults, society and culture. As a result, double standards regarding the acceptability of male and female premarital sexual behaviour are evident in the attitudes and behaviour of youth in all settings.¹⁷

Gender and sexual health

In contrast to boys, girls not only face the risk of unintended pregnancy, but also face higher risks of STI or HIV infections due to biological reasons. Social inequalities resulting from double standards further exacerbate their vulnerability.

In many regions, girls are perceived as less valuable than boys and are not taken seriously in refusing or negotiating (safe) sex. In addition, girls are often denied awareness of their own sexuality, their own enjoyment, to take initiatives and to make their own decisions and to stand up for themselves in case the male partner disagrees.

Effective communication between different genders fails if empathy, tenderness, intimacy and carefulness are not part of young men's characteristics and if they confuse sex with love and relational matters with sexual matters. For many young men, sexual technique dominates romance and performance dominates interaction, while for girls it is the other way around.

Gender inequality and particularly unequal power in relationships often limit young people's ability to refuse sex if they are not ready for it, not willing to have sex, or to negotiate condom use.

Sexual coercion and abuse can be the result of a lack of consensus between a male and female partner on sexuality and safe sex. In many cultures, the male partner often takes the decisions, while assertiveness of the female partner in negotiation is not welcomed or not allowed. A significant percentage of adolescent girls therefore report to be sexually initiated with force.¹⁸ However, male youths can also be victims of the abuse of power by older, mightier or wealthier individuals or by groups.

Sexual harassment or abuse are to a great extent related to power differences and power abuse. Sexual harassment, including verbal and non-verbal sexual insinuations, touching that seems to be accidental, and offering sexually obligating gifts, can also be the entry point of sexual abuse. It can make a victim powerless and can cause uneasy feelings. Systematic harassment can severely undermine a victim's self-esteem, and in some cases even lead to suicide.

3.3 Sexual and reproductive health

Many definitions of sexual and reproductive health are available. In this section we use the definitions that are provided by the World Health Organization.¹⁹

Reproductive health is marked by its emphasis on reproduction and is derived from a medical approach. *Sexual health* at the other hand focuses on individual needs, encourages individual capabilities to fully enjoy sexuality and uses a ‘common’ language.

WHO’s definition on *reproductive health* is not limited to family planning and being free of diseases. It also emphasises the capacity and right to a satisfying and safe sex life and includes the right to and freedom in family planning, as well as the right to education, contraceptives, health services and care in case of pregnancy.

WHO’s definition on *sexual health* is even more explicit on the positive aspects of sexuality and on rights. This definition urges for a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. To attain and maintain sexual health, this definition explicitly mentions that the sexual rights of all persons must be respected, protected and fulfilled.

These definitions stress the positive aspects of sexuality, the capacities for a satisfying and safe sexual life and protection by, respect for and fulfilment of sexual and reproductive rights.²⁰

Box 3.3 Definitions ‘Sexual and Reproductive Health’

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.²¹

Reproductive Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its function and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.²²

3.3.1 Integrating HIV/AIDS and SRH

In the early ‘90s, linking programs on STI’s and HIV/AIDS with existing SRH&R-programs slowly started.²³ However, up to now little attention has been paid to actual integration of HIV/AIDS programs and SRH&R programs, for example, to include sexual and reproductive health and ‘family planning’ into HIV/AIDS services.²⁴

Including STI/HIV prevention and related activities in existing family planning services is a logical and practical type of service expansion to serve clients who would otherwise be missed, demonstrating that integration of those vertical programs is obvious.

Although evidence shows that SRH-services can significantly contribute to HIV/AIDS prevention,^{25;26;27} in reality counselling and treatment services often focus either on SRH or on HIV/AIDS. Both SRH and HIV/AIDS programs address human sexuality, serve similar target groups, promote safe responsible sexual behaviour, treat STI’s and rely on effective prevention and care, including behaviour change.

In addition, they use similar communication channels and both may promote and distribute condoms within and outside health services. They both also require and use similar health skills and facilities,

rely on community participation, address vulnerability and high-risk behaviours of young people, aim at empowerment of women, male involvement and decision-making and strive to reduce mother to child HIV-transmission. In spite of all the similarities between programs on HIV/AIDS and programs on SRH&R, the many opportunities of linking SRH-promotion and fighting HIV/AIDS still are in practice not or insufficiently used.

Benefits of integration

Benefits of linking or integrating SRH&R and HIV/AIDS programs are recognised, but to date integration and the actual level of collaboration are far from optimal. Due to lack of political coordination and commitment from both working fields, even today HIV/AIDS education and services rarely meet broader reproductive health needs²⁸.

Educational HIV/AIDS programs are often exclusively knowledge-based and restricted to factual information about HIV transmission and AIDS prevention, primarily focusing on abstinence, monogamy, condom use (ABC) and partner reduction. VCT-services focus on HIV-testing and counselling, while a focus on sexuality and SRH&R is usually lacking.

At the other hand, SRH-programs aiming at family planning, reproductive health, maternal and child health incorporate the broader context of health challenges related to sexuality, relationships, unintended pregnancy, sexual abuse and violence, but do often not include strategies for HIV/AIDS prevention, nor do they address issues such as HIV/AIDS care and stigma.

Integrating SRH&R and HIV/AIDS results in more comprehensive programs that simultaneously target more health determinants. Linking these programs means that more groups of people have access to a broader range of services and education via one entry-point, while sharing capacity building, services and administration can result in cost-reduction. In addition, sharing experience, skills and knowledge will increase the quality of education, services and advocacy.

Addressing barriers of integration

To achieve a good linkage or integration of programs, several barriers have to be removed. Constraints may hinder a good linkage such as the history of segregated SRH and HIV/AIDS programs, each having its own approaches, networks and cultures. Further, either SRH or HIV/AIDS may not be a priority in every country and donor driven segregation may maintain separate programs and policies.

But also at the level of the working field, barriers may hinder linkage. For example, linkage may imply increased workload by including HIV/AIDS education, services and counselling in established SRH programs and vice versa. And specific target groups may be missed by their fear for stigma - i.e. sex workers, men having sex with men may need specific education and services to be kept group-specific²⁹, while (young) women may fear stigma when visiting HIV/AIDS services. Last but not least, weak health systems may hinder program linkage and integration.

This manual advocates the linking and integration of SRH&R and HIV/AIDS programs for young people, particularly in the case of school-based sexuality education.

3.3.2 Sexual and Reproductive Health of Young People

Many young people in developing countries live a healthy life. However, many of them also face various health problems. The boxes below shows some general figures on challenges and problems they risk: Teenage pregnancy, early child bearing and (unsafe) abortion; Sexually Transmitted Infections, including HIV/AIDS; Sexual abuse and harassment; Female Genital Circumcision (FGC); Male circumcision; Discrimination because of living with HIV/AIDS; and Discrimination because of sexual identity or sexual orientation.

Teenage pregnancy, early child bearing and (unsafe) abortion

- Worldwide, approximately 15 million young females aged 15-19, give birth each year, accounting for more than 10% of all newborn children. In the least developed countries 1 in 6 births is to girls between 15-19³⁰.
- About 17% of all young people use contraception methods.
- In developing countries, between 25-50% of all young women give birth before turning 18.
- Pregnancy is leading cause of death for young women aged 15 to 19 worldwide, with complications of childbirth and unsafe abortion being the major factors³¹.
- 25% of all maternal deaths are among teenage mothers. Young mothers, especially those under 15, have increased chances of serious health risks.
- The risk of death during childbirth is five times higher among 10-14 year-olds than among 15-19 year-olds and twice as high among 15-19 year-olds than among 20-24 year-olds. In addition, when young girls bear children, their offspring also suffer higher levels of morbidity and mortality.
- Unmarried pregnant girls often turn to unsafe abortion, particularly in countries where abortion is illegal.
- Every year nearly 70,000 women die from complications of unsafe abortion³², one every eight minutes. Thousands more suffer long-term injury resulting from unsafe abortions.
- Teenagers are more likely than older women to have clandestine or illegal abortions because of legal, social and financial reasons.
- Estimates of abortions performed on teenage women range from 1 to 4.4 million³³.
- Data from 13 studies in seven Sub-Saharan African countries show that adolescents comprised 39-72% of all cases of abortion-related complications. This tragedy is caused by the fact that an estimated one-third of all pregnancies is unwanted and that safe abortion services are not universally permitted or accessible to women, despite the fact that when qualified medical personnel properly perform abortions, abortion is one of the safest of all medical procedures.
- Of the 19 million unsafe abortions that occur every year, 99% occur in developing countries, where abortion is often barred or only allowed to save a woman's life, while family planning information and services that could prevent pregnancy are also scarce.

Sexually Transmitted Infections, including HIV/AIDS

- The incidence of sexually transmitted infections (STI's), including HIV, is the highest among young people. Worldwide, one in twenty youth contracts an STI each year, and half of all HIV-infections occur among people under age 25.³⁴
- Every day, 7,000 young people worldwide acquire the HIV virus, which yearly counts to around 2.6 million new infections among youth. Around 1.7 million occur in Africa and 700,000 in Asia and the Pacific.
- New infections among females outnumber males by a ratio of up to 16 to 1 in the worst affected regions.³⁵

Sexual abuse and harassment

- Worldwide, the prevalence and severity of sexual abuse and sexual harassment are still underestimated. Cultural customs may obscure or even hinder the acknowledgment of the existence of sexual abuse and harassment. Lack of research hinders the provision of clear figures.
- A review of 13 studies on sexual coercion among youth (generally aged 15-19) in developing countries showed that 2-20% of girls and almost 15% of boys reported that had ever had experienced sexual coercion.
- In a review of 14 studies on forced first sexual experience, about 15-30% of sexually active girls reported coercion; fewer than 10 % of boys reported forced first sex.³⁶
- Studies in several African countries show that more than 30% of girls have their first sexual experience as a forced experience.
- Many street children - in Latin America an estimated 40 million, 10 million in Africa and 25 million in Asia - have to survive by exchanging sex for food, money or protection.
- Sexual violence often is commonplace during war and in refugee camps.

Female Genital Circumcision (FGC)

- Female genital circumcision (FGC) is a cultural tradition in some countries or regions. Parts of the girl's genitals are removed, varying from an incision in the clitoris to complete removal of the labia.

- According to estimations of WHO, between 100 and 140 million women worldwide are circumcised today and yearly 2 million girls aged 8-11 risk genital mutilation.^{37;38}
- FGC is practiced in 26 African countries, including the Middle East, North and Central Africa,³⁹ a few Asian countries, and is increasingly practiced in Europe, Canada, Australia and the US among migrants.⁴⁰
- Female circumcision, especially when done by unskilled people or with unhygienic use of instruments, can cause severe bleeding, damage of surrounding organs, infections, infertility and problems with urination, problems with menstruation and problems with delivery. In addition to physical problems, FGC can lead to trauma and mental problems. On the other hand, in certain cultures female circumcision can be experienced by women as making them feel as a real woman in a physical way, giving them more opportunities in a social way, i.e., marriage or acceptance by other women in their communities.
- FGC is globally recognised as a violation of human rights. In 1982, the World Health Organization adopted a resolution to fight FGC.⁴¹

Male circumcision

- Male circumcision, an important part of many men's sexual and social identity, occurs in some regions and cultures. Currently, approximately one-fifth of the world's male population is circumcised, particularly on religious grounds.
- In Western society, circumcision is usually performed for non-religious, 'medical' reasons.
- Regarding the risks of male circumcision, a realistic figure on complication rates seems to be 2-10 percent.
- When circumcision is not hygienic, it can cause infections among males, particularly HIV infections when it is done in a rite where more than one boy or male is circumcised with the same knife or instrument.
- In the view of FGC, recently also male circumcision is debated as being a harmful practice and related to the rights of the child proposed to be only allowed if the child is of consenting age, fully informed about all possibilities which lay ahead of him or her, and can make up his or her own mind, choosing the way he or she thinks is best.⁴²

Discrimination because of living with HIV/AIDS

- Young people infected with or affected by HIV/AIDS often suffer from discrimination, rejection and even isolation.
- In 2003 an estimated 10 million young people were living with HIV, while about 40% of countries worldwide did not yet adopt anti-discrimination laws.⁴³
- Ignorance, fear and shame are main causes of HIV/AIDS-stigma and discrimination. Ignorance on how HIV is transmitted and wrong beliefs about how HIV is transmitted shape the breeding ground for irrational fear of HIV-infected people.
- Moral judgments that surround the transmission of HIV through sex and use of drugs (injections) often lead to shame for being infected or being associated with people living with HIV/AIDS.
- Stigma is not only against the rights of people living with HIV/AIDS. If HIV-infected people are reluctant to practice safe sex in the belief that it would raise suspicion about their HIV-positive status, then stigma also creates conditions for further spreading of HIV. The only way of making progress in eradicating the epidemic is to replace ignorance with facts, shame with solidarity, and fear with hope.⁴⁴
- Stigma hinders making PLHA part of the solution to containing and managing the epidemic.⁴⁵

Discrimination because of sexual identity or sexual orientation

- Sexual orientation refers to whether one desires sexual contacts or an emotional relationship with a person of the same sex. If one consistently desires someone of the same sex (men who prefer men and women who prefer women), this is called homosexuality.⁴⁶
- Sex between men and sex between women occurs in all cultures and all societies. In many developed and in most developing countries its existence has usually been ignored or denied by public opinion, governments, and the international community, making young men and women with same-sex feelings one of the most neglected groups in improving the sexual health of young people worldwide.

- Sexual orientation, same sex practices and discrimination and violence against homosexuals are often not considered to be serious health (/quality of life) issues and are therefore ignored. In many developing countries ignorance has led to systematic violations of the human rights and high violence rates against people with same-sex-contacts, and the neglect of the spread of HIV/AIDS among men who have sex with men (MSM) and women who have sex with women (WSW).
- Stigma associated with homosexuality can have negative, mental health consequences for young people with a homosexual orientation or with same-sex behaviour. They generally suffer more than their heterosexual peers from depression, loneliness, eating disorders, low relationship satisfaction, substance abuse, and sexual dysfunctions, even leading to a higher suicide rate.⁴⁷
- The silence surrounding diversities in sexual orientation and invisibility of gays and lesbians make it difficult to identify youths with homosexual contacts and to reach them with the guidance they deserve.

The evidence shows that many young people face or are at risk of sexual and reproductive health problems. Most of these problems are related to power differences, either between boys and girls, or even between adults and young people. And many of the problems are caused by unsafe and unhealthy sexual behaviour. To prevent these problems, it is therefore evident that education on these various topics should be integrated and presented in one coherent programme.

3.3.3 SRH and the need for a positive approach

Policies and programs that support and improve the sexual and reproductive health of young people often focus merely on the problems related to sexual and reproductive health. Evidence, however, shows that embedding education and prevention of SRH problems in a comprehensive approach of adolescent's sexual development, is more effective. Most people, including young people, experience sexuality as a source of intimacy, excitement, joy and pleasure and not as a source of problems.

By highlighting the positive aspects of sexuality, young people are empowered to perceive sexuality as a meaningful aspect of growing up, and a powerful force in self-determination and -expression, love and reproduction. Credibility and a positive approach towards sexuality improves communication with young people and supports them in making informed decisions.

A positive approach also avoids an exclusively problem-based or fear-based approach, for example, implementing a program that solely focuses on the consequences of HIV/AIDS. Fear and anxiety generally provoke unpleasant feelings and worries. As a result, the targeted audience may not want expose themselves to such messages and want do not want to have these feelings.

Particularly young people may have a feeling of invulnerability and would rather deny or moderate feelings of fear than to look for solutions seriously. Programmes should therefore combine fear-based information (e.g., on HIV/AIDS) with education and skills training about how to people are able to prevent it (e.g., about preventive measures).

'Human rights are the expression of those traditions and tolerance in all religions and cultures that are the basis of peace and progress. Human rights are foreign to no culture and native to all nations.

It is never the people who complain of human rights as a western or northern imposition. It is too often their leaders who do so. You do not need to explain the meaning of human rights to an Asian mother or African father whose son or daughter has been tortured or killed. They understand it - tragically - far better than we ever will.'

Kofi Annan

3.4 Sexual and reproductive rights

All young people around the world, regardless of their religion or culture, have sexual and reproductive rights. The rights-based approach serves the real needs of young people by involving them, which increases effectiveness and sustainability of policies and programs. This approach provides the necessary and legitimated freedom to meet the sexual and reproductive health needs of young people and not necessarily the needs as perceived by adults.⁴⁸

This section addresses the origin and meaning of sexual and reproductive rights of young people, as well as the main barriers in implementing these rights in policies and interventions.

3.4.1 Human rights

A rights-based approach on the sexual and reproductive health of young people is based on internationally agreed human rights, starting with the ‘*Human Rights Agreement*’ in 1948, stating that all people have a right to live with education, health care, protection, support and freedom of expression.⁴⁹ The underlying concept of a rights-based approach is investment in young people’s assets and protective factors instead of moralising and warning them. The assumption is that young people’s well being can be most effectively achieved by empowering them and strengthening their capabilities, enlarging access to opportunities and services and providing them with safe and supportive environments.⁵⁰ A rights-based approach facilitates young people in taking control over their own sexual and reproductive life and in mastering self-reliance.

3.4.2 International agreements

‘Young people’s sexual and reproductive rights’ has been a much-discussed topic, amongst others on international conferences, which has lead to various international conventions and the inclusion of SRH&R in the Millennium Development Goals.

Box 3.4 Definitions Sexual and Reproductive Rights

Reproductive Rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.⁵¹

Sexual Rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:⁵²

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services
- seek, receive and impart information related to sexuality
- sexuality education
- respect for bodily integrity
- choose their partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not, and when, to have children
- pursue a satisfying, safe and pleasurable sexual life

Conventions on sexual and reproductive rights

In 1989, the Convention on the Rights of the Child (CRC) introduced a rights-based approach towards the sexual and reproductive health of young people. 191 governments worldwide have signed and approved the CRC. They bound themselves to respect and promote young people's sexual and reproductive rights and to ensure that all children and young people below the age of 18 years survive, grow, are protected and participate as active members of society.^{53;54}

The following UN conventions reinforced and further elaborated on the rights of young people: the International Conference on Population and Development (ICPD, 1994), ICPD +5 (1999) and ICPD +10 (2004), UN Women's Conference in Beijing (1995), Being+5 (2000) and Being+10 (2005). These conferences contributed to agreements that today, young people are recognised, internationally, as sexual beings that have a right to self-determination, education and information, youth friendly services, protection and participation.⁵⁵ See Box 3.5 for an overview of conferences and conventions.

By signing these conventions, almost all governments worldwide have committed themselves to expand adolescents' access to reproductive health information and services, to promote young people's well being and to promote social equality and sustainable development for the twenty-first century.

Box 3.5 Conventions and conferences

Year	Conference/ convention	Themes
1948	Universal Convention of Human Rights	Human rights
1989	Convention on the Rights of the Child (CRC)	Introduction of rights based approach towards SRH of young people
1994	International Conference on Population and Development (ICPD) in Cairo (by UNFPA)	Shift from family planning (population reduction) to sexual and reproductive rights (own decision making) Acknowledgement of: - young people as sexual beings - young peoples right to self-determination, education, health care, protection and involvement in policies and programs targeting them
1995	UN Women's Conference in Beijing	Reinforcement of ICPD 1994
1999	ICPD +5 (in Den Haag, the Netherlands)	Reinforcement of ICPD 1994
2000	Beijing +5	Women's status
2000	8 Millennium Development Goals (UN)	SRH&R not explicit, but part of some of the goals; to be accomplished in 2015; overall aim is poverty reduction and promotion of people's well-being

Millennium Development Goals (MGD's)

Today, the commitment of governments is reinforced in the Millennium Development Goals (MDG's), set by the UN with all 191 Member States for the period up to 2015.⁵⁶ The 8 MDG's (see Box 3.6) aim at poverty reduction and the promotion of people's well being by the end of 2015 and includes, in some of its goals, the improvement of the Sexual and Reproductive Health of men, women and young people.⁵⁷

Millennium Development Goals and SRH&R

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. **Promote gender equality and empower women**
4. **Reduce child mortality**
5. **Improve maternal health**
6. **Combat HIV/AIDS, malaria and other diseases**
7. Ensure environmental sustainability
8. Develop a global partnership for development

To achieve the MDG's, a particular focus on HIV/AIDS, gender equality and women's empowerment is required. International forums state that in order to meet the MDG's it is required to make sexuality and reproductive health education a mandatory part of primary and secondary school curricula worldwide.

3.4.3 Young people's rights

The International Planned Parenthood Federation (IPPF) has defined sexual and reproductive rights specifically designed for youths in accordance with the international Human Rights Laws.⁵⁸

Central in the rights of young people is the right to take own, well-informed decisions on sexuality. Young people need to get information about the changes they go through during adolescence, the risks the face, and the rights they have when their government has signed these rights.

In case of any problem or concern, young people need to have access to accessible, affordable and confidential sexual and reproductive services, which are youth-friendly and provide counselling, contraceptives and condoms.

In addition, young people need to have the means to protect themselves and their partner and be protected, especially against sexual abuse. Finally, to ensure that policies, programs and services meet the real needs and rights of young people, young people must be part at all levels of decision making, empowering them to become active members of society.⁵⁹

A rights-based approach emphasises equal treatment of both males and females (gender), of people living with HIV/AIDS, people who have (had) a sexual health problem, and people with a different sexual orientation; and it encourages action if rights are violated (for example in case of sexual abuse or discrimination).

- **Right to be yourself:** free to make your own decision, to express yourself, to enjoy sex, to be safe, to choose to marry (or not to marry) and plan a family
- **Right to know:** about sex, contraceptives, STI's, HIV/AIDS and reproductive and sexual rights
- **Right to protect self and be protected by others:** from unplanned pregnancies, STI's, HIV/AIDS and sexual abuse
- **Right to have access to health services:** which is confidential, affordable, good quality and given due respect
- **Right to be involved:** in planning programmes with and for youth, attending meetings/seminars etc. at all levels and trying to influence governments through appropriate means

Many actors are responsible for the actual implementation of rights. It requires an equal working relationship; with amongst them national governments, organisations that serve young people, and, of course, young people themselves.⁶⁰ Relying and acting on rights is entangled with respecting the rights of others. The right to take own decisions implies that the decision protects the rights of others, including friends, partner, parents, family or community. Own decision-making means taking responsibility, and encompasses taking the expectations of relevant others into account.

UNFPA refers to this balance as the ‘reciprocal relationship between rights holders and duty bearers’ (see Box 6).⁶¹ There is a critical distinction: a *need* not fulfilled leads to dissatisfaction. In contrast, a *right* that is not respected leads to a violation, and its redress or reparation can be legally and legitimately claimed. A human rights-based approach to programming differs from the basic needs approach in that it recognises the existence of rights. It also reinforces capacities of duty bearers (usually governments) to respect, protect and guarantee these rights.

3.4.4 Barriers in adopting and applying a rights-based approach

In many countries, the sexual and reproductive health of young people is considered to be a problem, especially in countries that face high numbers of young people who get infected with HIV/AIDS. Sexual and reproductive health, however, is for many people also a sensitive subject to talk about and is therefore often surrounded with taboos.

This often results in programs and policies to address this ‘problem’ that are developed by adults and often view young people as exclusive recipients of the services offered, instead of seeing them as actors. A top-down approach however, does not effectively reach young people, especially those who are sexually active, having many and urgent needs and being most at risk for the negative consequences of sexuality. Only when they are perceived as social actors within their own rights, young people can be reached effectively.

Barriers

The main barriers for empowering young people to make own decisions on their sexual life are the lack of support by policy makers and program developers, insufficient trust of adults in young people’s capabilities and the tendency of adults to control young people’s sexual life as the best strategy to dissuade them from becoming sexually active and thus to prevent sexual health problems among youth. However, taking the prevalence of the sexual health problems among youth into account, this strategy does not seem to be effective.

Many adults are reluctant to give young people the freedom to take their own decisions. They may fear that young people abuse the power that is given to them, and that young people will be vulnerable for various health risks. Evidence however shows that sexuality education that focuses on own decision-making does not lead to earlier or increased sexual activity among adolescents, and can even result in safer sexual behaviour.⁶²

In addition, many countries fail to implement the ICPD agenda and its rights-based approach due to their inability to effectively match this agenda and approach with dominant religious and cultural norms in many communities concerning sexuality, sex before marriage, use of condoms and contraceptives by unmarried young people, abortion, family planning, masturbation and homosexuality.

The reciprocal relationship between rights holders and duty bearers



Religion and rights

When we take a closer look at the relation between religious approaches and the rights based approach, there seems to be a contradiction between the two.

The rights based approach at the one hand proclaims the freedom of speech and belief and freedom from fear as the highest aspiration of all human beings.⁶³ In other words, all human beings are free to have their own opinions and to take their own decisions.

Many religions, at the other hand, are based on one truth that is based on the Bible, Koran, other writings, or on religious institutions or leaders. This truth often indicates what is right or wrong. Doing so, many religions, implicitly, say that norms, values and behaviour that are not according this truth, are not 'right'. They often condemn the opinions and decisions of people who do not live according their 'right' principles. This approach conflicts the rights based approach.

Generally speaking, many norms and values of religions as well as the rights based approach overlap. It is striking however, that these approaches differ tremendously, especially with regard to values and norms about sexuality.

It has to be noted that we address religions and approaches and not necessarily the actual implementation of these religions and the rights based approach. Within religions and cultures, the meaning of sexuality and reproduction differs not only from country to country but also from person to person. And sometimes the religion in itself is not in accordance with the way it is communicated and practiced by religious communities.

Ideology and evidence

The relation between religion/ cultures and rights also concerns the conflict between 'what would be the ideal world' and what actually takes place. A religion may have the norm that people should only have sexual intercourse within a faithful marriage.

Evidence however shows that this is far from what actually happens: many young people are sexually active before they get married, and many married people are not faithful to their partner.

As we have seen in the figures above, this results in terrifying numbers of people who get sick or die from AIDS, or suffer from consequences of unwanted pregnancy, unsafe abortions and sexual abuse. It would not be ethical to ignore what actually takes place by focusing on ideology only. From an ethical perspective, we have to act and for example guide sexually active young people by providing them with the necessary skills, information and services to make healthy and responsible decisions. Religious leaders can take a lead in this guidance, quoting the South-African Archbishop of Cape Town in 2003, Njongonkulu Ndungane:⁶⁴

*“The church is made up with young people who, like Jesus, are full of energy and passion, in love with life. But we fall short in our efforts to guide and support them in their desire to express and experience love. Love and sex, which are the very essence of creation of God’s gift to all his creatures, are shrouded in guilt, ignorance and taboo”.*⁶⁵

3.4.5 Health promotion and the rights based approach

Health promotion aims at the improvement of quality of life and health of people, by focusing on behaviour change of people at risk, and by creating a supportive environment for healthy behaviour. In the context of health promotion, the rights-based approach empowers young people in voluntarily taking own decisions and standing up for their decisions, and mobilises young people to generate environmental support for their decisions.

By making young people aware of their rights, young people can rely and act on these rights. Rights can improve young people’s self esteem and support them to expect respect for their rights from people around them. Policies and programs, which acknowledge sexual and reproductive rights, then aim to enlarge young people’s access to opportunities, education and health services.

The strength of integrating a rights-based approach within health promotion is the reinforcement of the importance of voluntariness of making own, well-informed decisions. In health promotion, sexual and reproductive rights may be an additional tool for facilitating a supportive environment, which enables the adoption and implementation of health promoting behaviours. The rights-based approach can then be the tool to convince key figures in this environment to acknowledge young people as sexual beings, decision-makers and social actors in their own right. A rights-based approach serves in this way not only to bridge value systems between generations, but also to give young people an active role in making this environment youth-friendly and more effective in improving the quality of life of the young people living within this environment.



Annex 3.1 Concepts/ definitions related to sexuality and SRHR

Topic	Definition
Abortion	Planned pregnancy is wonderful and most women who get pregnant will give birth to their child after 9 months. However, some women do not want to be pregnant for different reasons and want it to stop. This can be done by an abortion : the unborn child is removed from the body and will die. Imagine that a girl of your age gets pregnant and wants to stop her pregnancy.
Abstinence	Not engaging in those sexual activities which can put a person at risk for of infections or pregnancy
Anal intercourse	Penetration of the female or male anus by the male penis
Caressing	To touch or kiss someone in a gentle and loving way.
Chlamydia	A sexually transmitted infection caused by bacteria that often has no symptoms. When symptoms occur, they can include burning during urination, discharge and bleeding during intercourse for girls. For guys, pain during urination and a watery discharge are common symptoms. Chlamydia can cause to preventable infertility and ectopic pregnancy since it can cause scarring and damage to the female reproductive system if it is not treated early. Because Chlamydia is a bacterial infection, it can easily be treated with antibiotics.
Contraceptive	Methods used to prevent pregnancy. Examples are condoms, the (oral) pill, and injections.
Condom	Do you agree on this: A sheath of latex rubber worn on the erect penis just before intercourse
Deep kissing	Kissing somebody on the mouth, using lips and tongue as an expression of love and passion
Ejaculation	The release of semen containing sperm cells (if the man is not sterilised) from a man's penis. Rhythmic contractions in males that propels the semen out of the penis in spurts.
Erection	When the penis is being filled with blood and becomes hard and stiff as a result of feelings of sexual excitement, or just spontaneous.
Family planning	Family planning means planning how to improve the quality of family life: It includes: <ol style="list-style-type: none"> 1. Taking decisions on regulating and spacing childbirth 2. Choosing suitable methods of contraception. 3. Helping childless couples to have children. 4. Counselling of both parents and would-be parents. 5. Developing parenting skills, social skills and family budgeting skills.
Flirting	To behave as if (sexually) attracted to someone, although not seriously.
Fondling	To touch gently and in a loving way, or to touch in a sexual way
Gender equality	Gender equality means equal treatment of women and men in laws, and policies and behaviours, and equal access to resources and services within families, education, health services, communities and society at large.
Genitals	The external sexual body parts. <ul style="list-style-type: none"> • In females they include the labia majora (outer lips), labia minora (inner lips), clitoris, mons pubis (a soft mound covered with pubic hair) and vestibule (where the urinary and vaginal opening are found). • In the male the genitals are the penis, and the scrotum, and the mons pubis.
Gonorrhoea	A sexually transmitted infection that causes discharge from the vagina or penis. Symptoms in men include a discharge from the penis, pain during urination, and increased need to urinate. For women, there may be a discharge from the vagina, but many women (and some men too) will not have any symptoms. Gonorrhoea is caused by a bacteria, and can easily be treated and cured with antibiotics. Also referred to as "the clap" or "the drip."
HIV	The Human Immunodeficiency Virus causes AIDS (Acquired Immunodeficiency Syndrome). The virus weakens a person's immune system so that a person can't fight off everyday infections. HIV is transmitted from exposure to an infected person's blood, semen, vaginal fluids or breast milk

Topic	Definition
Homosexuality	Most people fall in love and like to have sex with someone of the opposite sex. Some people fall in love and like to have sex with their own sex. This is what we call homosexuality . This means that males are sexually and emotionally attracted to males and females to females.
Kissing	To touch or caress with the lips as an expression of affection, greeting, respect, amorousness and love.
Lover	Your boyfriend, girlfriend, or (other) people you do sexual activities with.
Masturbation	Playing with your genitals for sexual pleasure. Masturbation can lead to an orgasm (girl) or ejaculation (boy)
Mutual masturbation	Playing with the genitals of another person. This can lead to an orgasm or ejaculation
Oral sex	Licking or sucking the other's genitals
Orgasm	A highly pleasurable, climactic response during sex, the peak of sexual pleasure, that is the result of a complex interaction of physical, emotional and hormonal factors. In men it is usually at the time of ejaculation. Multiple orgasms mean having several orgasms within a short period of time.
Petting	If two people are petting, they are kissing and touching each other in a sexual way heavy petting: when two people kiss, hold and touch each other in a sexual way, but do not have sexual intercourse
Pills	(contraceptive Pills, family planning Pills, birth control Pills) A method of contraception that prevents the monthly release of an egg from the woman's ovaries. Each pill contains a small dose of hormones that prevent ovulation (the release of an egg). The pills must be taken every day, except for the period you do not take the pill in the 'stop-week', in which there will be a menstruation. Does not prevent STIs, including HIV.
Sexual activities without having sexual intercourse	Often, when people have sex, they have sexual intercourse. But it is also possible to have sex without intercourse, but to practice other activities, such as kissing, deep kissing, fondling, petting, oral sex, mutual masturbation
Sex	The act of having sexual activities - such as mutual masturbation, petting, oral sex and vaginal or anal intercourse.
Sexual abuse	Any type of unwanted sexual contact, touching or fondling.
Sexual harassment	Any type of unwanted sexual attention, such as unpleasant sexual comments or physical gestures.
Sexual intercourse	By sexual intercourse we mean penetrative sex: penetration of the anus or vagina by the penis
Sexual orientation	A sexual preference or choice (heterosexual, homosexual, or bisexual) that determines whether one chooses a member of the same or the opposite sex, or both, for sexual satisfaction.
Sexually transmitted infections (STI)	Sexually transmitted infections (STI) can be spread from person to person when they engage in sexual intercourse. HIV is one of the STIs. In addition to HIV, there are also others, such as Chlamydia, Gonorrhoea or Syphilis.
Syphilis	A sexually transmitted infection that causes small sores in the genital area. Later stages are marked by fever, headaches, and pain in the bones and muscles. Syphilis is caused by a bacteria, and can be easily cured with antibiotics.
Vaginal sexual intercourse	Penetration of the female vagina by the male penis
Withdrawal	An unreliable method of birth control that occurs when a guy pulls his penis out of his partner's vagina just before ejaculation. It is not recommended at all, but it's better than not using any method of birth control. Also known as "pulling out" or "coitus interruptus."

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4. IM Step 1. Involvement of Relevant Stakeholders

Where are we in Intervention Mapping?

The first step in Intervention Mapping is involving all relevant stakeholders in intervention planning, such as young people, teachers, schools, parents and the wider community, and all other people who are in one way or another connected to the programme. This step is crosscutting through all the other steps of intervention mapping. The aim is to get those people on board who are influential in programme implementation and adoption, and can assist in the development of an effective programme.

Steps in Intervention Mapping

1. Involvement
2. Needs Assessment/ Situation Analysis
3. Objectives
4. Evidence-Based Intervention Design
5. Adoption & Implementation
6. Monitoring & Evaluation

One condition for successful intervention development is the participation of and collaboration with various stakeholders, including the target population (young people), users of an intervention (teachers, educators), decision- and policymakers, parents, community members, relevant organisations to collaborate with; program designers/curriculum developers; trainers, experts, and creative sources and producers.

Health promotion is based on the philosophy of 'community participation'. Talking and listening to people, freely sharing information and feedback on program progress will improve participation, consensus and trust in the process. This enhances the chance that goals will be achieved.

Participation is required to bring multiple perspectives to look at a problem and to create the most intelligent, productive and acceptable consensus possible. Ongoing interaction between programme planners, researchers, potential program users and participants is necessary for planners to fully understand and convey the 'real world' program context.

For many people all over the world, sexuality is a controversial topic. People may have very strong and sometimes different views on sexuality and AIDS prevention/ sexuality education in schools. Intervention planners therefore have to involve key decision-makers as early as possible and they need to have skills and knowledge to sensitise and communicate with them to convince them.

Involving key stakeholders increases ownership of the intervention, the feeling being taken seriously, and having the opportunity to give advice or comments. Involving key stakeholders from the start of the project may increase their commitment to the project and in turn can add to sustainable implementation.

Involvement can differ for different groups of people and can have various purposes. Planners have to give very clear instructions to certain people (e.g., designer of specific activities), have to have clear agreements on ownership (e.g., teacher trainer, curriculum developer), or with others they have to negotiate and come to an agreement (e.g., with policy makers, decision makers in school/ political level), or give people information or exchange ideas and values (e.g., parents, community leaders). In this chapter, some suggestions are given as how to approach, involve or collaborate with specific groups of stakeholders. But first, the team has to be established who will be responsible for intervention planning.

Tasks in Step 1

Task 1.1	Establish the planning team
Task 1.2	Conduct stakeholder analysis and set up linkage system
Task 1.3	Create community awareness
Task 1.4	Establish the advisory board
Task 1.5	Establish the working group(s)
Task 1.6	Plan involvement in the Intervention Mapping steps

4.1 Task 1.1 Establish the planning team

The spiders in the web of project planning is a planning group (or project team) of a small number of people, who guide and plan intervention development. Ideally, the planning group consists of a combination of: 1) members of research & development departments or universities or research institutions; 2) specialists in theories of behaviour change; 3) specialists in young people's SRHR; and 4) specialists in intervention development (e.g., developer of materials and activities).

Having the right people on board has proven to be one of the key conditions for successful intervention planning.¹ Sometimes it is difficult to employ people who can do the project, or to find a good combination of people in the project team. Of course it depends on the scope of the project who should be part of the team. In a more research-focused project, there will be more researchers and academics involved than in a project on a smaller scale which is more practical.

Box 4.1 Example - Tasks of the planning team

In a project in Uganda, aiming at development of an education and counselling package for HIV positive young people, the project team consists of a balanced mix of people. There are some researchers involved of Population Council, a lecturer on behaviour change theories of Makerere University, and a number of trainers and field workers of TASO (support organisation for people living with HIV/AIDS) and Mildmay (a clinic for people living with HIV/AIDS). As a team they have conducted the needs assessment/ situation analysis and are in the process of developing the interventions, based on the conclusions of the research.

One of the tasks of the project team is to involve other relevant stakeholders and experts when needed. The planning group can not do the project on their own. They need the involvement and participation of a number of stakeholders, including young people, educators/ facilitators (e.g., teachers, peer educators, counsellors, health care providers, community workers), relevant stakeholders from communities and organisations (e.g., school governing body, parent-teacher association, community leaders, traditional leaders, religious leaders, health care, youth clubs), and specialists in intervention material development (e.g., curriculum developers, artists, writers).

Worksheet 1.1 can assist planners to document the roles of the project team and to identify each member's roles and responsibilities.

Another task of the team is to create commitment for the project within the own organisation. It may be more difficult to get commitment in a large organisation with set priorities and policies than in smaller organisations. This was also our experience in MAIN PHASE in India. It requires sometimes

advocacy for the project in the own organisation, to make sure that employees have sufficient time and resources to do the project. The team keeps relevant colleagues involved and/or updated. In the next sections we further describe what can be expected from the various planning team members. Table 4.1 provides a summary of the tasks of each of the team members.

4.1.1 Project coordinator

The design, implementation and evaluation of an intervention require different people at different stages in the process, making management and planning very important tasks of a project coordinator. In most organisations, a project coordinator is primarily responsible for the planning and implementation of an intervention. The project manager is the person in the team who has some influence on policies in the organisation and on staff of the organisation. His or her tasks include amongst others to create awareness and commitment in the own organisation, influence decision-making in the own organisation with regard to the project, involve stakeholders, and organise internal team meetings with the researcher and research assistants. Finally, the project manager translates research results into guidelines for organisational messages and interventions.

4.1.2 Research experts

Preferably, the researcher has experience with conducting research, such as conducting focus group discussions, analysis of data, both qualitative and quantitative and reporting. The level of research may vary for each organisation.

The researcher has to be involved from the start until the end. It is crucial that this person has sufficient time to coordinate or conduct the research. In case the researcher decides to work with research assistants, the researcher is also responsible for the training of the assistants so that they are able to conduct data collection such as a literature search and interviews.

The researcher can also be involved in conducting the monitoring and evaluation of the project and interventions.

In case research capacity is not available in the organisation, the organisation may decide to appoint a researcher for the duration of the project or outsource the research to a research institute. Otherwise, the organisation may have a professional who is having affinity with research and is willing to do this job. It depends on a number of decisions of an organisation, how much time should be allocated for the researcher. This depends, amongst others, on the scope of the research (e.g., number of interviews, focus group discussions, literature review), and whether the research is outsourced or conducted by own staff.

Depending on the scope of the SA/NA, planners may involve a number of *research assistants* to collect the information, i.e., to do a literature search, facilitate the group discussions or interviews with young people. The research assistants should be trained to be able to understand the comprehensive concept sexuality and to talk with respondents about sensitive issues. The research assistants are most likely involved for about 2 months. Depending of the scope of the research, it may be useful to involve 2-4 research assistants (male and female).

4.1.3 Experts in young people's SRHR

In addition to the experts in research, the team should also consist of people who have experience in working with young people, and particularly on their sexual and reproductive health and rights. It is not always necessary to have experts in house, but it is also possible to involve experts from organisations that work from a rights-based approach towards young people's sexuality. Tasks of the

SRHR expert can include the training of others in open communication about sexuality; and provide input in various phases of intervention planning with regard to the approach and content.

4.1.4 Experts in intervention development

It is also advisable to have someone on board who is experienced in the actual development of materials for the target groups. For instance, someone who has expertise in designing interventions or writing student materials. It is also possible to not include this person in the team, but involve her or him from the start of the project, so that he or she is aware of the objectives and the actual needs of young people and other actors. Another task of intervention developers is to stay in touch with all kinds of people who develop the materials, such as writers, artists, or script writers.

4.1.5 Specialists in theories of behaviour change

Particularly for the design of theory-based interventions, it is useful to have someone in the project team who is familiar with health promotion and social-cognitive theories, such as the Social Cognitive Theory of Bandura and others. This can help in designing interventions that are effective in changing determinants, behaviour and environmental factors.

Table 4.1 Tasks of the planning team

Involved team member	Tasks
1. Project manager	<ul style="list-style-type: none"> · Create awareness in the own organisation · Create commitment of the organisation for this project · Influence decision-making in the own organisation with regard to this theme · Involve the stakeholders (an Advisory Board and Working Group) · Organise internal team meetings with the researcher and research assistants · Translates research results into guidelines for organisational messages and interventions
2. Research experts	<ul style="list-style-type: none"> · Conduct the SA/NA · Develop the tools · Coordinate data collection · Analyse the data · Incorporates the input from AB and WG · Involve relevant others · Train the research assistants · Write the report · Helps to translate research results into guidelines for organisational messages and interventions
3. Experts in young people's SRHR	<ul style="list-style-type: none"> · Provide training on SRHR and sexuality · Provide input on the content and approach in intervention planning
4. Experts in intervention development	<ul style="list-style-type: none"> · Design the intervention · Write intervention materials · Stay in contact with writers, artists
5. Specialist in behaviour change theories	<ul style="list-style-type: none"> · Provide input on effectiveness of interventions · Provide input on behaviour change theories

4.2 Task 1.2 Conduct stakeholder analysis and set up linkage system

To find out whom to involve or to collaborate with, a *stakeholder analysis* can provide a lot of information. A stakeholder analysis is a technique to identify and assess the importance of key people, groups of people, or institutions that may significantly influence the success of intervention planning. A *stakeholder* is an actor who has a vested interest in a given product, activity or issue.

Various categories of stakeholders can be distinguished related to sexuality education in schools:²

- *primary stakeholders*: young people in school
- *implementers*: teachers, health service providers
- *policy makers*: government, school administrators
- *gate-keepers*: parents, community leaders
- *donor agencies*
- *peers and reference groups*: young people, in and out of school
- *sources of information*: similar past and current projects, organisations

4.2.1 Stakeholder analysis

A stakeholder analysis can be accomplished by identifying people, groups, and institutions that will influence the project (either positively or negatively); to anticipate that influence; to develop strategies to get the most effective support possible for the project and reduce any obstacles to successful implementation of the program; and to get an overview of the organisations in the local country or region that deal with sexuality education for young people in schools, including their policies and plans.

The next step is to make an ‘organisation chart’ and map out all people and organisations that are relevant to be involved in any stage of intervention planning. Relevant questions to guide this are ‘Who do you need to get consent from to do your project (e.g., authorities)?’, ‘Who can help you in specific tasks within the process (e.g., curriculum development, teacher training, implementation, data collection, etc.)?’, ‘Who can take over diffusion of the program (e.g., Ministry of Education, trainers of teachers)?’, ‘Who have experience in doing a project like this and can advise you (e.g., other NGOs, universities, etc.)?’, ‘From whom do you need support if you want to implement the intervention (e.g., parents, school management)?’. See Table 4.2 for an example of various stakeholders in school-based sexuality education.

Intervention planners need to know each stakeholder’s authority, responsibilities, availability, and possible role in the project. In a stakeholder analysis, planners map out their characteristics (e.g., attitudes, structure of the organisation, status), their interest and expectations (e.g., rewards, ownership), sensitivity to and respect of cross-cutting issues (e.g., how do they see promotion of condom use among young people), their potentials (e.g., knowledge, influence) and deficiencies (e.g., lack of time), and the implications and conclusions for the project (e.g., are you willing to work with them, what are the conditions, what are the agreements).

4.2.2 Linkage system

Participatory planning is in Intervention Mapping operationalised in a ‘linkage system’^{3;1}, consisting of a number of entities (e.g., planning group, working group, advisory board, experts) that together design the intervention programme.

Table 4.2 Stakeholders in school-based sexuality education projects⁴

Primary stakeholders	Interest
Young people	<ul style="list-style-type: none"> · Have reliable information · Increase knowledge and develop skills and values on SRHR · Gain improved access to SRH services · Gain improved services · Prevent diseases, abortion and unintended pregnancy · Increase contraceptive choice · Increase control over SRH decision-making · Increase parental awareness · Improve gender specific constraints · Promote equality among boys and girls
Secondary stakeholders	Interest
Teachers	<ul style="list-style-type: none"> · Increase knowledge and skills in working with young people · Create better dialogue with pupils on sexuality · Develop positive attitudes towards young people's sexuality
Health workers	<ul style="list-style-type: none"> · Promote safer sexual behaviour · Promote responsible parenthood · Ensure access to services · Promote informed choices · Improve quality of SRH health care
School directors	<ul style="list-style-type: none"> · Support quality of life of students · Develop sexuality education within the school curricula · Use relevant surveys to measure progress in education
Key stakeholders	Interest
Parents	<ul style="list-style-type: none"> · Have better dialogue with their children · Contribute to positive choices and decisions in young people's life · Be more aware of age-related sexuality education
Ministry of Education	<ul style="list-style-type: none"> · Develop education curricula · Integrate sexuality education in schools · Develop legislation
Ministry of Health	<ul style="list-style-type: none"> · Prevention sexually transmitted infections including HIV · Reduce health risks · Improve services · Improve family life education
Local authorities	<ul style="list-style-type: none"> · Support healthy lifestyles of young people · Improve quality of life for young people · Increase local resources
Community leaders	<ul style="list-style-type: none"> · Integrate sexuality education within the school curricula · Support media involvement · Increase appreciation of parents, teachers, health workers
Religious and social groups	<ul style="list-style-type: none"> · Opposition against sexuality education for young people
Non-governmental organisations	<ul style="list-style-type: none"> · Support innovative projects · Build partnerships with Family Planning Associations and others · Provide technical assistance
Media	<ul style="list-style-type: none"> · Sensitise the public and raise awareness about SRHR · Announce and participate in events

The essence of a linkage system is that all parties match their needs and wishes at an early stage of the development process. This contributes to a match with the needs of the community, implementers and decision makers, and increases the chance that the final intervention will be implemented successfully. At best, a linkage group includes a so-called 'program broker', a well-respected representative of the user system who strongly favours the programme and its implementation.

A linkage system has two important benefits. At first, interventions are developed in a way that they are readily replicable and sustainable within the organisational and cultural contexts within which they are to be used.⁵ Secondly, plans for diffusion and adoption are well advanced when trials demonstrate the effectiveness of interventions.

4.3 Task 1.3 Create community awareness

In particular contexts it may be needed to first create community awareness, before anything else. For example, to make sure that a NA/SA can be done. In the MAINPHASE project in India, it turned out that the organisations first had to do a community awareness campaign. The organisations had taken up the topic of sexual and reproductive health and rights for first time and mainstreamed it in their ongoing programmes, particularly education projects. The communities where the organisations work, were not much aware of AIDS and sexuality related health issues.

The topic of sexuality being a sensitive issue in most Indian communities where the organisations work, all organisations felt that they first had to build up or build on existing rapport with the communities. This was done by organising awareness meetings with the community as a whole and organising meetings with particular groups within the community, such as local leaders. Only after the general awareness raising, it was possible to conduct the needs assessment/ situation analysis.

In order to point at the right topics, planners may consider to first get a good idea of what community members know, value and find important. In other words, they conduct a very brief needs assessment. This can be done by having some conversations with key informants and community leaders. When planners have a good idea about the needs of the community with respect to creating rapport and commitment, they can develop a small scale intervention.

4.4 Task 1.4 Establish the advisory board

An important task in involvement is the establishment of the advisory board (AB). This entity can contribute tremendously to the success of the implementation and up scaling of the intervention. The AB has an advisory role throughout the development and pilot of the curriculum and is expected to lobby and gather support for the project and assist in further dissemination once the CD ROM and additional materials are finalised.

Commitment of relevant authorities increases the likelihood that the intervention will be adopted and implemented according plan. An advisory board can be established at a national level, but can also be established at a local (e.g., village) level. This depends on the purpose of establishing the board. In some projects advisory boards are established on both levels.

Examples of relevant authorities for school-based SRHR education programmes are:⁶ national and/or local representatives of the Ministry of Education, Ministry of Health, Family Planning Association, UNFPA, UNESCO, UNICEF, National AIDS Committee/organisation, school management/ administration/ principals/ governing bodies, clinic directors or directors of local youth-based organizations, community organisations, community, traditional & religious leaders, parents, parent - teachers associations.

The board is officially established during a kick off meeting and the AB-members are invited to participate in periodical meetings. The role of an AB is to advise the planning team at particular points during the design and implementation of the intervention, and to use their status nationally or locally to influence decisions in favour of the programme. They can create a supportive environment by informing relevant stakeholders so that the programme can be developed and implemented. Their comments, remarks and advice however are not binding.

The lessons learned from previous projects are that it is very important to have clear expectations of the Advisory Board and to communicate this with them from the start. If you expect them to provide detailed feedback on the intervention materials, you may have to select other members than when you expect them to advocate on a national level for the programme. This also includes clear expectations with regard to acknowledgement and rewards. Equally important is to clarify with the board what their status is. For example, who decides at the end about the content of the intervention.

One of the major constraints is the turnover or lack of commitment of the AB members. It may be nice to have a director of an important organisation in the board, but if he or she is too busy to attend the meeting, you may think of giving that person another role and select someone instead who can spend time on the project. See Box 4.2 for the selection criteria used in a project in Indonesia.

Box 4.2 Example of the Advisory Board in WSWM project Indonesia

In the World Starts With Me (DAKU!) project in Indonesia, the following criteria were used in the selection of the AB-members:

- Preferably representatives that agree with the starting points of WSWM (i.e., rights-based approach, youth participation, comprehensive sexuality education, positive approach)
- Committed and having enough time to participate
- Balanced number of female and male participants

The AB was requested to attend at 3 meetings: 1. to discuss the intervention outline (3 hours); 2. workshop to discuss the first draft; 3. meeting to discuss the pilot results - and suggestions for adaptations.

4.5 Task 1.5 Establish the working group(s)

One of the ways to increase the quality of interventions is by involving young people from the start of intervention planning at relevant points of time. The quality and particularly the extent to which the programme is implementable and adoptable can be increased by involving the implementers or users of the programme from the start. In this manual we call them working groups. Sometimes it is

possible and has additional value when the users (e.g., teachers) and target group (young people) are part of one group. In other settings it is advisable to have separate working groups for youth and teachers.

4.5.1 Working group young people

Programmes that are developed ‘behind the desk’ of programme planners are less likely to be effective than programmes that developed in close collaboration with the users and beneficiaries (educators and young people). One way to do this is by setting up a ‘working group’ of young people that provides feedback and input at relevant points of time. A working group is established to ensure that there is input of young people at each stage of program development. Lack of involvement of young people may result in an intervention that does not fit with the reality of young people, includes activities they do not like, or a program that is too difficult.

The working group consists of a group of young people that is frequently informed and consulted, basically to provide feedback on the attractiveness of program components, on the link with their perceptions of life and youth culture. It is suggested to set up a group of different young people, representing the target population (e.g., both boys and girls, if needed both urban and rural).

Box 4.3 Example of a Working Group in WSWM project Indonesia

In the World Starts With Me (DAKU!) project in Indonesia, the following criteria were used in the selection of the Working Group members:

- healthy
- disciplined
- committed
- able to use a computer
- communicative
- enthusiastic
- respect other people’s opinion
- committed to follow the whole course
- open-minded and able to keep the privacy of others
- preferably balanced number of male and female
- representing the target group of WSWM
- active and creative

The working group is involved in planning of the intervention programme, during the NA/SA and the interpretation of conclusions, intervention design (including pre-testing), and planning of the implementation. Involving young people during the design of the intervention programme is one way of youth participation. See Box 4.4 for more information about the background and degrees of youth participation.

4.5.2 Working group facilitators

The involvement of the implementers of the program (teachers or health service providers) from the start is conditional to create their ownership and avoid the development of an intervention teachers do not feel comfortable with teaching (e.g., activities they do not like), that it is written in a language they are not familiar with, and that it does not fit with the goals they have to accomplish with their students.

It is advised to set up a (representative) working group of facilitators and consult them regularly during the project, especially at critical moments, for example to decide which topics are included in the program, certain activities, ideas about implementation, and production of the teacher instructions.

Youth participation

Youth involvement not only contributes to the efficacy of programs, policies and services targeting young people,⁷ it is also one of the sexual and reproductive rights young people have. The right to youth participation was introduced by the CRC in 1989 and reinforced during conferences such as the ICPD (1995).

Involvement of young people has to guarantee that policies and programs reflect the real needs of young people.⁸

Research and experiences suggest that programs for youth that are developed through a partnership of youth and adults are effective in building young people's skills and reducing their sexual risk-taking behaviours.^{9;10;11} Such programs benefit the youth who help to develop them and also have a greater impact on the young people served.¹² The degree to which young people are involved, can differ and depends on the kind of policies and programs as well as on young people's capacities.

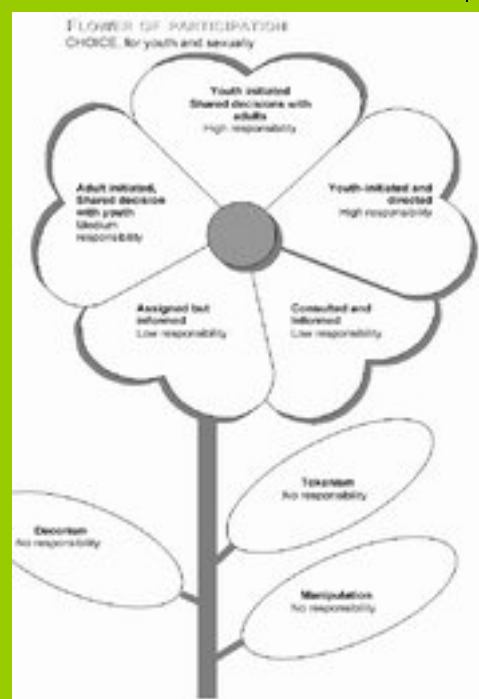
Degrees of participation

The 'flower of participation' illustrates different degrees of youth participation.¹³ The meaningless forms of involvement, including *manipulation*, *decoration* and *tokenism* are represented in the leaves of the blossoming plant, showing the kind of (ab)use of young people in the design of policies and programmes without participation or real influence of young people themselves.

All meaningful kinds of participation are full part of the flower itself, represented in the petals, ranging from low to high responsibility and participation.

Youth participation requires that young people involved are treated as equal partners. In youth-adult partnership, contributions of all young people and adults involved are acknowledged. Genuine and effective youth involvement requires a serious commitment by an organisation and all staff members.

Adults who intend to involve and integrate youth meaningfully into prevention programs will need to examine the organisational structure and culture in which they work in order to identify and dismantle barriers to youth involvement. Moreover, staff must understand and accept that effective youth involvement in prevention programming often means changing rules and practices.¹⁴



Barriers in effective partnership may be the underestimation of young people by adults and the fear of young people not to be taken seriously by adults, especially if cultural norms (i.e., hierarchal relationship between parents and children) are barriers for equity in the power dynamics underlying youth - adult partnership.¹⁵

However, sharing decision power between young people and adults, means that adults have to respect and trust young people's judgement, recognise the assets of youth, understand what youth can bring to the partnership, and are willing to provide additional training and support when youth need it.¹⁶

Young people as advocates

An important role of young people themselves in influencing policies and programs that target them, is their role as advocate. This form of youth participation increasingly gains popularity. Examples are Choice,¹⁷ a foundation of active Dutch young advocates for young people's sexual and reproductive health and rights world-wide; YouAct,¹⁸ a European network of foundations that advocate for the rights and participation of young people; and the Youth Coalition.¹⁹

Youth and adults can work together in a number of ways such as conducting a needs assessment, writing a grant proposal, raising funds, designing a program, training staff, delivering counselling, implementing interventions and projects, overseeing a program, collecting data, evaluating a program's effectiveness, improving unsuccessful aspects of a program, and replicating successful programs.²⁰

4.6 Task 1.6 Plan involvement in intervention planning

Many tasks have to be accomplished in Intervention Mapping (see Table 4.3).²¹ Before starting, the planning team should get a clear idea of people who can optimally accomplish these tasks. Different tasks require different skills and knowledge, such as research-specific, training skills, advocacy skills. Programme planners identify the qualities, qualifications and knowledge of personnel that are required to complete intervention development and implementation.

Worksheet 1.3 can assist planners to document the involvement of various people and groups in the planning of the intervention.

Table 4.3 Involvement in intervention planning

PLANNING PHASE	STAKEHOLDERS	TASKS
2 Needs Assessment/ Situation Analysis	a. Planning team	<ul style="list-style-type: none"> Assess the needs & capacities of young people & their social and political environment Organise involvement other stakeholders
	b. Working group young people	<ul style="list-style-type: none"> Involved in conducting focus groups with young people Start up meeting; training young people's SRHR
	c. Working group teachers	<ul style="list-style-type: none"> Start up meeting; training young people's SRHR
	d. Advisory board	<ul style="list-style-type: none"> Start up meeting; training young people's SRHR
	e. Others Experts in SRHR education, young people's SRHR, schools Researchers & research assistants	<ul style="list-style-type: none"> Provide information and linkage to organisations, schools, young people Assist in the needs & capacity analysis
3 Objectives	a. Planning team	<ul style="list-style-type: none"> Provide lists of objectives focusing on behavioural and environmental outcomes, and relevant and changeable 'change objectives' Ensure objectives are related to (national) educational objectives and young people's rights Get feedback from working groups, advisory board, and other stakeholders Instruct intervention developer(s)
	b. Working group young people	<ul style="list-style-type: none"> Provide feedback and agree with objectives: they need to address young people's needs and rights
	c. Working group teachers	<ul style="list-style-type: none"> Provide feedback and agree with objectives: they can be achieved by educators during implementation
	d. Advisory board	<ul style="list-style-type: none"> Provide feedback and agree with objectives
	e. Others Intervention developer(s)	<ul style="list-style-type: none"> Get involved and understand the objectives of the intervention programme
4 Evidence-Based Intervention Design	a. Planning team	<ul style="list-style-type: none"> Select 'basic intervention programme' Involve experts in health promotion/ behaviour change theories Organise involvement other stakeholders Design intervention programme in collaboration with curriculum developer Clear communication to producers of programme materials Organise involvement other stakeholders

PLANNING PHASE	STAKEHOLDERS	TASKS
	b. Working group young people	<ul style="list-style-type: none"> • Provide feedback on content, scope, lay-out, tone, etc. of intervention • Provide feedback on the selected strategies (class activities and materials)
	c. Working group teachers	<ul style="list-style-type: none"> • Feedback on feasibility of implementation of intervention • Provide feedback on the selected strategies (class activities and materials)
	d. Advisory board	<ul style="list-style-type: none"> • Feedback on intervention programme • Provide feedback on methods and strategies
	e. Others Producers of programme materials (including text writers, illustrators, graphic designers, photographers, video producers, etc.) Experts in 'health promotion' / behaviour change theories	<ul style="list-style-type: none"> • Produce brochures, videos, adds, lesson material, etc. • Assist in making the intervention programme theory- and evidence-based
5 Adoption & implementation	a. Planning team	<ul style="list-style-type: none"> • Organise teacher training • Organise other adoption & implementation activities • Organise involvement other stakeholders (e.g., teacher trainer)
	b. Working group young people	<ul style="list-style-type: none"> • Involved in activities to convince other stakeholders/schools to implement the intervention programme
	c. Working group teachers	<ul style="list-style-type: none"> • Involved in activities to convince other stakeholders/schools to implement the intervention programme • Feedback on planned adoption and implementation activities
	d. Advisory board	<ul style="list-style-type: none"> • Involved in activities to convince schools to implement the intervention programme
	e. Others: Parents Teacher trainer Health service providers Researchers	<ul style="list-style-type: none"> • Informed about or involved in implementation • Training teachers in communication sexuality, participatory teaching, content & activities SRHR curriculum • Informed about or involved in implementation • If needed assist in design of adoption and implementation activities and materials
6 Monitoring & Evaluation	a. Planning team	<ul style="list-style-type: none"> • Conduct the evaluation study • Involve evaluation experts if needed • Organise involvement other stakeholders
	b. Working group young people	<ul style="list-style-type: none"> • Involved in the planning of evaluation and if needed in the collection of information
	c. Working group teachers	<ul style="list-style-type: none"> • Involved in planning of the evaluation
	d. Advisory board	<ul style="list-style-type: none"> • Involved in planning of the evaluation
	e. Others Researchers and research assistants	<ul style="list-style-type: none"> • If needed provide additional expertise in conducting evaluation of behaviour change interventions

Intervention planners have to look at the tasks and decide who is going to be responsible for what. Once they have done this, it will become clear as to whether current team members have the skills they need for the duties they have been assigned to. If they do not, there are several options: add people to the team who have the needed skills, train people in the needed skills, or partner with another organisation who has people with the needed skills.

In addition to the planning team, advisory board, working groups and researchers, a number of other people or organisations are involved in intervention planning, sometimes during the whole planning exercise, sometimes only during particular tasks. Planners should involve experts in sexuality education interventions, experts in young people and experts with regard to the educational system as much as possible.

Some other examples of people who can be involved in intervention planning: to inform parents about the education their children receive in schools, a one-day meeting may be organised by the planning group; producers of the programme materials (the writers, translators, photographers, etc.) are primarily involved in the intervention design, but may require particular input from other entities in the linkage system, for example, the working group of young people; and (additional) researchers and research assistants that may particularly be involved in the needs assessment/situation analysis and in the evaluation planning.

Annexes

Annex 4.1 Worksheets IM Step 1. Involvement of Relevant Stakeholders

WORKSHEET 1.1 Roles and responsibilities planning team

WORKSHEET 1.2 Stakeholder analysis

WORKSHEET 1.3 Involvement of stakeholders

Annex 4.2 Outline documentation Step 1. Involvement

Annex 4.3 Planning Step 1. Involvement

WORKSHEET 1.1

Roles and responsibilities planning team

Instruction

· Describe the roles (researcher, SRHR expert, material developer, ...) of people who will be involved in the planning team, and what their tasks and responsibilities are. See section 4.1 for some examples.

Worksheet

Planning team

Role	Tasks/ responsibilities	Name

WORKSHEET 1.2

Stakeholder analysis

Instruction

- Describe the stakeholders on various levels that may be involved in planning SRHR education programmes
- Describe the reasons and interest for these stakeholders to be involved in one way or another

Worksheet

Stakeholders	Description	Interest

WORKSHEET 1.3

Involvement of stakeholders

Instruction

- Describe for each group of stakeholders, who they are and what their tasks are related to intervention planning (see section 4.1 for examples)
- Describe when and how during the project they will be involved

Worksheet

Working group young people

Role	Tasks/ responsibilities	Name

Working group educators/ teachers

Role	Tasks/ responsibilities	Name

Advisory board

Role	Tasks/ responsibilities	Name/ organisation

Others

Role	Tasks/ responsibilities	Name

Annex 4.2 Outline documentation Step 1. Involvement

A. Planning team

1. Who were in the planning team (from start till now)?
 - a. names
 - b. male/female
 - c. organisation
 - d. position in the organisation
 - e. role in the project
 - f. percentage of working time that was spent by each person to the project (e.g., 50% of time)

name	m/f	organisation	position	role in project	% working time

2. What were the tasks of each of the team members?
3. Looking back, what would you do different next time?

B. Other stakeholders

Answer the following questions for each of the following stakeholders, who were involved in planning and implementing the intervention:

- Advisory board
- Working group(s) of educators and youth
- Others, such as researchers, trainers, ...

1. Who are they?
 - a. names
 - b. male/female
 - c. organisation
 - d. position in the organisation

Name	m/f	Organisation	Position

2. What were their tasks?
 - a. E.g., how often did they have meetings?
 - b. At which point of time?
 - c. What was done during the meeting?
3. What was their added value to the project?
4. Looking back, what would you do different next time?

C. Activities to create awareness and commitment in community

1. What did you already do in the community with respect to awareness raising and creating commitment? E.g., rally, meetings with community members, establishing groups, one to one meetings.

Annex 4.3 Planning Step 1. Involvement

	Who	When
1.1 Establish the planning team		
· Select employees		
1.2 Stakeholder analysis and linkage system		
· Conduct the analysis		
· Decide about selection of stakeholders		
· Contact and involve relevant stakeholders		
1.3 Community awareness		
· Conduct short needs assessment		
· Develop community awareness intervention		
· Implement community awareness		
1.4 Advisory board		
· Select AB members		
· Establish the AB		
· Planning with the AB (roles and responsibilities)		
1.5 Working group(s)		
· Select WG members		
· Establish the WG		
· Planning with the WG (roles and responsibilities)		

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5. IM Step 2. Needs Assessment/ Situation Analysis

Where are we in Intervention Mapping?

In the first step (involvement of relevant stakeholders), a planning group is established, with expertise regarding SRHR, research, school based intervention development, health promotion theories and project management. The planning team has identified relevant stakeholders and has planned meetings with the advisory board (decision- and policy makers) and working groups (with young people and teachers). They also know when to involve other relevant stakeholders in each Intervention Mapping step such as curriculum developers, material designers, researchers and research assistants. When these conditional tasks are accomplished, planners start with the analysis of needs and capacities of young people and the context they live in: Step 2 (needs assessment/ situation analysis).

Steps in Intervention Mapping

1. Involvement
2. Needs Assessment/ Situation Analysis
3. Objectives
4. Evidence-Based Intervention Design
5. Adoption & Implementation
6. Monitoring & Evaluation

When health promotion planners develop an intervention for a particular group of people (for example, young people), it is important to explore their actual needs, the culture and environment they live in, as well as the regulations, rights and laws that are relevant to them. A number of examples are known of interventions that have not been effective in promoting health, because intervention planners did not examine the actual needs of the target population, or the regulations set by the government, resulting in interventions that were not tailored to the target population, or could not be implemented, and were based on the views and ideas of programme planners.

A thorough assessment of needs and the situation people live in, as well as their own ideas for solutions is therefore conditional for developing effective interventions. Various tools and manuals^{1;2;3} are available that can assist intervention planners in carrying out a needs assessment/ situation analysis (NA/SA).

Researchers from different disciplines use different words when they refer to a NA/SA. A *needs assessment* can be defined as a systematic study of quality of life and health status, and those factors that influence them, such as health behaviour and environment, and determinants of behaviour.⁴ A need indicates a difference between what currently exists and a more desirable state. A *situation analysis* studies the capacity, resources and strengths of a community to address the needs.⁵ Others call it a dynamic context analysis, baseline study or community capacity analysis. All assessments, studies and analyses aim to get to know the target population and the situation they live in.

Needs Assessment

Planners can follow the PRECEDE-PROCEED stages when they conduct the needs assessment.⁶ See Chapter 2 for an explanation about the model and its stages: 1) quality of life; 2) health problems; 3) behaviour and environment; and 4) determinants.

To be able to promote their health and their rights, intervention planners need to explore who young people are: where do they live, what are their daily activities, what is important to them, what motivates them, who influence them, what is their youth culture, how many are sexually

active and what determines their behaviour, which other programmes on sexuality education already exist, who do young people prefer as educators of sexuality education, etcetera. Planners should also take into account that specific groups of young people may have particular needs. For example, boys and girls, or rural and urban youth may have different cultural backgrounds, expectations and exposure to social influences.

Planners collect information about the **quality of life** of young people. This provides insight in the extent to which young people find health important or not. Intervention planners may think that sexual health problems are the most important constraints for young people, but maybe they are more concerned about how to get a job or how to take good care of their family.

Planners should therefore get hold of the actual forces, concerns and needs of young people, not necessarily related to sexual and reproductive health only.

This manual focuses particularly how to promote **sexual and reproductive health and rights** of young people, which all relates to exploring their sexuality and dealing with all the changes that occur during adolescence. Most programmes related to sexuality education have the aim to tackle health problems such as new HIV-infections, Sexually Transmitted Infections, early pregnancies with all its risks involved, unsafe abortions, and stigma for various reasons.

Secondly, planners explore the **behaviour** of young people and the environmental factors that are related to the abovementioned SRH problems. Related to behaviour, the two questions intervention planners should ask themselves are ‘Which behaviours of young people cause these problems?’ and ‘Which behaviours could prevent these problems and thus promote their health?’

The answer to the first question relates to **risk behaviours** and can be ‘Because young people have unsafe sex’ or ‘Because young people use drugs’. Planners then want to know what ‘unsafe sex’ and ‘use of drugs’ exactly means. Unsafe sex is usually related to early onset of sexual activity and sexual intercourse, to unprotected sexual intercourse (no use of condoms or other contraceptives), the number of sexual partners and the kind of partners they have sex with (e.g., their age and their number of sexual partners). Intravenous drug use can increase the chance of HIV-infection, when people do not use clean needles. If the prevalence of intravenous drug use is high among young people, this should be explored in the needs assessment. If the use of other substances (alcohol, drugs) proves to be an important factor in increasing (unsafe) sexual behaviour, planners should explore this behaviour.

Examples - Behaviour

- Age onset sexual intercourse
- Use of condoms
- Use other contraceptives
- Number of sexual partners
- Kind of sexual partner
- Health seeking behaviour
- Screening STI
- Testing HIV
- Abortion
- Alcohol/ drug use

Planners also explore the **protective behaviours**, as well as behaviours that could protect young people from sexual and reproductive health problems. What do adolescents do to protect themselves from HIV, STIs or pregnancy? For example, is there any information available about the mean or median age that young people start having sexual intercourse; and about the extent to which young people use condoms or other contraceptives when they have intercourse?

When planners explore protective behaviours, they should ask the question ‘What should young people do to perform this behaviour?’ Related to condom use they can ask the question ‘What should young people do to make sure they use condoms every time they have sexual intercourse?’

The answer can be that they need to *take the decision* to use a condom when they have sexual intercourse, that they need to *buy or obtain condoms*, that they need to always *take a condom along*, and that they need to *negotiate the use* of a condom with the sexual partner.⁷ These behaviours are also referred to as ‘performance behaviours’.⁸ In the needs and capacity analysis, planners explore whether they do perform these behaviours and why they do (not).

Other behaviours to address are so-called ‘health seeking behaviours’, including HIV-testing, STI-screening, and also acquiring information and support in case of (unwanted) pregnancy or rape. Information about SRH-related behaviour can be obtained through research articles and by discussions or interviews with young people themselves.

Box 5.1 Risk and safe sexual behaviour

Risk behaviour

Sexuality is more than (vaginal) sexual intercourse and also includes love, intimacy, masturbation and oral sex. Unprotected (without a condom) vaginal intercourse can result in STIs, HIV and pregnancy and unprotected (without a condom) anal intercourse can lead to STI and HIV transmission.

Less obvious risk behaviours are masturbation (small risk), petting (no risk) and oral sex (small risk on STIs). Risk behaviour can also be defined in the context of ‘stepping stones’: hugging, kissing or petting can be defined as ‘risky’, because it can lead to (unprepared and therefore unprotected) sexual intercourse.

Virginity and abstinence

The concept of virginity raises issues such as ‘is it gender-related’: only for girls, or also for boys? Can girls perceive themselves as being virgin after sexual abuse? Is a girl virgin when she has had anal sex? In some settings concepts such as ‘secondary virginity’ or ‘born again virgin’ are known.

The concept of sexual abstinence also raises questions related to ‘abstinence from what’? Abstinence from genital penetration, oral sex, anal sex, avoidance of sharing bodily fluids or any sexual activity that can lead to infection? Abstinence ‘until what time’: until a young person feels emotionally ready, is financial capable to support the other, until a certain age (e.g., 21 years old), after completing a certain level of education, until marriage, or until a condom fits a boy’s penis? Secondary abstinence was defined as refraining from sexual intercourse after having had sexual intercourse before, in the same or in another relationship.

One of the most important parts of the needs assessment is an analysis of behavioural **determinants**, including knowledge, attitudes, social influences, available services and commodities, skills and values. See Chapter 2 for an overview.

Young people’s sexual behaviour is generally not the only reason why young people face various health problems and quality of life challenges. Often, behaviour goes together with the availability of particular **environmental** conditions. For example, protective policies related to gender, or the availability of condoms and other health services influence to a large extent the health status of young people. The people who are responsible for a restrictive or supportive environment (environmental agents) are in itself a target group with ‘risk’ behaviour. Planners explore their behaviour and behavioural determinants. For example, what are the reasons for the youth worker in the health clinic not to make condoms available in the clinic?

The analysis of the environment includes questions such as: In which context do young people live? Who are important people around them (e.g., parents, peers) and how do they influence them? Which social norms in the community and in the school, and governmental laws have impact on their sexual health and rights? Do they have access to health services?

Factors that are frequently mentioned as being important determinants of behaviour or causes of health problems are ‘gender’, ‘culture’ and ‘poverty’. In a needs assessment, planners should make these general constructs more specific by listing questions such as ‘What do young people mean when they say that poverty causes AIDS?’, ‘What do policy makers mean when they argue that gender inequality results in unsafe sexual behaviour?’ And ‘What do they mean when they say that culture is the underlying cause of violation of rights?’

Situation Analysis

The needs assessment helps planners to get a clear picture of the needs of the target group and people in their environment. The situation analysis studies the capacity, resources and strengths of a community to address these needs.⁹ In this manual, this mainly refers to exploring the possibilities and constraints in the educational system to implement sexuality education. This ranges from the policy levels (educational goals of the Ministry of Education, policies within schools) to the possibility of teachers to implement sexuality education, up to the classroom level (how much space and privacy can be guaranteed for implementation).

In this chapter, we address four basic tasks to be accomplished in a needs assessment/ situation analysis (IM Step 2):

Tasks in Step 2

Task 2.1	Involve relevant stakeholders
Task 2.2	Conduct a literature review
Task 2.3	Collect new information
Task 2.4	Collect and review existing interventions

5.1 Task 2.1 Involve relevant stakeholders

In the Needs Assessment/ Situation Analysis, a number of stakeholders are involved. The planning group takes the lead in conducting the analysis and organising the involvement of stakeholders, including the working groups, advisory board and other stakeholders, such as experts in SRHR education, in young people’s SRHR and the school setting; and if needed, additional researchers and research assistants to collect the information.

Before going into the community to conduct the Needs Assessment/ Situation Analysis, it may be very important to first sensitise the community about the project and the reasons for conducting the research. For example, in India it turned out to be conditional for conducting the research to have a close relationship with the community. See Chapter 4 for more information.

Table 5.1 Involvement in the Needs Assessment/ Situation Analysis

PLANNING PHASE	STAKEHOLDERS	TASKS
2 Needs Assessment/ Situation Analysis	a. Planning group	Assess the needs & capacities of young people & their social and political environment Organise involvement other stakeholders
	b. Working group young people	May be involved in conducting focus groups with young people Start up meeting; training young people's SRHR
	c. Working group teachers	Start up meeting; training young people's SRHR
	d. Advisory board	Start up meeting; training young people's SRHR
	e. Others Experts in SRHR education, young people's SRHR, schools Researchers & research assistants	Provide information and linkage to organisations, schools, young people Assist in the needs assessment & situation analysis

One of the main tasks of the planners and researchers is to document the needs assessment/ situation analysis. We have provided an outline for documentation in Annex 5.2. The report can include the following aspects:

- background to the NA/SA; purpose, brief description of the project
- methods for data collection and respondents of FGDs, In Depth Interviews, possibly survey questionnaires, and other data collection methods
- results describing major findings
- discussion & conclusion; describing the major challenges, key findings, striking findings, etc.
- quality of the data collection and report
- summary of the report
- references to literature and reports
- annexes providing overviews of participants in research, sources, tables, etcetera.

The conclusions of the NA/SA are very useful for lobby and advocacy among stakeholders for the project and its implementation. One way of spreading the information is by organising a stakeholders meeting in which planners can present the most important findings, underpinning why it is important to do something about education of young people about SRHR, including HIV/AIDS. Another way of using the information for advocacy is by providing a fact sheet that includes these most important issues, describing the sources of evidence, in order to convince relevant stakeholders that problems do exist and that something needs to be done about it.

In Annex 5.3 we have provided a timetable that can assist planners to plan the various tasks of the NA/SA.

5.2 Task 2.2 Conduct a literature review

After planning the involvement of all relevant stakeholders in this step, planners start the analysis with a literature review. They explore whether others have already conducted research, whether there are any reviews or other publications that are relevant to the project. This is referred to as

‘secondary’ (existing) data analysis. Planners collect, analyse and report about existing data related to a number of topics including 1. SRHR problems among the target population (young people), 2. young people’s quality of life in general, their behaviour and environment, behavioural determinants, and rights; 3. existing structures and resources to address sexuality education; and 4. relevant policies with regard to young people’s SRHR and the educational system. Existing literature and documentation can amongst others be obtained from the Internet.¹⁰

5.2.1 Review documentation about SRHR problems

To be sure that they address the actual health needs of young people, planners need to know the national and local figures of sexual and reproductive health problems. These include amongst others: Sexually Transmitted Infections (STI’s), including HIV/AIDS; reproductive health problems, such as teenage pregnancy, (unsafe) abortion, maternal health and female genital mutilation; sexual abuse and harassment; and discrimination and stigmatisation based on gender, sexual orientation or HIV-status. The Internet provides a lot of information about these figures.¹¹ See section 3.3 for some global figures.

Planners need to keep in mind that various sub-groups may have particular challenges and needs. For example, in Uganda, the HIV-prevalence is six times higher among female adolescents compared to male adolescents, meaning that particularly young women face AIDS and its consequences, such as stigmatisation and decreased opportunities.

Planners start with formulating questions about statistics they want to collect. This will help to focus on data collection. If relevant, specific questions can be formulated with regard to specific groups of young people, for example whether there are differences between girls and boys, between rural and urban young people, in or out of school, or with different economic backgrounds. They then look for existing reviews that are relevant to their context on the Internet or in resource centres. In most countries, national figures can be obtained at the Ministry of Health, or at a bureau of statistics. Many countries also provide data of an annual or biannual ‘Demographic (Health) Survey’.¹²

Box 5.2 Examples of health figures

Sexual and Reproductive Health and Rights:

- HIV/AIDS - prevalence rates in country/district/state/...; specific rates on women/men, rural/urban, according age; groups with increasing/decreasing rates; major modes of transmission in country/district/state/...
- STIs - prevalence rates in own context; specific rates on specific groups as outlined above
- Teenage pregnancy
- Early marriage and motherhood
- Maternal (and child) health, morbidity & mortality (especially young people)
- (Unsafe) abortions
- Sexual abuse and harassment
- Discrimination because of gender (especially girls), HIV-positive status, sexual orientation (homosexual, bisexual)
- Other relevant SRHR problems and consequences

5.2.2 Review documentation about young people's sexual behaviour and rights

Secondly, planners explore existing literature, reports and other documentation with regard to young people in a particular context, their dreams, concerns, well-being, quality of life, sexual behaviour, determinants of behaviour, and the social context they live in. They also analyse existing information about the views of the social context of young people, for example, their family, parents, community, school, youth culture, and their access to health services and counselling.

This information is not always available and particularly not with regard to the specific target group organisations work with. Planners may particularly focus on exploring this by collecting new information (see the next section).

With regard to young people, planners can focus on the following topics: sexual behaviours of young people, including condom use, sexual intercourse, sexual partners; behavioural determinants (causing afore-mentioned sexual behaviours), including knowledge, values, attitudes, social/cultural norms, skills, peer influence; awareness, attitude, skills, social influence related to sexual and reproductive rights; environmental constraints for young people, especially related to the school setting; and access to and use of sexual health services, counselling and commodities (e.g., condoms) by young people. See an overview of important determinants in Box 5.3. The importance of determinants however varies from context to context.

With regard to the environment of young people, media is one of the topics to explore. Media plays an important role in many young people's lives. Television programs, radio programs, magazines and newspapers can have a big impact on young people's knowledge and norms, either positive or negative. To understand their impact and explore the opportunities that media offer, planners can analyse the programs young people like or dislike.

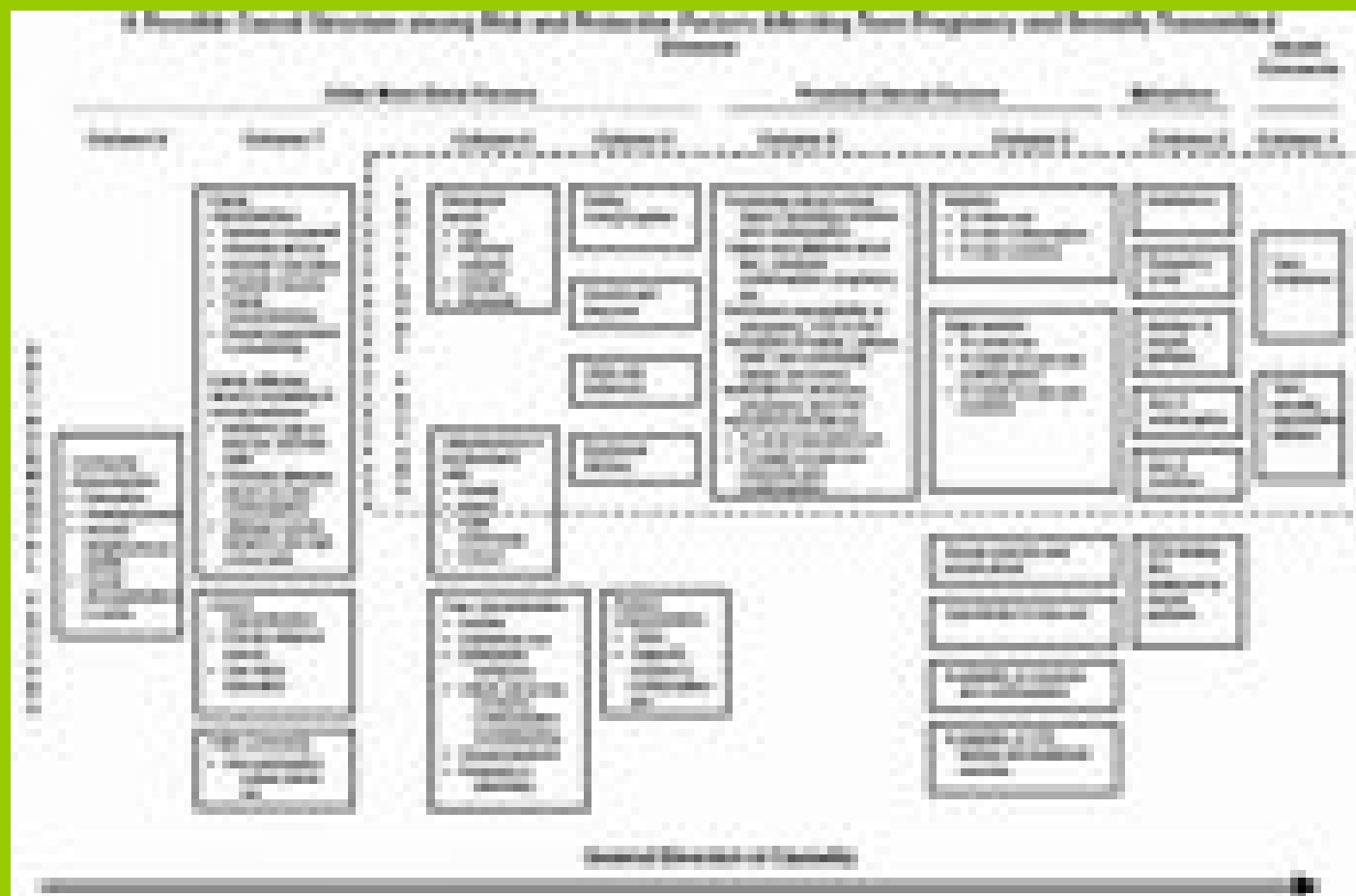
Information about AIDS and SRH is also often provided through mass media campaigns on TV, in radio programs or newspaper articles. These campaigns could complement the interventions intervention planners develop. Pornographic programs or magazines, on the contrary, often provide unrealistic and gender-insensitive information about sexuality. When planners are aware of the extent to which young people are exposed to this kind of information, this can help them in providing the correct information and meet the actual needs of young people.

Another category of information is the social influence of important others. Peers and parents/family are important actors in young people's life. Planners can identify the actual influence of other young people on the behaviour of adolescents: the social norms and their impact on self-confidence and practices. The norms and values of parents are generally also important in the behaviour of young people. In addition, it is useful to find out the attitudes and ideas of parents about sexuality education in schools.

And finally, planners can collect existing information about the availability of, access to, and youth friendliness of health services (including STI/HIV testing), availability and affordability of condoms/contraceptives, the availability of information, and availability of counselling for young people.

Box 5.3 Determinants of sexual behaviour of young people

A number of reviews is available on the factors that influence young people's sexual behaviour.^{13;14} Kirby et al. (2007) analysed a large number of publications and selected the following relevant determinants:



5.2.3 Review documentation about the educational system

The third category of information consist of the existing structures and resources to address sexuality education. Planners have to get a good idea about the educational system to be able to implement the interventions. They again start with the identification of question before starting the document review. They can find information on the Internet¹⁵ or in resource centres or at the Ministry of Education.

Topics they can explore include:

- Current activities in schools with regard to sexuality education, SRH, AIDS, counselling
- School setting: number of students/class, remarkable differences between schools?
- School policy related to pregnancy, sexual harassment and abuse, boy-girl equality, discrimination, access to information, access to products and health services
- Current problems of schools and of teachers to implement Life Skills, c.q. sexuality education
- Awareness of teachers and school administration of rights of young people

5.2.4 Conduct a policy review

To increase the chance that the intervention will be adopted and implemented, it is worth exploring the existing policies and legislation with regard to young people, their sexual and reproductive health and rights, and also the educational system and sexuality education.

Planners therefore collect and analyse policies and other relevant national, regional or institutional information or regulations. The aim of a policy review is to get an overview of the national/regional policies that are relevant for the adaptation and implementation of the programme. Before doing a policy review, it is important to have a clear focus on what exactly you want to obtain from the policies, to avoid getting lost in the amount of information.

Secondly, planners find out whether other organisations may have done a policy review that is relevant to them.¹⁶ If no review is available or not all questions are answered, collect the policies at resource centres, bookshops, at Ministries or on the Internet. And if possible obtain information about the extent to which policies and regulations are actually implemented.

Box 5.4 Examples of relevant policies

Relevant policies in the context of HIV prevention/ SRHR education include a focus on:

- Youth / adolescents
- Sexuality or Life Orientation Education and Education in general
- Curriculum policies of the Ministry of Education
- Reproductive Health (particularly on young people)
- Family Planning/ Population
- HIV/AIDS (particularly on young people)
- People living with HIV/AIDS
- Gender (particularly on young people)
- Human rights (particularly on young people and the UN Convention on the Right of the Child)
- Laws such as related to abortion or teenage pregnancy (e.g. school access and teenage pregnancy)
- Informed consent (of parents for their children to be exposed to sexuality education)
- Sexual harassment and abuse (particularly on young people)
- Sexual orientation (homosexuality), discrimination
- Sexual health services (particularly on young people)

The policy review serves various purposes:

1. To provide young people and teachers with information about the rights of young people, regulations and laws, and existing programmes related to sexuality of young people.
2. To make sure the sexuality education curriculum fits within the policies, which makes it more acceptable for schools and teachers to use it. From this perspective, it contributes to the adoption and implementation of the intervention programme.
3. If the curriculum is used on a broader scale, it may be more acceptable by for example a Ministry of Education, if the curriculum is linked to (national) policies. This may contribute to sustainable implementation of the intervention programme.

5.3 Task 2.3 Collect new information

Existing documentation does in general not provide sufficient information to be able to design a SRHR education programme. Based on the identification of gaps in existing literature, planners also collect new (primary) information. We provide some examples of ways to collect and analyse new information, but of course there are many other research methods to collect information.

In data collection, planners have to keep the rights of the respondents, in this case young people, in mind. Schenk & Williamson have provided an overview of guidelines and resources related to ethical approaches to gathering information from children and adolescents.¹⁷

5.3.1 Conduct Focus Group Discussions with young people

A frequently used method for the collection of new information is *focus group discussions* (FGDs). Some advantages of FGDs are that people interact in discussions about a topic and allows a greater breadth of ideas, opinions and experiences compared to individual interviews. FGDs about very sensitive issues, such as pre-marital sex, sexuality, use of condoms, or abortion, require specific skills and care of the facilitator. The Internet provides a lot of information about conducting Focus Group Discussions, including an online course to learn about how to conduct FGDs.¹⁸

Characteristics of FGD participants

Generally FGDs take place with a small group, usually 5-8 people. Small groups generally create a more open atmosphere than bigger groups of young people. The number of groups depends on the variety of the target group (related to for instance, age, gender, background, religion, in/out of school). The more variety, the more groups can be involved.

It is advised to have at least one group of boys, one group of girls and, if culturally possible, one mixed group of boys and girls, as this will most likely bring up different kinds of information. FGDs are more relevant to go in-depth, than to collect information from more participants about the same topics. So it is more about quality than on quantity. The FGD participants should be able and willing to talk openly about themselves and to discuss this in a group.

Characteristics and training of facilitators

FGDs need active facilitation and are highly dependent on the facilitators. Generally two facilitators are present during a FGD, one being the interviewer probing the questions, the other being the co-facilitator, who helps keeping the time, pointing out neglected topics or improvements as well as observe and take notes. The co-facilitator may also be responsible for recording the discussions on tape. Generally, the discussions should not take too long, approximately one or 1,5 hours, as participants may get exhausted. And the discussions should take place in a room where they feel comfortable and where privacy is guaranteed.

Key characteristics for a facilitator (especially the interviewer):

- good communication and listening skills
- is able to create a safe environment in which young people feel comfortable to openly talk about their personal concerns and experiences (ground rules: all opinions are respected; you should only talk when you want to, not against your will; everything said in the group stays in the group, etc.)
- speaks the same language as the FGD participants
- is someone young people feel comfortable talking to, for example, peer adolescents
- is trained in SRHR and sexuality, and has confidence in communicating about sensitive topics
- should not convey the impression of being an expert but nevertheless be sufficiently familiar with the subject matter to pose relevant questions
- should remain the leader of the group and encourage all to participate
- should be aware of own opinions and ideas and not to express these openly or supporting participants whose viewpoint concurs with his/hers
- should be alert to pick up new information or perspectives and ensure that these are discussed in-depth

After careful selection of the facilitators, it may be necessary to train them. The success or failure of the FGDs highly depends on the skills of facilitators. If there is time, the facilitators can pre-test the guide among some young people (as part of their training), and adapt the guide based on their experiences. See Tool 2.1 in Annex 5.4 for a guide for the training of research assistants.

Tips for FGDs about sensitive issues

Conducting FGDs with young people about sensitive topics requires some additional skills and methods to open up and get the correct information. One way of opening up is by organising more than one session with the same group of young people, for example, 2 or 3. During the second and third session they are more used to each other and the facilitators, they may feel more comfortable, and are more likely to open up about their experiences and concerns. Therefore address the more sensitive topics during the third or second session.

Another way is to start each session with something that is easy for them to talk about, make sure that all participants are involved and say something. Having an energizer or warm up may also create a positive atmosphere.

Especially when talking about topics that relate to sexuality and personal values and experiences, young people may find it difficult to open up about themselves, are not used to do that, or are afraid for the consequences. If open communication turns out to be a problem, facilitators can address the topics in a less sensitive way, by asking about the friends of the participants or using peer model stories. They can also start the discussion by using all kinds of games, video clips, stories as a starting point of discussion.

Generally, it is more easy for young people to talk about their friends and their experiences than their own behaviour and opinions. Instead of asking young people ‘Do you have experience with premarital sexual intercourse?’, facilitators can formulate the same issue related to their friends: ‘Do your unmarried friends have experience with sexual intercourse?’ If they answer ‘yes’, the facilitator can discuss this topic in depth, by asking ‘Why did they have sexual intercourse before they are married?’

Another way of avoiding direct questions to the participants is the use of peer model stories. Using the example of premarital sex, the facilitator can provide the following introduction:

‘Lydia (15 years) and John (16 years) are young people, just like you are. They are together in school and they like each other. They started a relationship and they had sexual intercourse.

- *Do you know what that means: sexual intercourse?*
- *What could be reasons for them to have sexual intercourse?*
- *Etc.’*

The table below provides a list of topics that can be discussed in FGDs with young people. In Tool 2.2 (Annex 5.4), we have provided an example of a topic guide that can be used to conduct the FGDs, and on the Internet planners can also find a number of examples of topic guides and guidelines.^{19;20}

Box 5.6 Topics in FGDs with young people

Topics that can be addressed in FGDs with young people include:

1. Dreams and opportunities
2. Ethnic identity and self perception
3. Sexuality and relationships
4. Knowledge of and attitudes to sexually transmitted infections
5. Views about sexual health services
6. Condom use
7. Social influences on sexual behaviour

Data collection, entry and analysis

One of the criteria for a high quality of data from FGDs is to tape the information on a tape-recorder, or other means (video). The advantage is that the information is very accurate and therefore of high quality. The main disadvantage is that it increases the workload, as all tapes need to be transcribed into a text processor (Microsoft Word, Data analysis programme).

After entering the data, these are analysed. See the Internet for some background about analysis of FGDs.^{21;22} This already starts during the FGDs when the observer takes notes about the group dynamics and important nonverbal behaviours and the facilitator documents a summary of the discussions right after the FGD. The analysis of the transcribed data requires many careful readings. One way is to use different colours to identify different factors or categories of information. Another way is to print all the text and cut and make different piles of pieces of paper with different categories of information. It is also possible to use computer software to go through the same process of categorising information. The research questions can be used to make the categories. Researchers can distinguish between different groups of young people in their analysis. The most important part of the analysis is for the researcher to stay open-minded and objective. And in that way get factual information.

5.3.2 Conduct In Depth Interviews (IDIs) with young people

Another method is *in-depth interviews*, which can be done with young people. In addition to the Focus Group Discussions, this method provides deeper understanding about underlying motives of behaviours, self-efficacy, knowledge and reception of messages.

The IDIs provide insight and understanding of the context in which behaviours occur and the broader structural determinants of behaviour. Individual in-depth interviews can range from very open to semi-structured and are of a conversational style rather than having a question-answer format.

The interviewer encourages the respondent to talk freely and merely guides the discourse towards new topics from time to time. It is advised to start up with a subject that is not too sensitive and build up a trustworthy relation. This method can provide greater depth and detail of information. The tool in Annex 5.2 can be used as a starting point for conducting the IDIs.

5.3.3 Conduct Focus Group Discussions and In Depth Interviews with other stakeholders

To be able to plan school-based sexuality education interventions, planners also need information from important people in young people's environment. They can collect information from people in the educational system, including teachers, school administrators, school counsellors, and all others who are important stakeholders. And they can also obtain information from others such as parents,²³ community members, health service providers, or peer educators.

Planners can collect this information from all relevant stakeholders using FGDs or IDIs. For the selection and conduction of the sessions, planners can take the same issues into account as highlighted in the sections above.

5.4 Task 2.4 Collect and review existing interventions

Most project planners already have an idea about the kind of intervention they would like to develop. As part of the needs assessment/ situation analysis, they can therefore collect existing materials, such as sexuality education or life skills curricula, teacher manuals, games, posters, leaflets, instructions for skills exercises with young people, scripts for drama plays, etcetera. And they can also collect examples of documents with referral systems to refer young people to health service providers, or materials or existing practices to involve parents and the community. It is often very useful to learn from the experiences from other organisations, and not to reinvent the wheel.

Planners start with getting a general idea of what kind of materials they are looking for. In addition to materials for young people, they can also look for materials or background information for schools and educators/teachers, or materials for the involvement or education of the community and parents. One way of finding materials is looking on the Internet; many materials can often be downloaded for free. Other ways are by contacting organisations, either directly, or through experts in sexuality education, or visit libraries or resource centres. It is important to ask permission to use and/or adapt the materials to the local context (language, culture). Some organisations have strict policies on this.

When planners find the intervention materials, it may also be useful to ask for background information about the materials, including the objectives planners like to achieve with the materials (e.g., do they want to raise general awareness?), the approach used, a description of the intended target group, and describing how the materials can be used. If possible planners can ask for lessons learned by the organisation that has designed and/or implemented the materials. This may save them from experiencing the same pitfalls.

Annex 5.4 provides a tool that can help to document the intervention materials in a structured way. After that, planners can make a start with the analysis of the interventions, using Tool 2.9 (Annex 5.4). An in-depth analysis of existing materials will be done when planners start with the design of the intervention (IM Step 4).

Box 5.7 Criteria for the selection of existing materials

Some criteria that can be used in prioritising/selection of existing materials (in random order):

- Materials that have shown to be effective in achieving their objectives (e.g., good practices)
- Innovative materials
- Materials that are ‘close’ to the own project, e.g., regarding language, culture, context, educators, rural/urban/slum setting, etcetera.
- Materials that are based on a needs assessment and/or are developed together with young people and/or the educators
- Materials that provide clear instructions to educators what they can or should do in the education of the programme
- Materials that not only address knowledge, but also other behavioural determinants, such as value and attitude development, skills training, dealing with social influence, personal risk awareness
- Materials that have a variety of participatory exercises and activities (e.g., small group work, role plays, etc.) instead of materials with knowledge-transfer only
- Materials that address sexuality and prevention in a positive way (not fear-based)
- Materials that address important information related to SRHR of young people, including self-awareness & self-esteem; decision-making; physical, emotional, and social changes during adolescence; friendship; love; (communication about) sexuality; rights of young people; HIV/AIDS, STIs, teenage pregnancy, abortion; sexual harassment & abuse; prevention methods, including condoms; future planning

Annexes

Annex 5.1 Worksheets IM Step 2. Needs Assessment/ Situation Analysis

WORKSHEET 2.1	Involve relevant stakeholders in the NA/SA
WORKSHEET 2.2	Assess young people's health, rights and quality of life
WORKSHEET 2.3	Assess behaviour and environment of young people
WORKSHEET 2.4	Assess behavioural determinants
WORKSHEET 2.5	Analyse the educational system

Annex 5.2 Outline Documentation Step 2. Needs Assessment/ Situation Analysis

Annex 5.3 Planning Step 2. Needs Assessment/ Situation Analysis

Annex 5.4 Tools Step 2. Needs Assessment/ Situation Analysis

TOOL 2.1	Manual 'Training of research assistants'
TOOL 2.2	Topic guide 'Young people' (FGDs/ IDIs)
TOOL 2.3	Topic guide 'Parents' (FGDs/ IDIs)
TOOL 2.4	Topic guide 'Teachers' (FGDs/ IDIs)
TOOL 2.5	Topic guide 'Health care providers/ counsellors' (FGDs/ IDIs)
TOOL 2.6	Topic Guide 'Experts' (IDIs)
TOOL 2.7	Topic guide review of existing literature and reports
TOOL 2.8	Sheet 'Description of existing interventions'
TOOL 2.9	Checklist 'Analysis of existing interventions'
TOOL 2.10	Checklist to describe experience of organisation with SRHR

WORKSHEET 2.1

Involve relevant stakeholders in the NA/SA

Instruction

- Describe how and when programme planners will involve relevant stakeholders (working groups, advisory board, and/or others) in conducting the needs & capacity analysis.

Worksheet

Stakeholder	Tasks/ responsibilities	When

WORKSHEET 2.2

Explore young people's health, rights and quality of life

Instruction

- Describe the most important needs of young people with regard to their quality of life, sexual and reproductive health and their sexual and reproductive rights.
- See the introduction to Chapter 5 for examples.

Worksheet

1) Quality of life

What are the major quality of life concerns of young people?

2) Health (SRH)

What are the most important sexual and reproductive health problems of young people?

3) Rights (SRR)

Which (sexual and reproductive) rights of young people are violated?

WORKSHEET 2.3

Assess behaviour and environment of young people

Instruction

- Describe which behaviours and environmental factors cause the SRHR needs of young people

Worksheet

SRHR problem: _____

1) Behaviour

Which behaviours of young people either put them at risk or protect them from SRHR problems?

2) Environment

Which environmental factors contribute to or protect young people from SRHR problems?

WORKSHEET 2.4

Assess behavioural determinants

Instruction

- Describe the determinants of behaviour of young people
- Describe the determinants of behaviour of actors in the environment who are responsible for the environmental factors

Worksheet

Behaviour: _____

Actor: _____

Determinants:

1) Knowledge

-
-
-

2) Risk perception

-
-
-

3) Attitude

-
-
-

4) Social influence

-
-
-

5) Skills and self-efficacy

-
-
-

6) External barriers

-
-
-

WORKSHEET 2.5

Analyse the educational system

Instruction

- Describe the possibilities and constraints in the educational system and the community to implement sexuality education in schools

Worksheet

1) Community/parents

2) Youth culture

3) Health care system

4) School setting (school structure, Ministry of Education, curriculum)

5) Teachers and school administration

Annex 5.2 Outline Report Needs Assessment / Situation Analysis

General suggestions:

- Keep the final report short (max. 40 pages excluding references and tables & figures) and provide additional information as much as possible in annexes to the report - this makes the report easier to read by others
- Keep record of references to literature/articles/publications/reports and provide a list of references at the end of the document

1. Introduction

Approximately 4 pages

Describe the background of the needs assessment/situation analysis:

- Purpose of doing the needs assessment/situation analysis, e.g.,
 - o Getting to know young people, their SRHR needs and capacities, and the environment they live in
- What will be done with the information of the analysis (e.g., input for the programme; publication; sharing with others)

2. Methods of data collection

Approximately 3 pages

Describe how you collected the information (literature, reports, focus group discussions, interviews, etc.) and among whom (organisations, experts, internet, young people, community, etc.).

Provide tables in the annexes describing additional information about data collection.

3. Results

Approximately 11 pages

Describe the results of the data collection. There are different ways to do this:

- Using the topics of the Needs Assessment/ Situation Analysis as a framework
- Describing the results for primary and secondary data collection
- Describing the results for each method of data collection

You can provide quotes, tables, overviews, and figures if relevant and supportive to the results.

4. Discussion and conclusions

Approximately 10 pages

Do NOT again describe the results in this chapter, but focus on the highlights of the data collection:

- Which findings show very important information?
- Which information did surprise you?

5. Quality of the data

Max. 1 page

Briefly describe the quality of the data. What were constraints in data collection and how have these influenced the quality of the data?

6. Summary

Max. 1 page

Provide a brief summary of the report, describing the aim of the needs assessment/situation analysis, the methods of collecting information, and the main conclusions/findings.

7. References

Provide references to the literature/reports/documents that were used in the Needs Assessment/ Situation Analysis.

8. Annexes

Provide tables and background information in the annexes of the report.

Annex 5.3 Planning Step 2. Needs Assessment/ Situation Analysis

	Who	When
2.1 Plan involvement		
• Make overall planning		
• Plan involvement of all relevant stakeholders in NA/SA		
2.2 Literature review		
• Research questions literature review		
• Collect and review policies		
• Literature, publications, reports		
• Document the results		
2.3 Collect new information		
• Research questions data collection		
• Design data collection tools		
• Recruit research assistants		
• Train research assistants (and pre-test tools)		
• Select respondents <ul style="list-style-type: none"> ○ Schools ○ Young people ○ Teachers ○ Parents ○ Community leaders ○ Health care providers ○ Counsellors 		
• Practical organisation data collection <ul style="list-style-type: none"> ○ Transport ○ Communication ○ Copying/ printing ○ Introduction letters 		
• Collect information <ul style="list-style-type: none"> ○ FGDs and IDIs young people ○ FGDs and IDIs parents ○ FGDs and IDIs teachers ○ IDIs health care providers/ counsellors ○ IDIs school administration ○ IDIs community leaders ○ IDIs with experts 		
• Transcribe and clean data		
• Analyse data		
• Conclusions & recommendations		
• Relate new data to literature review		
• Write report		
2.4 Existing interventions		
• Collect existing interventions		
• Review existing interventions		
• Ask permission for use of materials		
2.5 Intervention framework		
• Specify target group		
• Specify health outcomes and quality of life outcomes		
• Decide about the implementation setting		

Annex 5.4 Tools Step 2. Needs Assessment/ Situation Analysis

TOOL 2.1	Manual ‘Training of research assistants’
TOOL 2.2	Topic guide ‘Young people’ (FGDs/ IDIs)
TOOL 2.3	Topic guide ‘Parents’ (FGDs/ IDIs)
TOOL 2.4	Topic guide ‘Teachers’ (FGDs/ IDIs)
TOOL 2.5	Topic guide ‘Health care providers/ counsellors’ (FGDs/ IDIs)
TOOL 2.6	Topic Guide ‘Experts’ (IDIs)
TOOL 2.7	Topic guide review of existing literature and reports
TOOL 2.8	Sheet ‘Description of existing interventions’
TOOL 2.9	Checklist ‘Analysis of existing interventions’
TOOL 2.10	Checklist to describe experience of organisation with SRHR

Tool 2.1 Manual 'Training of research assistants'

Contents

1. Training programme
2. Logistics
3. Instructions for data collectors
4. Standard introduction talk
5. Referral list health centres/counsellors
6. Contact information

1. Training programme

Date:

Place:

Time:

8.30 - 9.00

Day 1

Introduction

- Introduce each other
- Introduce organisation
- Expectations of the training
- What is expected of research assistants
- Distribute training schedule, notebook, pen, ppt sheets/manual
- Appoint a time keeper
- Appoint a research assistant to do recap of the day the following day

9.00 - 10.30

Overview of adolescent's SRHR the particular country

- Explain about STIs, HIV/AIDS, contraceptives
- Explain about SRHR
- Explain situation in the country

10.30 - 11.00

Break

11.00 - 12.30

Introduction to the research (research questions, aim of data collection)

12.30 - 13.30

Lunch

14.00 - 15.30

Exercise 'Talking about sexuality'

15.30 - 17.00

Explanation research methods (Focus Group Discussions, In Depth Interviews)

- How will they collect the data (discuss 'instructions for data collectors' and 'standard talk')

At home

Look at the data collection tools

Time:

8.30 - 8.45

Day 2

Recap of day 1 (research assistant)

8.45 - 10.30

Discussion of student topic guide

- Go over each question (do they understand what is meant? Do they understand definitions? They will have to be able to explain to the students!)

10.30 - 11.00

Coffee/tea break

11.00 - 12.30

Discussion of teacher topic guide

12.30 - 14.00

Lunch

14.00 - 15.30

Discussion of parent/ health care worker topic guide

15.30 - 17.00

Discuss how to do the pre-testing

- Discuss programme of following day
- Let them prepare all tasks (going to principal, do introduction talk etc)

At home

Prepare pre-test

Time:	Day 3
8.30 - 9.00	Travel from training site to pre-test school <ul style="list-style-type: none"> • Arrange vehicle • Bring questionnaires, pens • Arrange for soda & snacks (also for research assistants)
9.00 - 10.00	Prepare pre-test (research assistants) <ul style="list-style-type: none"> • Divide tasks by research assistants (who goes to principal, who will do the talk, who keeps the time etc) • Talk to teacher, find room etc
10.00 - 12.00	Conducting the FGDs and IDIs with students, parents, teachers, ...
12.00 - 12.15	Sodas and snacks
12.15 - 13.00	Discuss topic guides, FGDs and IDIs with respondents
13.00 - 14.00	Finalise at school and travel back to training site
14.00 - 15.00	<i>Lunch</i>
15.00 - 16.00	Plenary discussion of the pre-testing <ul style="list-style-type: none"> • Evaluate performance of research assistants, provide feedback, were there difficulties? Do they feel confident to go into the field now? • Discuss suggestions of the students
16.00 - 16.30	Logistics and finalisation <ul style="list-style-type: none"> • Who will pair up with whom? Which sites will they visit? • Number of days, payments, contract • Contact by e-mail/ phone
16.30 - 17.00	Evaluation of the training

2. Logistics

Arrange

1. Research assistants (e.g. 1st year University students)
 - a. Contracts
 - b. Travel allowance
2. Training instructors
3. Training schedule
4. Training site
 - a. Drinks and food for breaks and lunches
5. School for pre-test
 - a. Transportation to and from the pre-test school

List of items

1. Tools for data collection
2. pens for research assistants and if necessary for pre-test
3. note books
4. bring presentations/manual for research assistants
5. flip charts
6. markers
7. Promotion material of the organisation

3. Instructions for data collectors

1. **Before going to the schools**
 - Make sure you have correct topic guides with you
 - Bring pens, paper to make name/number list
 - Make sure the snacks and sodas for the students are available
 - Permission to go to that school (introductory letter from relevant authorities)

- Inform teachers (contact person) when you expect to come to the school
2. **After arrival in the schools**
 - Get in touch with school authority (principal). Be honest about the time you need.
 - Get in touch with the responsible teacher
 - With the teacher responsible identify the students
 - Organise the session in a good space/ class room: privacy (not outside)
 - Make sure that teachers are not present in the class room at all and cannot be seen anywhere (for confidentiality, be diplomatic to teachers)
 - Make sure no students are coming in to bring the snack and sodas, let them put it outside the class
 3. **Before starting the discussion/ interview**
 - Create a friendly, relaxed atmosphere (but not too informal)
 - Introduce yourself as a research team - independent of the school
 - Give a good explanation about the research, what we expect from them
 - Explain that it is voluntary, they don't have to participate if they don't want to
 - Emphasize anonymity:
 - Assure the students that the school will not have access to the data
 - Explain them that when they have finished, they will get a snack and soda as appreciation. There is no (monetary) incentive!
 - Explain them that if after the discussion/ interview they have any questions, want advice or want to talk about personal issues, they can go to a counsellor/health centre (see referral list). Don't be the expert yourself.
 4. **During the discussion/ interview**
 - If they have any questions, make sure they are able to ask for clarification
 - Make notes on behaviour of students: who is talkative, who is not? Nonverbal communication.
 5. **After the discussion/ interview**
 - Give the respondent a referral list with youth-friendly health centres.
 - Make sure that all respondents who have personal issues feel comfortable to raise these issues with a counsellor or are well referred to a health worker/ counsellor
 - Provide students with snack and soda and make sure the rooms are left the same way you entered them (clean)

4. Standard introduction talk

Hello everyone, my name is (name of research assistant) and this is (name of other research assistant). We are from (name organisation) and we are assisting in a research about sexuality education for young people in (name of country). We would like to know more about young people's knowledge and ideas about sexuality.

We will ask you some questions. Apart from us, nobody will know that you participate and what your answers are. It is not a test and there are no right or wrong answers. Please be honest in your answers. Do not give us answers that you think we want. We need to know what young people really think, to develop the best programme. It is voluntary for you to participate in the interview. You can withdraw at any time.

Does anyone have a question right now? (if they ask if there is a (monetary) incentive, tell them no: it's voluntary. But at the end we will give you a soda and a snack to thank you).

5. Referral list health centres/counsellors

Since it may be difficult for pupils to ask the research assistants for a referral to a health centre or counsellor in class, we provide each pupil with a list with health centres or counsellors in their district. We will give them to you when you go to the schools, so you can distribute these referral lists to the pupils after they have filled in the questionnaire.

6. Contact information

Organisation

Phone:

Email:

Research assistants:

Phone:

Email:

Websites:

Tool 2.2 Topic Guide 'Young People' (FGDs/ IDIs)

Topics

1. *Social life*

- a. How spending time and leisure time? In day and evening?
- b. Family, friends and support; important people?
- c. Information resources and communication means
- d. Need for more information?
- e. Need for services?
- f. What to do to improve young people's lives?

2. *Puberty*

- a. What are your most important health needs?
- b. Do you know about menarche, wet dreams? What has been your own experience with it?

3. *Ethnic identity and self perception*

- a. What are the most important things in life to you right now?
- b. Is staying healthy important to you?
- c. Do you take any steps to ensure that you stay healthy?
- d. Finish this sentence, "Being a young woman/man in ... [name city/...] means..."

4. *Sexuality and relationships*

- a. What are some of the things you look for in a relationship?
- b. Who would you define as a boy/girlfriend?
- c. Do you think people should stick to people from their own background in having a relationship? What is your experience in this regard?
- d. What are some of the difficulties you experience in relationships?
- e. What do you think about friendships, including with opposite sex?
- f. Do you agree or disagree that sex should only be part of a steady committed relationship?
- g. What factors affect whether you decide to have sex with someone or not?
- h. Do you ever discuss with people you may be thinking of going out with anything about their sexual past?
- i. Do you ask them about infections which can be passed on by sex?
- j. Have there been times when you have made a decision not to have sex with someone?

5. *Knowledge of and attitudes to sexually transmitted infections*

- a. Do you know the names of any infection that you can catch from having sex?
 - i. What symptoms?
 - ii. What problems do they cause?
 - iii. How common do you think they are?
- b. How can you know if someone has an infection?
- c. Does the risk of catching an infection bother you?
- d. How would you feel if you found out that you had an infection like gonorrhoea (not HIV)?
- e. What can you do to protect from STIS, HIV/AIDS, and pregnancy? What are advantages and disadvantages?

6. *Views about sexual health services*

- a. What would you/your friends do if you/they thought you/they had an infection?
- b. What would

- i. Encourage you to go for help?
 - ii. Be barriers to go for help?
- c. To what extent are contraceptives
 - i. Available
 - ii. Affordable
 - iii. Accessible

7. *Condom use*

- a. What do you/friends think about using condoms?
- b. What are the reasons to either use or not use condoms?

8. *Social influences on sexual behaviour*

- a. How did you learn about sex?
 - i. Exposure to messages about SRHR, family planning
 - ii. What kind of resources? By whom?
- b. Do you ever seek advice or discuss important issues about sex or relationships with other people (i.e., parents, peers, teachers, family members)?
- c. From whom do you prefer to learn about sex?
- d. Do you ever feel pressures from others to act in particular ways?
- e. How many of your fellow young people have sex before marriage?
 - i. At what age for the first time?
- f. What kind of sexual acts do they perform?
- g. At what age do your fellow friends get married?
 - i. Why?
- h. At what age do young people in your country give birth to their first child?

9. *Dreams and opportunities*

- a. What are your dreams for the future?
- b. What makes you happy as a young person?
- c. What is most important to do to improve your quality of life (related to SRHR)? Who can do something about that?

Tool 2.3 Topic Guide ‘Parents’ (FGDs/ IDIs)

Topics

1. *Ethnic identity and self perception of young people*
 - a. What are the most important things in life for young people?
 - b. Finish this sentence, "Being a young woman/man in ... [name city/...] means..."
2. *Communication between parents and young people*
 - a. What is your opinion about sexuality education for young people?
 - i. By parents/ family
 - ii. By teachers
 - iii. By health care providers
 - b. Do you communicate with your children about sexuality and related topics?
 - c. What is your opinion about sexual behaviour among young people?
 - i. Condom use
 - ii. Taking own decisions with respect to sexuality
 - iii. Sex before marriage
 - iv. Abortion
3. *Health of young people*
 - a. How healthy is the development of adolescents in your society/community? What are the ideals of adolescents and which are the conditions for young people to reach their ideals?
 - b. What are successes and opportunities and what are the barriers?
 - c. What do you recommend for reinforcing the successes and creating more opportunities and what for overcoming barriers?
 - d. What are in your view the main health problems young people face today?
 - i. How is that when you look to their physical, psychological and social development?
 - ii. What is the role of sexuality in problems young people face today?
 - iii. Are gender differences important? Why?
 - e. How important is puberty in defining adolescents' health needs?
 - f. Are sexual contacts among adolescents increasing? Is this reflected in health problems of adolescents?
4. *Supportive environment*
 - a. Are policies at national level supportive for improving young people's sexual health? Are international policies relevant as well?
 - b. Are children's rights relevant? Why (not)? And policies on gender?
 - c. Are policies at community level supportive?
 - d. Does the community offer appropriate services (education, counselling, health and treatment) and facilities (meeting places, supplies)?
 - e. Is the social norm supportive?
 - f. Are there advocacy interventions related to SRH&R to improve policies?
5. *Improving young people's health*
 - a. What in your view can best be done to improve young people's health? Are you already active or do you plan things? Who is doing what and how?

- b. What other sectors are relevant to act in your view? Are they already active and how? Who should have to do what in your view?
 - c. What information and support do you need to contribute to supportive interventions for the young people in your community?
6. *Other relevant stakeholders*
- a. Who should I speak to as well?

Tool 2.4 Topic Guide ‘Teachers’ (FGDs/ IDIs)

Topics

1. *Teaching experience*

- a. What has been your experience in teaching?
 - i. Which subject?
 - ii. To what extent do you use a participatory approach in teaching (versus lecturing)?

2. *Experience in teaching sexuality education*

- a. What has been your experience in teaching sexuality education? (if no experience, continue with next question)
 - i. What kind of intervention?
 - ii. How long did you teach this?
 - iii. Which grades/ages and subjects do you teach?
 - iv. What questions of students on reproductive health and sexuality education are most common?
 - v. Did you difficult face situations related to reproductive health and for sexuality education?
- b. How was it for you to communicate with young people about sexuality and related topics?
 - i. What did you like most?
 - ii. What were the major challenges?
 - iii. What skills/ knowledge/ support did you lack?
- c. Are you already active in learning life skills on reproductive health and sexuality education?
 - i. Did you have training?
 - ii. Which materials are appropriate and which materials do you use?
 - iii. Do you use interactive teaching methods such as group discussions and role plays?
- d. What are your lessons learned for effectively teaching on life skills on reproductive health and sexuality education?
 - i. What for having a supportive environment (social norm, services on counselling and health care, facilities, policies in the organization and in the community)?
- e. Which grades/ages and subjects are most appropriate for learning life skills on reproductive health and sexuality education?
- f. Are teachers knowledgeable about young people’s sexuality?
 - i. Are they able to openly communicate about sexuality?
 - ii. Are parents and community supportive to teachers in openly communicating sexuality?
 - iii. Are they involved in those projects?
- g. Are young people involved and implementing in developing courses on learning life skills on reproductive health and sexuality education?
- h. Are children’s rights relevant in projects and teaching on life skills on reproductive health and sexuality education?
- i. Are gender differences relevant and what do they mean for projects and teaching on life skills on reproductive health and sexuality education?

- j. Are age differences relevant and what do they mean for projects and teaching on life skills on reproductive health and sexuality education?
3. *Health of young people*
 - a. What are in your view the main health problems young people face today? How is that when you look to their physical, psychological and social development?
 - b. What is the role of sexuality in problems young people face today?
 - c. Are gender differences important? Why?
 - d. How important is puberty in defining adolescents' health needs?
 - e. Are sexual contacts among adolescents increasing? Is this reflected in health problems of adolescents?
 4. *Attitude towards young people's sexuality*
 - a. What is your opinion about sexuality education for young people?
 - i. By parents/ family
 - ii. By teachers
 - iii. By health care providers
 - b. What is your opinion about sexual behaviour among young people?
 - i. Condom use
 - ii. Taking own decisions with respect to sexuality
 - iii. Sex before marriage
 - iv. Abortion
 - c. Are you able to approach young people without judging them?
 5. *Confidence in teaching sexuality education*
 - a. What are important reasons for you to teach sexuality education?
 - b. Do you think you are able to communicate openly with students about sexuality and related topics?
 - c. If not, what skills/ knowledge/ support do you need?
 6. *Training and support for teaching sexuality education*
 - a. What support do you expect from
 - i. School administration
 - ii. Other teachers
 - iii. ...
 - b. What other sectors are relevant to act in your view? Are they already active and how? Who should have to do what in your view?
 - c. Are policies at community level supportive?
 - d. Does the community offer appropriate services (education, counselling, health and treatment) and facilities (meeting places, supplies)?
 - e. Is the social norm on young people and sexuality supportive? For both gender?
 - f. Are there advocacy interventions related to SRH&R to improve policies?
 - g. What information and support do you need to implement learning life skills on reproductive health and for sexuality education in your activities?
 7. *Other relevant stakeholders*
 - a. Who should I speak to as well?

Tool 2.5 **Topic Guide ‘Health care providers/ counsellors’ (IDIs)**

Topics

1. *SRH problems of young people*
 - a. What are the most important problems young people come with to you?
 - i. Differences between sub-groups of youth (age, male/female, etc)
 - b. What is your impression about figures among young people of
 - i. HIV/AIDS
 - ii. STIs (which ones)
 - iii. Unplanned pregnancy
 - iv. Unsafe abortion

2. *Cooperation with schools*
 - a. To what extent do schools refer young people to your services?

3. *Attitude towards young people’s sexuality*
 - a. What is your opinion about sexuality education for young people?
 - i. By parents/ family
 - ii. By teachers
 - iii. By health care providers

Tool 2.6 Topic Guide 'Experts' (IDIs)

Topics

1. *Expertise in sexuality education or working with young people*
 - a. What has been your experience in sexuality education or working with young people?
 - b. What are the most important issues for young people at this moment?
 - c. What is your perception of the current youth culture?
 - b. What is your opinion about sexuality education for young people?
 - iv. By parents/ family
 - v. By teachers
 - vi. By health care providers
 - c. What kind of education do young people need?

2. *Sexuality and relationships*
 - a. What is your perception on young people's sexual activities and relationships?
 - i. At what age do they get sexually active?
 - ii. Can young people take their own decisions about their own sexuality?
 - iii. With whom do young people have sexual relationships?
 - iv. What kind of knowledge, attitudes, skills do they need? What is lacking?
 - b. What are some of the difficulties young people experience in relationships?
 - c. What factors affect whether young people decide to have sex with someone or not?
 - i. Accessibility of condoms
 - ii. Knowledge
 - iii. Attitude
 - iv. Skills
 - v. Social influence
 - d. What factors affect whether they use a condom or not?
 - i. Accessibility of condoms
 - ii. Knowledge
 - iii. Attitude
 - iv. Skills
 - v. Social influence
 - e. With whom do young people discuss these issues?
 - i. Other peers
 - ii. Parents
 - iii. Teachers
 - iv. Others

Tool 2.7 Topic guide review of existing literature and reports

1. *Health status target group*
 - a. morbidity and mortality
 - b. development stages: physical, social and sexual maturation
 - c. common infections
 - d. disabilities
 - e. psychological problems
 - f. lack of parental guidance, percentage of street kids and orphans
 - g. problems related to social norm, gender, stigma and discrimination
2. *Socio-cultural economic and political context related to SRHR*
 - a. social norm regarding youth and sexuality, including sexual rights
 - b. minimum age of consent
 - c. minimum age of marriage
 - d. minimum age and laws on labour
 - e. policies regarding adolescent SRH (prevention & services), including gender, abortion, homosexuality
 - f. educational policies regarding sexuality education, counselling and school policies, including school leaving age, provisions for pregnant girls, married students and YPLHA, protocols in case of sexual violence and homosexuality and homophobia
 - g. policies related to consent and confidentiality regulations for services, including youth-friendly access, supply provision, testing, treatment
 - h. policies regarding children's rights
 - i. policies regarding HIV/AIDS, including treatment and reducing stigma of PLHA, prevention, counselling and testing
3. *Socio-demographic factors related to SRHR*
 - a. prevalence rates HIV/AIDS, STIs, early marriage, teenage pregnancy, abortion, sexual abuse, homosexuality, stigma
 - b. data on sexual behaviour and determinants, risky and protective factors, high risk target groups
 - c. access to and use of education, including on SRH&R
 - i. knowledge
 - ii. attitudes
 - iii. social influences
 - iv. skills
 - d. access and use of SRH services
 - i. knowledge
 - ii. attitudes
 - iii. social influences
 - iv. skills
 - e. youth participation/peer education and its degree
4. *Educational capacity*
 - a. subjects which include SRH&R issues and curricular and extra-curricular time available
 - b. teacher selection
 - c. capacity teachers related to SRH&R
 - d. availability teacher training on SRH&R
 - e. availability programs on SRH&R
 - f. role of peer educators/youth participation
 - g. availability of in-school counselling and health care services and access to supplies

- h. capacity of counsellors
 - i. availability training for counsellors on SRH&R
5. *Capacity community related to SRH&R*
- a. availability and youth-friendly access to IEC related to SRH&R
 - b. availability and youth-friendly access to counselling and health care services related to SRH&R
 - c. availability supportive policies related to SRH&R
 - d. advocacy interventions related to SRH&R

Tool 2.8 Sheet ‘Description of existing interventions’

	Title materials	Developed by	Year	Context (country, culture, etc.)	Age group	Kind of i (leaflet, comprehensive curriculum, ...)	Language	Consent to use materials	General comments
1									
2									
3									
4									
5									
6									
7									
..									

Tool 2.9 Checklist 'Analysis of Existing Interventions'

A checklist composed by WPF using references from WHO and UNICEF

Type of material: (leaflet, brochure, manual, et cetera):

Name of the material:

Edited by:

Number of pages:

Year of publication:

Target population:

Target group

- | | | | |
|--|------------------------------|-----------------------------------|-------------------------------------|
| 1. The material is clearly meant for a specific target group | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 2. The material is clearly meant for a specific age-group (or grade) | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 3. The material can also be used by: | | | |
| illiterate youth | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| low educated youth | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| migrant youth | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| urban youth | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| rural youth | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| only boys | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| only girls | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| homosexual youth | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |
| other: | <input type="checkbox"/> yes | <input type="checkbox"/> possibly | <input type="checkbox"/> not at all |

Judgement on usefulness:

Form and packaging

1. Presentation

- | | | | |
|---|------------------------------|-----------------------------------|-----------------------------|
| a. The material is attractively presented (clear, vivid, pictures, graphs) | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| b. Content and examples are relevant to the target group | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| c. Content and examples are relevant to the community | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| d. Language is matching age and literacy level of target audiences | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| e. Content and language are gender sensitive | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| f. Pictures, images, graphs, etc. are appropriate to targeted age | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| g. Pictures, images, graphs, etc. are appropriate to community context | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| h. Pictures, images, graphs, etc. are not racist, sexist, homophobic, coercive or judgmental; are sensitive to values and culture of the target group | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |

Specific comments:

2. Packaging

- a. Size & weight of material are reasonable (to transport, keep private) yes somewhat no
- b. The material is resistant, durable yes somewhat no

Specific comments:

3. Technical aspects of material, graphical quality

- a. Font & readability is appropriate for the target group yes somewhat no
- b. Printed/ printable space is efficiently used yes somewhat no
- c. Cost is reasonable yes somewhat no

Specific comments:

Judgement on usefulness:

Approach

1. Young people are approached as sexual beings yes somewhat no
2. Young people are approached as a heterogeneous, diverse group yes somewhat no
3. Young people are approached as able to make own decisions yes somewhat no
4. Rights of young people are acknowledged yes somewhat no
5. Sexuality is approached in a positive way yes somewhat no
6. The approach of sexual health is not fear-based yes somewhat no
7. Sexual health problems are embedded in a positive approach yes somewhat no
8. Circle the dominant approach: yes somewhat no
- a. Biological
 - b. Medical
 - c. Psycho-social
 - d. Ethical, moral, religious
 - e. Social-cultural
 - f. Rights-based
 - g. Other:

Judgement on usefulness:

Accessibility

1. The information on content is:

- | | | | |
|---------------------------------|------------------------------|-----------------------------------|-----------------------------|
| a. comprehensive | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| b. explicit | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| c. unambiguous | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| d. unbiased and non-judgemental | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| e. convincing | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |
| f. credible | <input type="checkbox"/> yes | <input type="checkbox"/> somewhat | <input type="checkbox"/> no |

Judgement on usefulness:

Content

1. The content includes attention for:

PUBERTY/ BECOMING AN ADULT

Physical, emotional, psycho-social changes

Self image, autonomy and decision making

Menstruation

Masturbation

Sexual orientation

SOCIAL ENVIRONMENT

Relationships with parents, friends and peers

Rights

Gender

Culture and religion

SEXUALITY

Sexuality

Sexual practices

Sexuality and pleasure

Sexuality, intimacy, love and relationship

SEXUAL HEALTH PROBLEMS

Pregnancy

Abortion

STI's and HIV

Sexual harassment and abuse

Living with HIV/AIDS

PREVENTION

Abstinence

Monogamy

Safe sex

Contraception use

Condom use

SUPPORT IN SEXUAL HEALTH PROBLEMS

	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
Support in/ of own environment	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
Professional support (counselling, care, testing)	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
Addresses/ references for support	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no

Judgement on usefulness:

Goals and Objectives

1. The material/ information outlines clear goals: yes no not applicable
2. The material/ information outlines messages in line with appropriate key messages? yes no
3. The objectives/ information in the material include attention for:
 - a. Knowledge mainly somewhat not
 - b. Risk perception mainly somewhat not
 - c. Attitudes mainly somewhat not
 - d. Social influence mainly somewhat not
 - e. Skills mainly somewhat not
4. The material/ information outlines messages in line with appropriate specific messages? yes no
5. The objectives mentioned in the material are:
 - a. specific yes no not applicable
 - b. measurable yes no not applicable
 - c. achievable yes no not applicable
 - d. relevant yes no not applicable
 - e. time-bounded yes no not applicable

Judgement on usefulness:

In case of materials for teachers or youth intermediaries:

Educational methods/ strategies

1. Attention is given to confidentiality and a safe atmosphere yes somewhat no not applicable
2. Methods focus on participation of young people/students yes somewhat no not applicable
3. The methods are appropriate for achieving the objectives yes somewhat no not applicable
4. The skills are supported by appropriate learning experiences yes somewhat no not applicable

5. The methods are well varied yes somewhat no not applicable
6. Detailed and coherent instructions are provided to teachers/ youth intermediaries for each unit including: yes somewhat no not applicable

Judgement on usefulness:

Material development

1. Material includes assessment tools to measure impact yes no not applicable
2. Material is part of a prescribed wider framework yes no not applicable
- If yes: ...
3. Material has official endorsement (Ministry of Education, university, NGO, etc.) yes no not applicable
4. Material was developed based on research among the target population yes no not applicable
5. Material was developed with involvement of yes no not applicable
- a. Young people themselves yes no not applicable
- b. Youth intermediaries (teachers, school staff, ...) yes no not applicable
- c. Representatives of the wider community yes no not applicable
6. Material was based on theoretical framework yes no not applicable
7. Material was based on rights of young people yes no not applicable

Judgement on usefulness:

Overall conclusion

Tool 2.10 Checklist to describe experience of organisation with SRHR

1. Documents

- a. annual report
- b. organisation structure
- c. most recent project description, particularly related SRH&R
- d. (examples of) SRH&R materials (curriculum, brochures, leaflets)
- e. most used strategies and principles, including children's rights
- f. experience with SRH&R and capacity within organisation, related to prevention, counselling, testing, treatment, care, supply provision and advocacy for supportive social norms and policies
- g. community involvement
- h. collaboration with others (education, services, advocacy, youth participation, community mobilisation)
- i. description target group
 - i. sex
 - ii. age
 - iii. differentiation
 - iv. education
 - v. rate literacy
 - vi. prevalence rates HIV/AIDS, STIs, early marriage, teenage pregnancy, abortion, sexual abuse, homosexuality, stigma
 - vii. data on sexual behaviour and determinants, risks and protective factors, high risk target groups
 - viii. social norm regarding youth and sexuality, including sexual rights
 - ix. communication means
 - x. settings to reach target groups
 - xi. access to and use of education, including on SRH&R
 - xii. access and use of SRH services
 - xiii. youth participation/peer education and its degree
- j. studies on target group related to life skills, SRH&R and other relevant issues to develop a project on SRH&R

2. Organisation and capacity

- a. structure of organisation and capacity regarding young people and education
- b. experience with SRH&R and capacity within organisation, related to prevention, counselling, testing, treatment, care, supply provision and advocacy for supportive social norms and policies
- c. most recent project description, particularly related SRH&R (education, services, advocacy, youth participation)
- d. (examples of) SRH&R materials (curriculum, brochures, leaflets)
- e. most used strategies and principles, including children's rights, for intervention development and implementation
- f. research-based development of interventions, use of M&E systems, in-house program development, research and training
- g. community involvement in program development and implementation
- h. young people's involvement in program development and implementation
- i. collaboration with others (education, services, advocacy, youth participation, community mobilisation)
- j. description target group
 - i. sex
 - ii. age

- iii. differentiation
- iv. education
- v. rate literacy
- vi. communication means
- vii. settings to reach target groups
- viii. sources for information

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- ¹⁹ www.who.int/reproductive-health/adolescent/docs/fgd_question_ex.pdf; www.who.int/reproductive-health/adolescent/docs/fgd_idi_notes.pdf
- ²⁰ www.extension.iastate.edu/publications/pm1969b.pdf
- ²¹ www.tcall.tamu.edu/orp/orp1.htm
- ²² www.idrc.ca/en/ev-56615-201-1-DO_TOPIC.html
- ²³ www.policy.hu/ghukasyan/FG_Guide_Parents.html

6. IM Step 3. Objectives

Where are we in Intervention Mapping?

The previous step provides planners with information and evidence that can be used to identify the objectives of IM Step 3. It also gives information to define the need for segmentation of target groups, and to decide about the intervention setting and implementers. Objectives guide intervention design, and planning the implementation of the intervention. The task in IM Step 3 is to identify objectives on different levels, ranging from the desired outcomes on the level of Sexual and Reproductive Health and Rights to the level of behavioural determinants.

Steps in Intervention Mapping

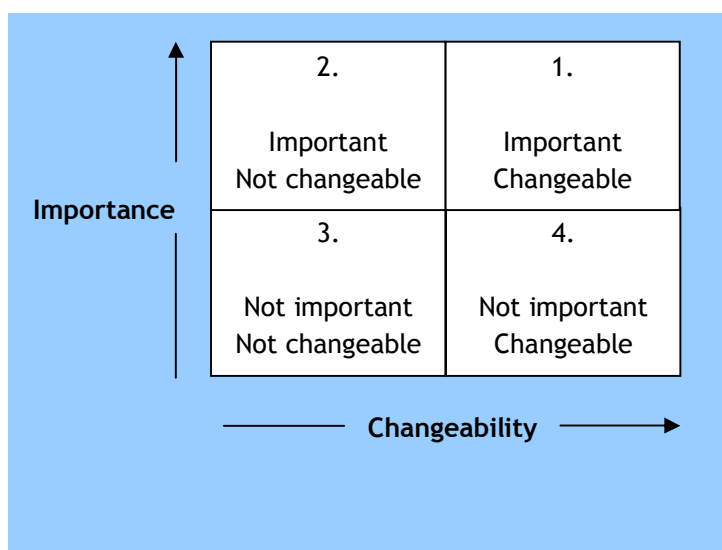
1. Involvement
2. Needs Assessment/ Situation Analysis
- 3. Objectives**
4. Evidence-Based Intervention Design
5. Adoption & Implementation
6. Monitoring & Evaluation

This chapter describes Intervention Mapping Step 3, stating the objectives that guide intervention design. Planners state behavioural and environmental outcomes and they specify change objectives (on the level of determinants).

To be able to identify the objectives on different levels, programme planners start with a brainstorm about all desired and possible changes in behaviour, environmental conditions and determinants. The result is a provisional list of objectives. Secondly, planners find evidence in the needs assessment/ situation analysis (IM Step 2) that supports or rejects these objectives.

- 1. Brainstorm**
- 2. Find evidence**
- 3. Importance & changeability**

Finally, they evaluate the *importance* and *changeability* of the objectives and narrow the set of objectives to those that will have the most effect on health behaviour, environmental conditions and health status, and concurrently can be changed. This results in a final list of objectives of the intervention(s).



They first select the **most important** needs, problems or expectations. Interventions cannot address everything and planners need to take decisions about what to address and what not. A useful way of doing this is by making a 'priority list' describing the needs that are most relevant, based on the outcomes of various sources of data (statistics about SRH problems, discussions with young people, interviews with experts and community members).

Secondly, they select the **most changeable** needs, problems or

expectations. Especially in the field of communication about sexuality and SRHR related needs, there may be quite some resistance from parents, schools or community members. In addition, educators may not feel comfortable to educate young people about all topics. Other factors that may be very important are all environmental factors (e.g., availability of condoms), but may be very difficult to change by the project.

Matching importance and changeability results in four categories of priorities:

1. Planners select those topics and needs that are **most important** and **most easy to change**; for example, providing information, talking with young people about their future planning, or about friendships. Some issues are very important but also require a lot of advocacy or training of community members and/or educators to change.
2. When issues or needs are **important** but **not changeable** within the project, planners can leave them out, but these can be a very important risk to the project and planners can even consider to not continue with the project. For example, a sexuality education programme in a context where condoms are not easily accessible for young people.
3. Needs that are **not important** and **not changeable** are of course not useful to address in intervention programmes.
4. Issues that are **not important** but **changeable** can be included in the programme, but can also be left out. Planners should rather focus on the needs that are important and changeable.

Tasks in Step 3

Task 3.1	Involve relevant stakeholders
Task 3.2	Identify the target group
Task 3.3	State SRHR outcomes
Task 3.4	Specify health promoting behaviours
Task 3.5	Specify performance objectives
Task 3.6	Specify change objectives

6.1 Task 3.1 Involve relevant stakeholders

In this manual we stress the importance of *involvement* and participation of stakeholders, including young people, educators, parents, community members, programme planners, project managers, researchers, health workers, policy makers, and other decision makers.

Educators (the users of the program), young people and policy makers (for instance, head teachers and representatives of the Ministry of Education and Health) should check whether the objectives are relevant and important, and whether they fit with national policies and the expectations and capacities of the implementers (educators) of the intervention, as well as parents and community members.

Planners ask feedback about the selection of the target group: do relevant stakeholders agree with the target population, or do they have any suggestions? The working groups and advisory board need to agree with the behavioural and environmental outcomes of the intervention programme. For example, stakeholders may need to agree with the inclusion of condom use as one of the behavioural messages for sexually active young people. Do young people, educators, schools,

service providers, parents, community members and relevant authorities agree with the desired outcomes and objectives of the intervention programme?

Table 6.1 Tasks of the planning team

3	OBJECTIVES	STAKEHOLDER	TASKS
		a. Planning group	<ul style="list-style-type: none"> • Provide lists of objectives focusing on behavioural and environmental outcomes, and relevant and changeable ‘change objectives’ • Ensure objectives are related to (national) educational objectives and young people’s rights • Get feedback from working groups, advisory board, and other stakeholders • Instruct intervention developer(s)
		b. Working group young people	<ul style="list-style-type: none"> • Provide feedback and agree with objectives: they need to address young people’s needs and rights
		c. Working group educators	<ul style="list-style-type: none"> • Provide feedback and agree with objectives: they can be achieved by educators during implementation
		d. Advisory board	<ul style="list-style-type: none"> • Provide feedback and agree with objectives
		e. Others Intervention developer(s)	<ul style="list-style-type: none"> • Get involved and understand the objectives of the intervention programme

Not all stakeholders may need to be involved in every decision. Planners have to think carefully who they will involve and consult. It is suggested to select relevant stakeholders who have power to support the programme in its pilot implementation, but also for sustainable implementation. It is also suggested to select stakeholders who are knowledgeable, and supportive to the programme. Planners identify how and when they involve them, e.g., by organising (expert) meetings, sending information letters and asking for feedback. Other projects provided evidence that this task is very important and if not taken well, may lead to a lot of discussion and even resistance later on in intervention design and implementation. Involving stakeholders in the right way, most likely increases agreement, commitment and ownership of the programme.

If an *intervention developer* is involved in the design of the intervention, he or she should already be involved in IM Step 3 to make him/her familiar with the expected outcomes and the intervention objectives, and why particular objectives were excluded or included.

6.2 Task 3.2 Identify the target group and implementers

The identification of target groups and implementers is not something that is done only at one moment. This is a back and forth process, depending on a number of factors, including the magnitude of SRHR challenges that young people face; the implementation setting; most optimal age for young people to get exposed to sexuality education; and sometimes funding possibilities.

Planners who design sexuality education interventions aim to address the needs and rights of young people and mobilise their capacities to create social change. Often, planners already know the target group (or beneficiaries) and who will deliver the intervention before they even start with the

analysis. For example, they have already planned to target youth in school aged 12-15, and teachers who will deliver the intervention to them. However, both in the analysis (IM Step 2) and when stating the objectives (IM Step 3), planners should (re-) decide about the exact target group and implementers of the intervention.

6.2.1 Identify the target group

In this section, we distinguish between the at-risk group and target group of an intervention. The *at risk group* can be defined as the population at risk of a particular health problem; for instance, young people who are at risk of HIV-infection. The *target group* (or intervention recipients) of an intervention consists of people who are exposed to an intervention in order to promote the health of the at risk group. The target group and at risk group may be the same, but may also be different.

In target group selection, planners decide on whom they focus the intervention. Target group selection can be based on many variables, including:

- *personal characteristics*; age, stage of development, gender, sexual orientation
- *social characteristics*; educational level, rural/urban environment, geographic location, socio-economic status, cultural origin/ethnic background, religious background, and language, migrants
- *behavioural characteristics*; stages of behavioural change, experience with desired behaviour, sexually active, experience with sexual intercourse, number of (current/lifetime) sexual partners, marriage status, parenthood, having been/made pregnant, having had an abortion; or for policy makers and other environmental agents: different attitudes and behaviour regarding sexuality of young people

Young people living in different contexts (e.g., rural or urban) may have different lifestyles, values and opportunities. Planners can either decide to develop an intervention for a large group of people, or to develop different programmes for different groups (e.g., rural and urban youth, girls and boys).

For example, boys may need different skills than girls or may have particular attitudes that do not support safe sexual behaviour or well-being of girls. If relevant, intervention planners therefore state specific objectives for specific target groups.

Box 6.2 When to start with sexuality education for youth?

With regard to the age of the target group of sexuality education, evidence shows that effective sex education should start early, before young people reach puberty and before they have developed established patterns of behaviour.^{1;2}

The precise age at which information should be provided, depends on the physical, emotional and intellectual development of the young people as well as their level of understanding. What and the way it is covered, depends on who provides the sex education, when, and in what context, as well as what the individual young person wants to know about. It is important not to delay providing information to young people but to begin when they are young. Providing age and development stage specific information, creates the foundation on which more complex knowledge is built up over time.

Some people are concerned that providing information about sex and sexuality arouses curiosity and can lead to sexual experimentation. There is no evidence that this happens.^{3;4} It is important to remember that young people can store up information provided at any time, for a time when they need it later on.

Planners should discuss whether differences between these subgroups can be dealt with within the scope of one single intervention, or whether different interventions, or parts of interventions, have to be designed for different subgroups. For practical or for ethical reasons it is sometimes not possible to differentiate on certain aspects. Providing different programmes for young people who are sexually active and young people who are not, could result in stigmatisation.

Every target group differentiation doubles the work, the manpower needed to be able to develop an intervention (e.g., working group, intervention developers), and of course the development costs. The expenses of target group segmentation can be so high, that intervention planners may only decide to differentiate when they see no other way out, and when they have resources to design more than one intervention.

Box 6.3 Example - BCC strategy Vietnam

In Vietnam, a Behaviour Change Communication Strategy was developed in collaboration with World Population Foundation. Different health problems were identified among different sub-groups.

	Target groups	SRH PROBLEMS				
		Unintended pregnancy	Abortion (unsafe)	Sexual abuse	RTIs/ STIs/ HIV/ AIDS	Discrimination PLWHA
1.	In school					
1.1	Both secondary and high school pupils (including ethnic minority groups)	+	+	++	+	+
1.2	Students (University, colleges)	+++	+++	++	+++	+
2.	Out of school					
2.1	Street children	+	+	++	+++	++
2.2	Youth working in factories, offices	+++	+++	++	+++	++
2.3	Youth working in restaurants, hotels	++	++	++	+++	++
2.4	Youth working as farmers	++	+	++	++	+
2.5	Ethnic youth living in mountainous areas	++	+	+	+	+
3.	Young people living with HIV/AIDS	+	+	+	+++	+++

6.2.2 Identify the implementers

Secondly, planners should get an idea of who will provide the education to the target group. Preferably, planners have asked young people in the NA/SA what they would prefer as deliverers of sexuality education. This may vary from context to context. Sometimes youth prefer teachers, sometimes they like to receive particular information from ‘experts’ (such as medical professionals) and other information from peer youth.

Evidence shows that facilitators should be able to relate to youth and be youth friendly,⁵ should have a background in health education and especially sex or HIV education, is motivated to work on SRHR of young people, and is willing to promote sexual and reproductive rights young people.⁶

IM Step 5 (Adoption and Implementation) pays more attention on the selection of implementers of the programme, and how to support and train them to be able to facilitate sexuality education for young people.

6.3 Task 3.3 State SRHR outcomes

After collecting, analysing and describing the NA/SA, the information is used in the next steps of intervention planning. Based on the findings, planners state the expected outcomes related to quality of life and health outcomes of young people, particularly their Sexual and Reproductive Health and Rights.

Box 6.4 shows the SRHR outcomes of The World Starts With Me in Uganda. In some sexuality education interventions, outcomes are added with regard to reduction of abuse of alcohol and drugs, when this is an important problem among young people in itself, and also related to increased unsafe sexual behaviour.

Box 6.4 SRHR outcomes in 'The World Starts With Me' Uganda

The NA/SA in Uganda showed that young people face various SRHR challenges, which were addressed in 'The World Starts With Me'. The following SRHR outcomes were formulated:

Sexual and Reproductive Health

- Reduce new HIV-infections among young people (incidence)
- Reduce number of new Sexually Transmitted Infections
- Reduce rates of unintended pregnancy and early motherhood among young people
- Reduce the number of (unsafe) abortions

Sexual and reproductive Rights

- Reduce stigmatisation for various reasons (including HIV/AIDS status, religion, gender, sexual orientation)
- Promote gender equality of boys and girls
- Reduce sexual harassment and abuse
- Improve access to health care and counselling, including HIV and STI testing and treatment
- Promote young people's freedom to take own informed decisions related to sexuality

Other interventions do also include a broader approach on life skills, increasing young people's skills to improve their quality of life. There may however be a risk in specifying too many health and quality of life outcomes, as this also increases the scope of the intervention programme. If the NA/SA shows that particular factors are very important, planners should consider whether to include it or not.

6.4 Task 3.4 Specify health promoting behaviours

In Chapter 2, we have described the PRECEDE model, showing that Sexual and Reproductive Health and Rights (SRHR) is influenced by 1) **behaviour** of the at risk group, and 2) **environmental** conditions. For example, HIV/AIDS can be caused by unsafe sexual behaviour, but also by the unavailability of condoms (environmental condition). In Intervention Mapping, the environmental conditions are also translated into behaviours. Using the same example, the unavailability of condoms is translated into behaviour: who is able to provide the condoms (behaviour of the actor in the environment)? In this task planners identify the health promoting behaviours of both the at risk

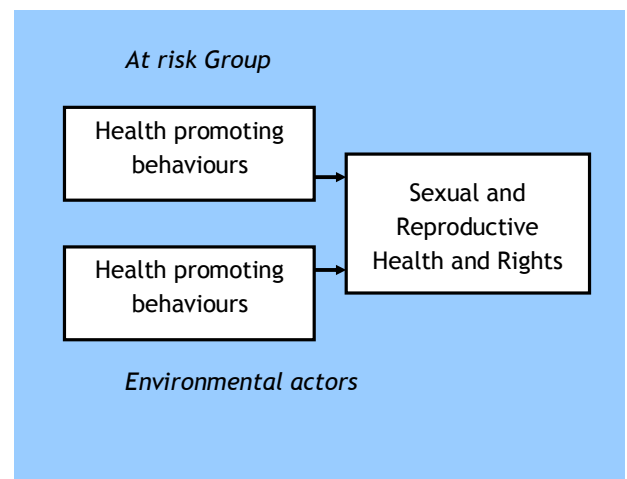
population (young people) and of people in their environment (such as health care providers, parents, teachers, etcetera). See Figure 6.1.

Planners start with looking at the risk behaviours which are identified in the NA/SA. And after that they specify the behaviours that promote the health and rights of young people.

In this stage of programme planning, it is very important to get consent from relevant policy makers, the community and programme users to include particular behavioural outcomes. If this is not done, programme planners may find out too late (during intervention design or even during implementation) that the intervention may not be implemented because of lack of support of the people who are in charge of the implementation.

Planners should be able to convince policy makers (with sufficient evidence and arguments derived from the needs assessment/ situation analysis , as well as UN conventions) about the importance of giving young people choices, including the option of condom use when they are sexually active and delay of sexual intercourse as behavioural outcomes of the intervention.

Figure 6.1 Health Promoting Behaviours



6.4.1 Health promoting behaviours of young people

Planners can identify risk behaviours related to health (SRH) and rights (SRR). The question is ‘which risk behaviours of the target population (young people) lead to SRHR-related problems?’

Sexual and Reproductive Health

In developing countries, HIV/AIDS, STIs and unintended teenage pregnancies are particularly caused by unprotected vaginal sexual intercourse. Sexual intercourse with older and often more experienced sex partners increases the chance on HIV-infection and the transmission of STIs. HIV can also be transmitted through anal sexual intercourse, intravenous drug use, mother-to-child transmission, or blood transfusions. Transmission routes and rates may differ for each country and planners have to identify and provide evidence for the major risk behaviours for their particular context among their particular target group.

Although *intravenous drug use* is not directly related to sexuality, in a number of countries, particularly in South-East Asia, HIV/AIDS is to a large extent transmitted through drug use. *Alcohol use* is often identified as one of the behaviours that increases unsafe sexual behaviour. It depends on the context whether this behaviour would be part of the list of priorities of behaviour outcomes. Finally *unsafe blood transfusion*, being one of the underestimated factors leading to high levels of HIV-infection. Planners have to decide whether they want to focus on this issue or not in programme planning, as it requires a very different approach and intervention.

Sexual and Reproductive Rights

One of the rights of young people is that they are free to take their own, well-informed decisions whether they are sexually active or not. Another right relates to their access to health services and their health seeking behaviour. Other rights relate to lack of discrimination because of sexual orientation, HIV-status, and specifically to the equality of boys and girls.

Main risk behaviours young people

- Unprotected sexual intercourse with new sexual partner without taking a HIV-test
- Unprotected sexual intercourse with multiple sexual partners
- Unprotected sexual intercourse with older sex partners
- Sharing needles during intravenous drug use
- Lack of health seeking behaviour, including HIV and STI testing & treatment

The next step is to translate the risk behaviours into health promoting behaviours (HPB). Planners make a switch in perspective from problem to solution, as the intervention will focus on what needs to be improved, changed, or reinforced. See Box 6.6 for some examples of health promoting behaviours related to the promotion of young people's SRHR.

Planners provide evidence for the list of health promoting behaviours. Substantial evidence shows the effectiveness of comprehensive sexuality education programmes that promote abstinence as the most effective way to prevent pregnancy and STIs while also providing medically accurate facts and clear messages about condoms and contraceptive use.^{7;8}

Based on the evidence-based list of health promoting behaviours, programme planners select the behavioural outcomes that are most relevant and changeable among young people within the particular context.

Health promoting behaviours young people

- Well-informed decision-making about own sexuality
- Abstinence from sexual intercourse
- Delay of onset of sexual intercourse
- Correct and consistent use of condoms
- Having sex with one partner
- Having sex with a sexual partner of the same age
- Health seeking behaviour
- Abstinence from intravenous drug use
- Using clean needles when using drugs

Decision-making

The most important health promoting behaviour is the personal decision-making of young people related to their own sexuality and sexual behaviour. For young people to feel comfortable with their own sexuality and with the people around them, it is fundamental that they can take healthy decisions about their sexuality, i.e., whether to be sexually active or not. Young people have the right to take their own decisions, independent of age, gender, sexual orientation or HIV-status.

In UN Conventions is agreed that young people have rights, but many adults have a problem with the right of young people to decide whether they want to be sexually active or not and providing them with information to take that decision. However, evidence shows that giving them information

does not increase their sexual activity⁹ and when young people take their own decisions, this is much more effective than prescribing behaviour.

Box 6.7 The ABC approach: opportunities and limitations

An often-used communication approach providing several options is the ABC approach,¹⁰ endorsed in 2001 by the United Nations General Assembly Special Session (UNGASS). A stands for Abstinence, B for Be faithful and C for Condom use. ABC is sometimes completed with a D for Drugs, referring to intravenous drug use and recreational use of alcohol, which increase the likelihood of unsafe sex. Some also refer to ABC+, which includes the message to get tested and treated for HIV and STIs (as STIs increase the risk of HIV-transmission in unprotected sex).^{11,12}

Although the ABC message seems to have been successful in some countries, such as Uganda, there is mounting evidence that this approach is only effective when it fits within a framework that stresses an explicit and balanced explanation of each component of ABC, considers the impact on both males and females and puts decision-making in the broader context of the social and political environment.

A or B or C

Presenting each component of the ABC message in a comprehensive and balanced way means in the first place to avoid a hierarchic order. Abstinence is often labelled as the best option whereas condoms are mainly recommended to young people who fail to abstain from sex and further also fail to be monogamous.

The hierarchic order of ABC may then result in sexual active young people diverting themselves from the message, perceiving its hierarchic order as prescribing and implicitly frowning upon changing partners and thus condom use. Increasing numbers of adolescents experiment with sex and many have various subsequent monogamous relationships (*serial monogamy*). Changing partners is a common phenomenon among young people.¹³ The hierarchic ABC approach may therefore not be applicable to them. There is a need to also inform them about testing on HIV and STI's.

The ABC message also needs to be further expanded to meet the needs of women and girls. According to Noerine Kaleeba (UNAIDS), the ABC approach “*simply misses the point for the majority of women and girls in many cultures and situations*”. For example, abstinence is meaningless to girls and women who are coerced or forced into sexual activity.

In addition, faithfulness offers little protection to (young) wives whose husbands have several partners or were infected before they were married. This is particularly true for young women with a much older husband due to an arranged marriage or marriage at a very young age. And finally, condoms require the cooperation of men, who may refuse to use them for various reasons. They may perceive condoms as reducing pleasure, artificial, casting suspicion as being promiscuous or HIV positive, and indicating a lack of trust.

In principle, all options of ABC are important and depending of the lifestyle of each youngster, are almost equally effective in preventing HIV. Experience has demonstrated that providing people with the alternatives of health promoting sexual behaviours so that they can take their own decision based on advantages and disadvantages of that option, is more effective than prescribing them behaviour.¹⁴ It increases the probability that the decision remains in the long term, also in difficult situations.

Supportive environment for ABC

Life skills, including decision-making, are a crucial part of sexuality education programs. Policy makers therefore have to consider the context in which those decisions about sexuality take place. Providing ABC messages is not effective in an environment that does not accept young people's sexuality, is not gender-sensitive, does not give youth access to comprehensive information, counselling, health services and condoms, and does not protect young people in the case of sexual coercion and abuse. This environment will hinder and even frustrate young people in their efforts to make own their decisions.

Implementing the ABC approach requires a supportive, social and political environment, to be realised with accompanying interventions on advocacy and accessible health services. Balancing the ABC-approach therefore requires a multi-faceted package of interventions, in which gender has to play a crucial role.

Views on communicating sexuality with young people differ from culture to culture. There is the traditional view that sexuality is related to reproduction, and only within marriage. Another (more pragmatic) view, particularly driven by the AIDS epidemic, has become more common across all cultures, acknowledging that many young people are sexually active and therefore deserve information about STIs (including HIV), pregnancy, contraceptives, risk reduction and prevention.

Policy makers and program planners have different perspectives on sexuality education for young people. Some favour communication messages within the framework of comprehensive sexuality education. Others favour communication messages related to education that promotes abstinence until marriage: abstinence-only communication.¹⁵ Today, there is growing influence of the United States policy the global AIDS plan only funds an abstinence-only approach in programs for young people. As a result, particularly in countries which now adopt the US - funded 'Abstinence and Being faithful (AB)' policy, examples of conflicting communication messages can be found for one and the same target group, sometimes even at one spot from different programs.

The debate on how to communicate sexuality with young people started already since AIDS became an important health problem in many countries, and resulted in young people being bombarded with conflicting and often-confusing communication messages about sexuality, sex and abstinence, while many young people do not exactly know what the broader concept of sexuality includes.¹⁶

Box 6.8 Effectiveness of abstinence-only programs

Epidemiological figures on teenage pregnancy and HIV show that a large part of young people are sexually active. Abstinence-only programs do not meet these young people's reality and neither their rights nor do they reach the group of young people with the most urgent needs on how to protect themselves and their partners. There is growing evidence that abstinence-only programs show no long-term success in delaying sexual initiation or reducing sexual risk-taking behaviours among youth.^{17;18} In addition, participants in abstinence-only programs are less likely to use contraceptives once they become sexually active.^{19;20;21;22;23}

In addition to the lack of evidence in improving young people's sexual health,²⁴ abstinence-only programs also reinforce the taboo surrounding sexuality and often rely on scare tactics, give insufficient and inaccurate information, being often sex-stereotyped and discriminatory. These programs increase the chance that young people link sex with only guilt, fear, and shame and not with love, intimacy, proud and pleasure.²⁵ However, it is evident that for all young people who are not yet sexually active, abstaining from sex or delaying their first sexual intercourse are the best options to prevent sexual health problems. These options are particularly important for girls, as they face some of the highest sexual health risks, with many of them forced to sex or getting abused. But as condom use has been a key element in reductions in HIV prevalence in many countries,²⁶ the message of condom use for those who are already sexual active is relevant to accompany the message of abstinence.

If communication messages are developed, they should provide options in behaviour for the diversity within the group of young people and should justify the sexual and reproductive rights of young people, as they are agreed upon in UN Conventions. Communication messages have to be carefully designed, related to each other and being coherent with already existing communication messages. They preferably fit in a framework around which focused communication activities can be planned. The importance of such a framework for messages is to ensure that aspects of the information received by the targeted groups via different channels and via different GOs, NGOs and other intermediaries, reinforce each other.²⁷

6.4.2 Health promoting behaviours of environmental actors

The Sexual and Reproductive Health and Rights of young people usually not only depend on the behaviour of young people themselves, but also on behaviour of people in their social environment. Lack of condoms or youth unfriendly health care can be important obstacles for their health and rights. Planners therefore identify health promoting behaviours of the environmental actors.

In the NA/SA, planners may have come across obstacles that lead to SRHR problems among young people. For example, young people may be hindered to get STI treatment, because services are not affordable or not youth-friendly. These obstacles can vary widely between countries and cultural contexts. Condoms may be available to young people in one country, but in another country only for married young people, or not at all. Environmental outcomes can be identified on different environmental levels. See Box 6.9 for examples of environmental factors.

Box 6.9 Example - environmental factors

Interpersonal environment

- Communication about virginity, reproduction, and sexual health among parents, educators, and the community
- Social norms in communities towards premarital sex, pregnancy, STIs, HIV/AIDS, abortion, stigma
- Beliefs/ norms related to teaching young people about their SRH and sexuality
- Awareness and beliefs of communities and people surrounding people living with HIV/AIDS about HIV transmission and infection, stigma
- Youth culture, including Internet, youth media, social norms

Organisational environment

- Participation of young people in the development, implementation, monitoring and evaluation of sexuality education programmes
- Mass media campaigns with messages for young people
- Access to SRH curricula for young people in school and out-of-school
- Skills and attitudes of educators and schools
- Access to quality, rights-based IEC materials relating to SRH
- Pedagogical climate
- Counselling and referral

Community environment (e.g., availability, accessibility and affordability of youth friendly health care)

- Condoms, contraceptives, emergency contraception for young people in health services and/or pharmacies
- Health care, including HIV/ STI testing and treatment for young people
- SRHR counselling

Society

- National policies and strategies that focus on adolescent SRHR, including the fight against sexual abuse of children and young people, and the implementation of these strategies in school-based and out-of-school education and services at grassroots level
- Key community leaders at all levels who are interested in and supportive of SRHR programmes
- Advocacy activities to create an enabling environment for SRHR programmes
- UN organisations and NGOs make efforts in supporting the Government in SRHR projects in general, and ASRH in particular

After identifying the barriers, planners translate these into desired outcomes (solutions). For example, one of the desired outcomes could be that condoms are provided in the community where the target group lives in an affordable and anonymous way.

When planners want to change the environmental conditions, they have to identify the people who have the responsibility and/or the power to do something about it. The next step therefore is the identification of the people or organisations that are responsible for changing these conditions, referred to as *environmental actors*. For example, health care providers may be responsible for the provision of condoms in their community. Planners should identify the individuals in the health clinic who are actually able and have the mandate to do something about it. This could lead to an intervention composed of training and advocacy targeting these health care providers.

Box 6.10 Example - health promoting behaviours environmental actors

Health promoting behaviours environmental actors

- Parents and wider community support sexuality education for young people
- Health care providers provide youth friendly health care to young people
- Policy makers provide and implement legislation and policies that support young people’s SRHR
- Schools provide counselling to young people and refer them to health services

Finally, planners identify the environmental outcomes that are most relevant and achievable and provide evidence. It may be difficult to address all environmental factors, because some environmental issues may be very difficult to change, for example, changing legislation or policies that hinder young people’s SRHR. Strong restrictive values and norms related to young people’s sexuality in the community are usually a very important factor, but may be very difficult to change within a short period of time.

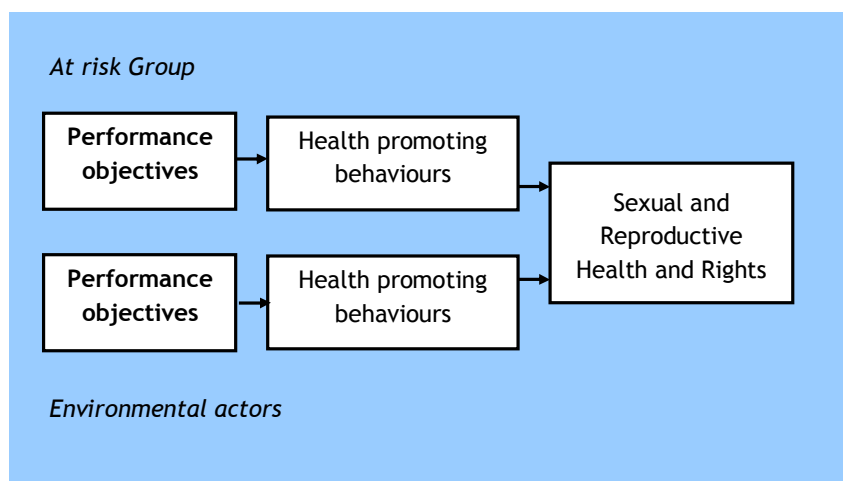
6.5 Task 3.5 Specify performance objectives

In this task, planners specify performance objectives (POs) for both the at risk group (young people) and for the environmental actors. Performance objectives describe concretely what the actor (young people, or environmental agents) has to do to perform the health promoting behaviour. The question is: ‘What does someone do (actions) when he...’

... eats a banana. These actions are the performance behaviours.

For example: 1. He decides which banana to pick, 2. Picks it, 3. Peels it, 4. Takes a piece, 5. Puts it in the mouth, 6. Chews, 7. Swallows, 8. Disposes the peels. The same can be done for other behaviours such as abstinence from sexual intercourse. What does someone do (actions) when he or she abstains?

Figure 6.2 Performance Objectives



The additional value of specifying performance behaviours, is that the objectives of the programme are much more specific and increase the chance that the programme addresses the actual needs and rights of the target population.²⁸ It results in making behaviour and behaviour change & reinforcement much more practical and concrete.

6.5.1 Performance objectives young people

Performance objectives are stated for each of the health promoting behaviours of young people. For example, which actions should young people undertake to be able to use condoms? The table below shows some examples of performance objectives of the health promoting behaviours mentioned before. Evidence is available related to the performance objectives of consistent condom use.^{29;30} Little evidence is available related to performance objectives of delay of sexual intercourse and abstinence.³¹

Box 6.11 Performance objectives young people

Health promoting behaviour		Performance objectives	
1	Take own, well-informed decision about own sexuality	1.1	Express self-awareness and self-esteem
		1.2	Deal in a healthy way with the changes (emotional, physical, social) during adolescence
		1.3	Take own decision, based on SRHR related facts
		1.4	Have consensual sex (absence abuse & harassment)
		1.5	Stand up for the rights of both boys and girls
2	Delay onset of sexual intercourse	2.1	Decide not to have sexual intercourse for a particular period of time
		2.2	Avoid situations that could lead to sexual intercourse
		2.3	Escape risk situations that could lead to sexual intercourse
		2.4	Negotiate with partner safe alternative (non-penetrative) sexual practices
		2.5	Negotiate with partner on not having sexual intercourse
		2.6	Maintain abstinence from sexual intercourse
3	Consistent condom use	3.1	Obtain/ buy condoms
		3.2	Always take condom along
		3.3	Negotiate condom use with sexual partner
		3.4	Use condoms every time when having (anal or vaginal) sexual intercourse
		3.5	Use condoms correctly
		3.6	Store condoms correctly
4	Use of health services	4.1	Seek information about SRHR and sexuality
		4.2	Visit SRHR services and Youth Friendly Centres
		4.3	Get HIV/STI testing and counselling
		4.4	Use reliable and professional SRH services or Youth Friendly Centres for counselling

6.5.2 Performance objectives environmental actors

In addition to performance objectives for young people, planners also specify the performance objectives for behaviour of the environmental actors. For example, which actions should a head of HIV-unit in a clinic take to provide condoms in the clinic? He/she may need to buy the condoms,

he/she may need to convince others in the clinic that it is important to provide condoms in the community and particularly to young people, he/she may need to make the condoms easily accessible for young people, etc. See the table below for some examples of four environmental conditions.

Box 6.12 Performance objectives environmental actors

	Environmental conditions	Performance objectives
1	Parents and the wider community support sexuality education for young people	Allow/ encourage their children to participate in SRHR curriculum
		Communicate with their children about sexuality and SRHR
		Convince other community members of the need of SRHR education for young people
2	Health care providers provide youth friendly health care & commodities to young people	Approach young people in a non-judgemental way
		Provide confidential services
		Provide care and counselling at convenient place and time
		Provide affordable condoms and other contraceptives or commodities
		Provide testing services and counselling for HIV, STI, pregnancy
3	Policy makers provide and implement legislation and policies that support young people's SRHR	Make policies supportive to young people's SRHR
		Implement policies supportive to young people's SRHR
		Make funds available for young people's SRHR
		Influence norms in society supportive for young people's SRHR
4	School counsellors provide counselling to young people and refer them to health services	Provide confidential and non-judgemental counselling
		Refer young people to youth friendly health services

Parent involvement in sexuality education

Many parents are uncomfortable talking about issues related to sexuality, especially with their children. There are three things that parents may need in favour of supporting sexuality education of their children: 1. they need factual information, 2. they need to clarify their own values about sex so they can share them with their children, and 3. they need to overcome their own discomfort in discussing sexuality.

Involvement of parents may range from only informing them about the programme, to intensive participation of parents in the intervention programme in schools. This partly depends on what is conditional for successful implementation of the sexuality education programme in the school. And this may differ for each context and country.

Examples of performance objectives related to parents' involvement are: parents allow/ encourage their children to participate in SRHR curriculum, they communicate with their children about sexuality and SRHR, and they convince other community members of the need of SRHR education for young people.

Youth Friendly Services

The lack of youth friendly services is often an important barrier for young people's SRHR and health seeking behaviour. The internet provides a lot of information about the exploration of these factors.^{32;33;34;35;36;37;38}

Although the following list is by no means comprehensive, successful reproductive health services for adolescents cite all or some of the following guidelines as contributors to their effectiveness:³⁹

Identifying and Involving Important Groups

- Clearly identify the group to be served to avoid treating adolescents as a homogeneous group. Services may need to be tailored.
- Involve the target group of youth during the planning, implementation, and evaluation of services.
- Involve leaders of groups important in the lives of adolescents, including parents, educators, sports coaches, and youth club directors. These adults may play critical "gatekeeper" roles in whether adolescents know about and use services.
- Involve leaders of other important community groups--for example, religious and cultural leaders.

Identifying and Removing Barriers

- Remove logistical impediments to access to make services convenient and flexible.
- Remove financial, informational, legal, or other barriers to access. Youth are more likely to use services if they are free or inexpensive.
- Create a youth-friendly setting, especially at sites that also serve adults. Youth may feel more comfortable if the waiting room contains some posters and literature dealing with, adolescent issues.
- Ensure privacy and confidentiality. Fears about the lack of privacy and confidentiality can be among the biggest disincentives keeping adolescents away from services.

Enhancing Counselling for Youth

- Train staff to refrain from judging. Fears of negative or harsh reactions from health providers may keep young people away from reproductive health services. In general, providers must be able to listen openly and honestly to young clients' concerns and avoid treating adolescent sexuality as a disease.
- Train staff to feel comfortable discussing adolescent concerns. Providers should be conversant in the social issues that young people face, including pressures to use drugs or have sexual intercourse.
- Use role playing to help adolescents practice negotiating skills, especially "saying no".
- Enlist peer educators, who, as young people themselves, are less likely to have prejudices that adult counsellors might have and are more likely to be in tune with adolescent concerns.

Offering Appropriate Contraceptive Methods

- Offer contraceptive methods that are attractive to youth. Adolescents are likely to seek methods that are not easily detectable, that can be used only at the time of intercourse, and that are easily obtained and inexpensive
- Make condoms easily available without the need for counselling or appointments, both of which are potential sources of embarrassment.

Offering a Range of Reproductive Health Services

- Offer services tailored to young men and encourage them to attend.
- Offer a wide range of reproductive health services relevant to youth health needs, including: STI prevention, diagnosis, and treatment; pregnancy and early childhood care; prevention and treatment of sexual abuse and incest; and counselling regarding gender relations, responsible behaviour, family life, and violence.
- Provide referrals to other services important for youth when services are not available on-site, including mental health services for trauma following abortion, incest, sexual abuse, or rape.

Policy makers

A third category of a supportive environment for sexuality education for young people consist of the policies and implementation of policies related to young people's SRHR and sexuality education. To improve effective implementation of supportive policies, planners need to identify desired policy

makers' behaviour. Looking more specifically at policy makers' behaviour, they preferably need to make policies supportive to young people's SRHR, implement policies supportive to young people's SRHR, make funds available for young people's SRHR, and influence norms in society supportive for young people's SRHR.

Performance objectives for policy makers' behaviour may differ from context to context. In some countries, policies are supportive to sexuality education of young people, but in other countries, the government is strongly against it.

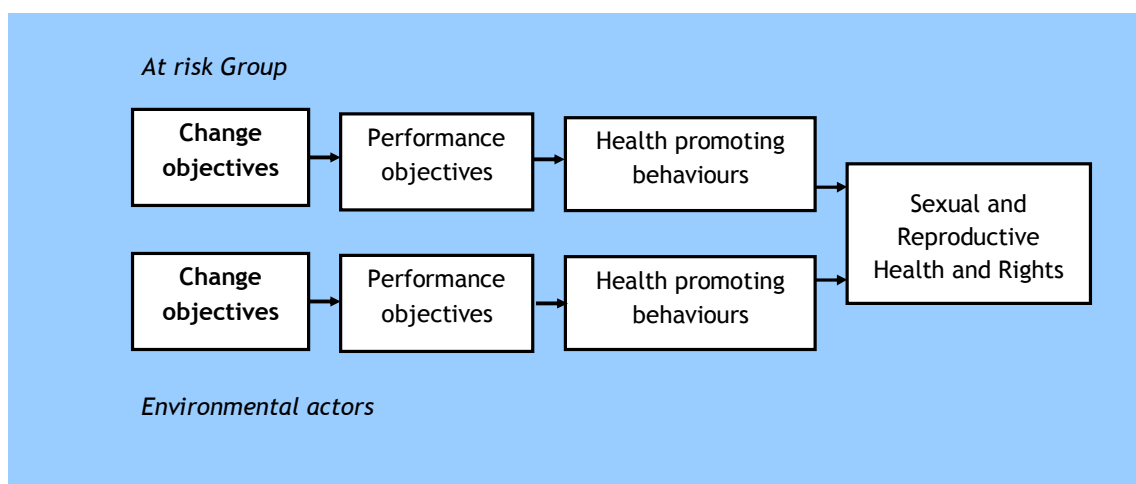
6.6 Task 3.6 Specify change objectives (determinants)

After specification of the performance objectives of both young people and environmental actors, planners identify change objectives. Change objectives are related to the level of determinants: knowledge, attitudes, risk perception, social influence, skills and self-efficacy.

In this task, planners identify all relevant and changeable factors that determine behaviour of young people and the people in their environment. The result of this task is a matrix with change objectives for young people, and a matrix with change objectives for the environmental actors. See Annex 6.3 and 6.4 for examples of matrices with change objectives.

Change objectives may differ for the different target groups of young people or the environmental agents. For example, rural young people may not know where to buy condoms, while urban youth do know. Different objectives are therefore set for different groups. The same kind of differentiation can be made for example with regard to gender (male versus female) or age.

Figure 6.3 Change Objectives



IM offers some suggestions for phrasing the change objectives.⁴⁰ The idea is that by phrasing the objectives very specifically, the change objectives provide a practical guide for the design of the intervention. In fact, the matrices together provide a blueprint of the objectives of the programme and guide intervention design. The matrices are also the basis for evaluation of the intervention (see Chapter 9 Monitoring & Evaluation).

Change objectives specify what individuals need to learn or what must be changed in the organisational or community environment. They may refer to individual level change (e.g.,

'adolescents express confidence regarding negotiating condom use with a sexual partners'), organisational level change (e.g., 'school administrators acknowledge the advantages of condom distribution in school'), or community level change (e.g., 'community leaders approve of the sale of inexpensive condoms in schools and youth meeting places').

Each objective should start with an 'active', finishing the quote 'After the programme, young people can...'. For example, '... name three places where they can buy a condom'; or '... explain step by step how to say 'NO' if a sexual partner wants to have sexual intercourse'. Box 6.14 provides for each determinant some examples. The objectives should be formulated as specific as possible. For example, instead of phrasing an objective as 'young people can describe contraceptives', an objective is more measurable if it is formulated as 'young people can name at least three contraceptives that can prevent teenage pregnancy.'

Box 6.14 Phrasing change objectives

Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
<ul style="list-style-type: none"> · Explain · List · Compare · Describe · State · Discuss · Identify · Name · Mention 	<ul style="list-style-type: none"> · Recognise · Describe · Explain · List · Express · Perceive 	<ul style="list-style-type: none"> · Emphasise · Argue · Subscribe · Convince others · Perceive · Recognise · Anticipate · Respect 	<ul style="list-style-type: none"> · Explain · State · Describe · Discuss · Adduce arguments · Experience the influence of · Explain how others influence 	<ul style="list-style-type: none"> · Give instruction to · Provide scenario · Explain step by step · Reflect · Express (confidence) · Summarise · Advocate · Demonstrate · Attribute · Initiate

6.6.1 Change objectives young people

At first, planners state change objectives related to the desired performance behaviours of the at risk group, young people. The change objectives describe what programme planners expect to be changed among the target group after the programme is implemented.

To create a matrix of change objectives, planners first look at the determinants of sexual behaviour of young people. The NA/SA shows the most relevant factors that shape young people's sexual behaviour. Annex 6.3 provides an overview of examples of change objectives for the four selected Health promoting behaviours of young people.

In the matrix, planners write different objectives for different sub-groups of the target group, for example, they describe specific change objectives for boys and girls if that is relevant. In particular settings it may not be an option at all for girls to obtain condoms at a centre or shop. It would not be an achievable objective to provide girls with skills to obtain condoms. Specific objectives may therefore be stated for boys. It may also be possible that boys in a particular setting are willing to use condoms during sexual intercourse, but that the attitude of girls is negative towards it. This results in specific objectives targeting girls.

Planners may also identify specific objectives for young people from rural or urban areas. For example, youth from urban areas may have more knowledge and risk perception with regard to risks of unprotected sexual intercourse. In the matrices, planners identify these specific objectives for specific groups of people. The same holds for all other segments of young people, such as married and unmarried youth, older and younger youth, migrants, youth with different socio-economic backgrounds.

Box 6.15 Comprehensive programmes

In those situations where young people are exposed to sexual and reproductive health and life skills education in schools, the impact on actual sexual behaviour is often insignificant. Generally speaking, exposed students are well informed, but the remaining major hurdle is translating this knowledge into behaviour learning and change.

Comprehensive sexuality education includes therefore more than only knowledge objectives on HIV/AIDS or other sexual health problems. Comprehensive sexuality education can be defined as seeking to assist children in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health, and to help them acquire skills to make decisions now and in the future. A comprehensive sexuality education program thus includes knowledge objectives as well as an opportunity to explore attitudes and develop skills in such areas as human development, relationships, personal skills, sexual behaviour, sexual health, and society and culture.⁴¹ Factors at various levels define the comprehensiveness of school-based sexuality programs:

1. In addition to knowledge objectives, objectives on attitude development, coping with social influence and skills building are included as well
2. The overall goal goes beyond the mere prevention of sexual health problems by aiming at improving decision-making skills, the quality of life and human development as well
3. Sexuality is positively approached and SRH problems are coherently addressed in the context of building self-esteem, (sexual) development of adolescents, diversity and gender and preventing stigma, while integrating HIV/AIDS and SRH&R issues
4. To meet the needs and rights of the diversity of young people they are offered choices, supporting them in voluntarily making own, informed decisions, and as such goes beyond the promotion of abstinence only.

The boxes below provide examples of change objectives for abstinence and for obtaining condoms.

Box 6.16 Example change objectives ‘Delay/abstinence of sexual intercourse’

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
2.1 Decide not to have sexual intercourse for a particular period of time	1. Explain that abstinence means abstinence from sexual intercourse and not necessarily from other sexual behaviours	1. Perceive themselves being vulnerable to the risks when having unprotected SI: pregnancy, abortion, STIs, HIV	1. Explain their attitude towards sex and abstinence from sexual intercourse	1. Describe their perception of the norms of significant others (peers, parents) related to sex and abstinence (supportive or not)	1. Express confidence in own skills to resist SI

Box 6.17 Example change objectives ‘Obtain condoms’

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
3.1 Obtain/ buy condoms	Boys: List two places where they can obtain condoms for free	Rural: Express that unprotected sexual intercourse may lead to HIV infection, STIs, unintended pregnancy	Girls: Express positive attitude towards condom use		

Based on the NA/SA, planners decide about the inclusion of those objectives that are most relevant and most changeable. If a planner knows beforehand that particular objectives will not be achieved, it is not useful to include these in the matrix. And if planners are aware that young people already know a lot about growing up and reproductive health (for example, through other educational (media) programmes), planners may decide not to put too much emphasis on these topics, and rather focus on determinants that need more attention. This has to be reflected in the final matrices with change objectives.

And finally, planners provide evidence for the selected change objectives. The evidence will be derived from the needs assessment/ situation analysis, both primary and secondary data. Various publications have identified important determinants of sexual behaviour of young people.⁴² Relatively much (‘Western’) evidence is available about determinants of condom use (and its performance behaviours). Box 6.18 provides an overview of global available evidence.

Box 6.18 Global evidence determinants of condom use

Determinants of condom use (& performance behaviours)

Relatively much (‘Western’) evidence is available about determinants of condom use (and its performance behaviours). Some of the findings include:

- Four cognition measures show medium to large correlations with condom use,⁴³ namely (1) attitudes towards condoms, (2) descriptive norms in relation to condom use (i.e., perceptions that others approve of and use condoms, in particular the sexual partner), (3) intentions to use condoms, and (4) pregnancy motivation (e.g., the belief that condoms should be used for contraceptive purposes, as well as, STI protection). A fifth cognition,⁴⁴ perceived control over the behaviour (including self-efficacy), also showed correlation with condom use.
- These findings suggest that health promotion materials designed to encourage condom use should establish positive attitudes towards condom use; advocate their acceptance as a method of contraception; promote the view that others (and particularly sexual partners) accept and use condoms, and also strengthen intentions to use condoms.⁴⁵
- Other studies support these conclusions: interventions that had greater effects on cognitive mediators (including knowledge, beliefs, intention, and self-efficacy) were found to have greater effects on behaviour. For example, those with stronger effects on cognitive mediators had a larger effect on condom use. Similar results were found for sexual abstinence.⁴⁶
- Knowledge, and to a lesser degree risk awareness, usually hardly differentiate between those who practice safe sex and those who do not. However, it is hard to imagine a reproductive health promotion program without paying attention to these issues.
- A review was conducted in 2005 of studies investigating determinants of sexual behaviours of young people in developing countries. The review and a summary are available on the Internet.⁴⁷

With regard to the correlates of delaying the onset of sexual activity and related sub-behaviours, the scientific literature hardly provides studies on the correlates of the onset of sexual activity and the situations in which young people start their sexual career. A review was conducted in 2005 of studies investigating determinants of sexual behaviours of young people in developing countries. The review and a summary are available on the Internet.⁴⁸ Evidence can be provided as a background document, ensuring that all change objectives are addressed in the description.

6.6.2 Change objectives environmental actors

The same steps are taken to create matrices of change objectives on the level of environmental change, by specifying the determinants of the behaviour of environmental actors.

For each of the environmental outcomes, planners identify the determinants and change objectives. Based on the NA/SA, planners identify the knowledge, risk perception, attitudes, skills and self-efficacy of parents, health care providers, counsellors and policy makers, with regard to sexuality education and care for young people. Annex 6.4 provides examples of matrices with change objectives for the four environmental outcomes. See one example below with regard to support of parents and community of sexuality education for young people.

Box 6.19 Example change objectives environmental agents

Performance objectives	Knowledge	Risk perception	Attitude	(Perceived) Social influence	Skills & self-efficacy
1.1 Allow/encourage their children to participate in SRHR curriculum	1. Explain that sexuality education does not increase sexual activity among youth	1. Explain that if their children do not get educated about SRHR-related topics, they are vulnerable for SRH problems	1. Express a positive view on sexuality education	1. Explain that other parents and community members also support youth to participate	1. Demonstrate how to resist pressure of other community members against sexuality education

The groups of environmental agents may consist of particular sub-groups. For example, the group of parents and community members may be differentiated with regard to gender: men and women may have different opinions on sexuality education for their children. In some contexts, the social norm is that women do not talk with their children about sexuality related issues. It may not be achievable in the programme to let mothers talk with their children about it.

It may not be possible to achieve all change objectives that are stated in the matrices. The next step is to select only those objectives that are most important and most changeable. Planners can use evidence from the needs assessment/ situation analysis to make that selection. They can also involve relevant stakeholders to assist them with selecting these objectives.

Finally, planners provide evidence for all change objectives they have selected, based on the information of the needs assessment/ situation analysis. They have to describe the underpinning why to focus on the selected objectives related to changing knowledge, risk perception, attitude, social influence, skills and self-efficacy.

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Annexes

Annex 6.1 Worksheets IM Step 3. Objectives

WORKSHEET 3.1	Involve relevant stakeholders in identifying objectives
WORKSHEET 3.2	Selection of Target groups and Implementers
WORKSHEET 3.3	Sexual and Reproductive Health and Rights outcomes
WORKSHEET 3.4	Health promoting behaviours
WORKSHEET 3.5	Performance objectives
WORKSHEET 3.6	Change objectives

Annex 6.2 Outline Documentation Step 3. Objectives

Annex 6.3 Examples Change Objectives - Behaviour young people

Annex 6.4 Examples Change Objectives - Environmental actors

WORKSHEET 3.2

Selection of target groups and implementers

Instruction

- The target groups consist of the people who will be exposed to the intervention. For example, young people, parents, policy makers, health care workers ... Planners can decide to identify sub-groups in each group - for example boys and girls in the group of young people.
- The implementers are the people who deliver the intervention to the target groups.

Worksheet

1. Who are the target groups of your intervention programme?

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-
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2. Are there sub-groups in each target group? If yes, which sub-groups?

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.....

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3. Why are these target groups selected? And why are these sub-groups identified?

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4. Who will implement the intervention, and why?

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WORKSHEET 3.3

Sexual and Reproductive Health and Rights Outcomes

Instruction

- On the long term, what are desired Sexual and Reproductive Health and Rights (SRHR) outcomes?
For example related to HIV/AIDS, gender, abortion, stigma, unintended pregnancy, Sexually Transmitted Infections (STIs), rights, ...
- What evidence did the NA/SA provide?

Worksheet

1. Desired changes in sexual and reproductive health of young people

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-
-

2. Desired changes in sexual and reproductive rights of young people

-
-
-

WORKSHEET 3.4

Health Promoting Behaviours

Instruction

- What are the health promoting behaviours of young people that will improve their SRHR?
- What are the health promoting behaviours of environmental actors that will improve (directly or indirectly) the SRHR of young people?

Worksheet

1. Health promoting behaviours young people

-
-
-
-
-

2. Health promoting behaviours environmental actors

-
-
-
-
-

WORKSHEET 3.5

Performance Objectives

Instruction

- Select one of the health promoting behaviours and specify its performance objectives.

Worksheet

Health promoting behaviour:

Performance objectives:

1.

2.

3.

4.

5.

...

WORKSHEET 3.6
Change Objectives

Instruction

- Select one of the performance objectives and identify the change objectives for relevant determinants.

Worksheet

Change objectives

Health Promoting Behaviour:

At the end of the programme, people can ...

Performance objectives	Knowledge	Attitude	Risk perception	Social influence	Skills & self-efficacy

Annex 6.2 Outline Documentation Step 3. Objectives

General suggestions:

- Keep the final report short (max. 20 pages excluding references and tables & figures) and provide additional information as much as possible in annexes to the report - this makes the report easier to read by others
- Keep record of references to literature/articles/publications/reports and provide a list of references at the end of the document

1. Introduction

Approximately 2 pages

Describe the background of IM step 2 Objectives:

- Purpose of identifying objectives, i.e., blueprint for intervention design, communication with stakeholders, relation to monitoring and evaluation
- What will be done with the lists of objectives

2. Results and conclusions

Approximately 15 pages

Describe the results of the tasks in identifying objectives, using the worksheets below. Pay attention to describing WHY you have taken particular decisions. If possible, provide references to the evidence you use for your decisions. Describe:

- 2.1 involvement of stakeholders
- 2.2 selection of target group and implementers
- 2.3 SRHR objectives
- 2.4 health promoting behaviours
- 2.5 performance objectives
- 2.6 change objectives

3. Reflection

Max. 1 page

Briefly describe the quality of the information in IM step 2. What were constraints in identification of the objectives on the different levels?

4. Summary

Max. 1 page

Provide a brief summary of the report, describing the main conclusions/findings.

5. References

Provide references to the literature/reports/documents that were used in the identification of objectives.

6. Annexes

Provide tables and background information in the annexes of the report.

Annex 6.3 Examples Change Objectives - Behaviour young people

Examples are provided for the four behavioural outcomes:

1. Take own well-informed decision about own sexuality
2. Delay onset of sexual intercourse/ abstain from sexual intercourse
3. Consistent condom use
4. Health seeking behaviour

Behavioural outcome 1. Take own well-informed decision about own sexuality

At the end of the programme, young people can ...					
Performance objectives	Knowledge	Risk perception	Attitude	(Perceived) Social influence	Skills & self-efficacy
1.1 Express self-awareness and self-esteem	1. Explain the concepts of self-esteem and self-awareness	1. Argue that people with low self-esteem are more vulnerable for peer pressure and bullying	1. Argue the importance of self-awareness, self-esteem, self-respect and the right to self-reliance	1. Express that they experience respect from classmates	1. Initiate a conversation in which they talk about their own personalities
	2. List five words to describe themselves and one characteristic that describes them most	2. Explain that, to a large extent, it is up to themselves to make their dreams come true	2. Mention four values and 4 strong personal characteristics that are important to them	2. Give names of those people who will help to make their dreams come true	2. Demonstrate that they are able to reflect on their own personalities and characters
	3. Explain that the choices they make now have a big impact on their future		3. Show they recognize themselves as a unique person	3. Provide a scenario for requesting assistance of people who can help in achieving their own goals	3. Show an action plan, which goal can be achieved in what way and with whose support
	4. State that every person has the right to dream of a bright future and to build up a good life		4. Show they are proud of their characteristics and strong points and show awareness of their points for improvement		
	5. Describe their future dream and explain a plan of action to realise this dream		5. Show motivation to support other people in achieving their dreams and to support them in achieving these dreams		
1.2 Deal in a healthy way with the changes (emotional, physical, social) during	1. List four personal emotions and how they can be (non-verbally) expressed	1. Describe how peers and media can - negatively - influence their opinion about themselves	1. Argue that emotions can be controlled and do not have to rule their thinking and behaviour	1. Expect support of relevant others when negative emotions rule their state of mind	1. Show how to deal with challenging emotions at this stage of their lives

Performance objectives	Knowledge	Risk perception	Attitude	(Perceived) Social influence	Skills & self-efficacy
adolescence	<p>2. Explain that fluctuating emotions are part of adolescence</p> <p>3. List four changes during adolescence and explain that developing sexual feelings and feelings related to love is part of growing up</p> <p>4. List four changes in the body of a girl and four in the body of a boy during puberty</p> <p>5. Explain the difference between sexuality, friendship and love with the opposite sex</p>	<p>2. Describe the influence of their own social environment (family, friends, other people) on their opinions and behaviour</p>	<p>2. Describe that everyone changes at a different pace and in a unique way</p> <p>3. Show that they accept and understand their own body changes and show awareness that changes in the body are a normal part of growing up</p> <p>4. Argue whether platonic friendship with someone of the opposite sex is possible or impossible in their opinion and respect other people who have friendship with someone of the opposite sex</p> <p>5. Respect parents' instructions and value their positive intentions and respect the need of maintaining a mutual understanding between parents and children</p>	<p>2. Provide a scenario for how to initiate a friendship and how to initiate support from friends</p> <p>3. Explain that most adolescents experience similar challenges and uncertainties with regard to body changes, and emotions</p> <p>4. List names of six people they interact most with and names of six people who have the biggest influence on their lives</p>	<p>2. Explain step by step how to solve a problem with other people they feel bad about</p> <p>3. Demonstrate communication skills to communicate and share concerns with parents and friends</p> <p>4. Demonstrate how to negotiate with friends in taking their own decisions, without breaking off the friendship</p>
1.3 Take own decision based on SRHR related facts	<p>1. Explain the concepts of being sero-positive or HIV-positive, AIDS, HIV test, window period, stigma</p> <p>2. Describe the monthly menstruation cycle, including fertile days, that the menstruation cycle of teenage girls is not yet regular, and that a girl can get pregnant from having sex only once</p> <p>3. Describe how conception takes place</p> <p>4. Mention two places or clinics where a girl can take a pregnancy test</p>	<p>1. Express that they perceive themselves at risk of unintended pregnancy, HIV or STIs when they have unprotected sexual intercourse</p> <p>2. Describe the possible consequences of pregnancy, HIV/AIDS and STIs</p> <p>3. Explain that faithfulness to a partner can only protect them against STIs and HIV if both partners are 100% faithful and can prove that their previous partners were not infected</p>	<p>1. Boys: Argue that both girls and boys are responsible for the consequences of sexual intercourse and take care of girlfriends who fall unwanted pregnant or have an abortion</p> <p>2. Describe the (dis) advantages of safe and in-time abortion</p> <p>3. Show they are convinced of the importance of visiting a VCT centre if necessary</p> <p>4. Show they are convinced that they have to test for STIs and HIV when they are starting a new sexual relationship</p>	<p>1. Describe the norms in the community related to HIV, teenage pregnancy (outside marriage), and abortion</p> <p>2. Mention the name of one person they would talk to if they had an STI or suspected they might have HIV/AIDS</p>	<p>1. Express that they are able to cope with peer pressure to have (unprotected) sexual intercourse</p> <p>2. Explain that sexual partners have to talk 'at the right time' (not in a romantic setting or when sexually aroused) about condom use and sexuality</p> <p>3. Demonstrate that they can refuse and persuade a sexual partner not to have sexual intercourse</p> <p>4. Express confidence that they are able to negotiate and take their own decision and stick to their decision, regardless of what their sexual partner will say</p>

Performance objectives	Knowledge	Risk perception	Attitude	(Perceived) Social influence	Skills & self-efficacy
	<p>5. List three options what they can do in case of an unintended pregnancy</p> <p>6. Explain that an STI, except HIV/AIDS, can be cured if it is detected in time</p> <p>7. List three signs or symptoms of an STI and explain that it is possible to have an STI without symptoms</p> <p>8. Explain that they have to go to a health clinic or VCT centre in time to be tested for STIs and get treatment</p> <p>9. Explain what ABC means</p> <p>10. List three ways to prevent pregnancy, to prevent STIs and to prevent HIV-infection</p> <p>11. List the four bodily fluids in which HIV is apparent</p>		<p>5. Express awareness of their rights on making own decisions and respect the rights to decision making of their partners</p> <p>6. Express positive attitudes towards contraceptives, being confident in contraceptives' effects and advantages; and being willing to use contraceptives (especially condom, contraceptive pill, and ECP)</p>		
1.4 Have consensual sex (absence abuse & harassment)	<p>1. Give a definition of 'unwanted sex', 'sexual harassment', 'sexual abuse' and 'rape'</p> <p>2. List 3 consequences of sexual abuse and harassment</p> <p>3. Explain that girls or women generally are, but boys and men also can be, victims of sexual harassment and abuse</p> <p>4. Explain that most rapists are usually not strangers but people known to the victim</p> <p>5. List three risky situations and three defence tips to escape risky situations</p>	<p>1. Express to what extent they are at risk of sexual harassment or abuse</p> <p>2. List four possible mental and physical consequences of sexual abuse or harassment</p> <p>3. List some features of someone who could possibly force them to have sex</p>	<p>1. Convince others that sex should either be voluntary or should not take place at all</p> <p>2. Show they are convinced that sexual harassment, forced sex or violence, sexual abuse and rape are violations of human rights</p> <p>3. Explain that victims are never to be blamed</p> <p>4. State that sexual harassment and abuse are a crime and a violation of other people's rights</p>	<p>1. Express sympathy and show support for victims of sexual abuse</p> <p>2. Encourage friends to accompany them as 'bodyguard'</p>	<p>1. Provide a scenario for finding support after sexual abuse, harassment or rape (trusted adult(s)/ (mental) health care/ juridical support)</p> <p>2. Explain step by step how to refuse someone who is pressurizing them into having sex</p> <p>3. Demonstrate three ways of defending and protecting themselves physically when in a rape situation</p> <p>4. Provide a scenario for communicating their limits in the matter of sexuality to someone they are dating</p>

Performance objectives	Knowledge	Risk perception	Attitude	(Perceived) Social influence	Skills & self-efficacy
	6. Explain that after abuse or harassment, they have the right to be protected and supported by relatives, authorities, police and health services				
1.5 Stand up for the rights of both boys and girls	<p>1. List at least four rights related to sexual and reproductive health for young people</p> <p>2. Explain what human rights are, who have formulated these rights, where they come from, who is responsible for implementing these rights</p> <p>3. Give three reasons why human rights have not yet been fully implemented in their country</p> <p>4. Describe how rights and responsibilities are related and list two responsibilities</p> <p>5. Recognise how these rights apply to their own life and community and to act if these rights are violated</p> <p>6. Give one example of the vulnerable position of girls and women in their own country/ context</p> <p>7. Explain that sexual expectations of boys and girls can be different</p> <p>8. Explain the terms 'gender' and 'gender roles', their relation with rights and how they impact on themselves and on their social environment</p>	1. Explain how a lack of implementation of their rights affects their health and well-being	<p>1. Convince others that that all young people, both boys and girls, have the right to education and youth-friendly, non judgemental health services</p> <p>2. Argue that all people, including themselves, have the right to be supported, helped, protected and cared for by their families, the community and the government</p> <p>3. Express that they value and respect their own rights and those of other people</p> <p>4. Convince others that both unmarried and married people have rights to know and use contraceptives</p> <p>5. Explain that inequality between males and females is one of the underlying causes of SRH problems, including violence</p> <p>6. Argue that girls and women should have equal opportunities in education and leadership</p> <p>7. Express they are aware of their own values and standards in relation to gender issues and describe differences with others</p> <p>8. Argue the right to an equal relationship between boys and girls and men and women and the advantages of sharing responsibilities</p>	<p>1. Explain the norms in the community related to rights of young people</p> <p>2. Show awareness of how peers, friends, the community and the media perceive gender roles</p>	<p>1. Provide a scenario for how they would defend their rights and advocate their own rights</p> <p>2. Demonstrate how to discuss sexuality and gender issues with others</p>

Behavioural outcome 2. Delay onset of sexual intercourse/ Abstain from sexual intercourse

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
2.1 Decide not to have sexual intercourse for a particular period of time	<p>1. Explain that abstinence means abstinence from sexual intercourse and not necessarily from other sexual behaviours</p> <p>2. List three potential consequences of SI</p> <p>3. Identify the factors that influence one's ability to resist partner pressure to have SI, e.g. financial independence, self esteem, communication skills</p> <p>4. Explain the difference between sex and sexual intercourse</p>	<p>1. Perceive themselves being vulnerable to the risks when having unprotected SI: pregnancy, abortion, STIs, HIV</p>	<p>1. Explain their attitude towards sex and abstinence from sexual intercourse</p> <p>2. List 4 perceived benefits of abstinence and 4 benefits of sexual intercourse</p> <p>3. Express a positive attitude towards abstinence of sexual intercourse</p> <p>4. Explain that besides sexual intercourse, one can practice other sexual behaviours as well</p>	<p>1. Describe their perception of the norms of significant others (peers, parents) related to sex and abstinence (supportive or not)</p> <p>2. Discuss the norms that enable them, or make it difficult, to say no to sex</p> <p>3. Identify two peers at school who are supportive of abstinence from sexual intercourse</p>	<p>1. Express confidence in own skills to resist SI</p> <p>2. Express confidence that they can abstain from sexual intercourse</p>
2.2 Avoid situations that could lead to unintended sexual intercourse	<p>1. List one context that can put one at risk to have SI (related to violence, alcohol & drugs, being alone with boy/girl friend)</p> <p>2. List characteristics of situations that could lead to sexual intercourse</p>	<p>1. Perceive themselves at risk to have SI in contexts of violence, substance use, when alone with boy/girlfriend</p> <p>2. Write down risks (health, emotional and social) associated with unprotected sexual activity</p>	<p>1. Express own attitude towards the possibility of having sex with boy/girl friend when alone</p>	<p>1. Share with boy/girl friend ideas on how to avoid situations that may lead to SI</p> <p>2. Sign an abstinence pact with close friend/current boy/girl friend</p> <p>3. Explain the difference between their personal norms and the norms of the sexual partner regarding sexual intercourse</p>	<p>1. Explain how to recognise situations that could lead to unintended sexual intercourse</p> <p>2. Express the feelings (of unsafety) that they may experience in that situation</p> <p>3. Explain how they would let somebody know that they are feeling unsafe/uncomfortable</p> <p>4. Express the belief that they can successfully avoid risky situations</p>
2.3 Escape situations that could lead to unintended sexual intercourse	<p>1. List two ways to escape a situation that may lead to unintended sexual intercourse</p> <p>2. Explain what would make it difficult to escape risky situations and how they can overcome this</p>	<p>1. Explain that boys and girls may have different expectations of being private with someone of the other sex</p>	<p>1. Express a positive attitude towards escaping risky situations (i.e., violence, substance use and being alone with boy/girl friend)</p>	<p>1. Write down the norms of significant others (peers, parents, teachers) about escaping situations that could lead to unintended and/or unprotected sexual intercourse</p>	<p>1. Explain step by step how to get out of a situation that could lead to sexual intercourse</p> <p>2. Express their confidence that they can successfully escape risky situations</p> <p>3. Explain step by step how to refuse and persuade the partner not to have sexual intercourse</p>

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
2.4 Negotiate with partner not to have sexual intercourse	<p>1. Explain that healthy sex requires personal decision-making and that sex is not an uncontrollable force for either boys or girls</p> <p>2. Explain that they have to communicate with partner about sexuality and own view on sexual intercourse</p>	1. Explain that when both partners are sexually aroused, it may be more difficult to discuss about sexuality	1. Explain own values related to sexual intercourse	1. Express awareness of the norms of relevant others related to having sexual intercourse	<p>1. Express confidence that they can negotiate not to have sexual intercourse with their partner</p> <p>2. Explain step by step how to discuss sexuality and refusal to have sexual intercourse with their partner</p>
2.5 Negotiate with partner safe alternative (non-penetrative) sexual practices	<p>1. Define the following terms: kissing, French kissing, petting, masturbation, pornography</p> <p>2. List five ways of being intimate or of having sex with a loving partner, as an alternative to sexual intercourse</p> <p>3. Explain that sexuality is more than (vaginal) sexual intercourse</p> <p>4. Describe the concepts of sexuality, sex, sexual practices, sexual intercourse, sexual feelings and sexual attraction and the differences between them</p>	1. Explain that alternative sexual practices can reduce or eliminate health risks	<p>1. List and explain the sexual practices they are uncomfortable or comfortable with</p> <p>2. Recognise that sexuality can be a positive force in their own lives and in other people's lives</p> <p>3. Convince others that sexual partners should communicate with each other about sexuality</p> <p>4. Explain their own attitude towards masturbation and other sexual practices</p>	<p>1. Explain the norms of peers about negotiating alternative safer sexual practices</p> <p>2. List four arguments often used by young boys or young girls to pressurize another person into having sexual intercourse</p> <p>3. Express awareness of the influence of peers, the media and the community on sexuality-related decision-making</p>	<p>1. Demonstrate skills of talking about sexuality and abstinence</p> <p>2. Explain why they believe they have mastered the ability to successfully negotiate alternative safer sexual practices with sexual partner</p> <p>3. Demonstrate skills (verbal and self confidence) to negotiate about alternative sexual practices</p> <p>4. Explain negotiation, assertiveness and refusal skills step by step</p>
2.6 Maintain abstinence from sexual intercourse	<p>1. Explain how they can maintain abstinence from sexual intercourse</p> <p>2. Explain how substance/ alcohol/ drug use can alter interpersonal behaviour and can influence sexual decision-making</p>	1. Express awareness of situations that could lead to having sexual intercourse, within or outside a relationship	1. Explain own values related to sexual intercourse	1. Explain how they mobilise support of relevant others to be able to abstain from sexual intercourse	1. Express their confidence that they are able to maintain abstinence from sexual intercourse

Behavioural outcome 3. Consistent condom use

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
3.1 Obtain/ buy condoms	<p>1. List two places where they can obtain condoms for free</p> <p>2. List two places where they can buy condoms</p>	<p>1. Identify three health risks when having SI without a condom</p> <p>2. Explain how condoms prevent HIV transmission</p>	<p>1. List at least two positive and negative aspects of buying condoms</p> <p>2. Bust myths about not using condoms and provide counterarguments for disadvantages of condom use</p>	<p>1. Explain norms, related to obtaining condoms, of significant others like parents, close friends, teachers</p> <p>2. Explain that both boys and girls use condoms</p>	<p>1. Describe step by step how to buy or obtain a condoms</p> <p>2. Express confidence in the ability to obtain condoms</p> <p>3. Express confidence to deal with embarrassment when buying or obtaining a condom</p>
3.2 Always take condom along	<p>1. State how long condoms can be carried in wallet without decreasing efficacy</p>	<p>1. Perceive self at risk for STIs/pregnancy if failure to carry condoms</p>	<p>1. Describe 2 advantages and 2 disadvantages of taking a condom along</p>	<p>1. Describe peers as carrying condoms</p> <p>2. Discuss with peers whether carrying condoms is acceptable, and especially for a girl</p>	<p>1. Express self-confidence to always carry condoms</p> <p>2. Describe a plan of where to carry condoms in different situations</p>
3.3 Negotiate condom use with sexual partner	<p>1. Explain that having sex with a one-night-stand or within a steady relationship can both lead to health risks</p> <p>2. Describe the steps of successful negotiation</p>	<p>1. Express risk perception when not discussing condom use with sexual partner</p> <p>2. Discuss potential risks and gains to the relationship of discussing condom use with partner</p>	<p>1. Describe their feelings about discussing condom use with a partner</p> <p>2. Explain that condom use is important both in steady relationships as well as in one-night-stands</p> <p>3. Explain that use of condoms is a sign of trust, respect and care</p> <p>4. Express the belief that negotiation will lead to condom use</p>	<p>1. Discuss accurate perceptions of what young people think, fear, and do with regard to AIDS and STI prevention</p> <p>2. Discuss the responsibility of each partner in initiating and maintaining discussions about condom use</p> <p>3. Explain the process of social influence and conformity</p> <p>4. Adduce arguments countering proposals to have unsafe sex</p>	<p>1. Explain step by step how to negotiate condom and contraceptive use with a sexual partner</p> <p>2. Express confidence in successfully discussing condom use with partner</p> <p>3. List several techniques for initiating, maintaining & terminating conversation in general, about condom use</p>
3.4 Use condoms every time when having (anal or vaginal) sexual intercourse	<p>1. Explain that continuous condom use is effective in reducing the risk of pregnancy, STIs and HIV</p>	<p>1. Express personal risk perception related to STIs, HIV/AIDS and pregnancy unless condoms are used consistently</p>	<p>1. Express a positive attitude towards use of condoms during every time when having sexual intercourse</p>	<p>1. Describe the norms of significant others (parents, peers) that are positive towards consistent condom use</p>	<p>1. Express confidence to successfully use condoms every time of having sexual intercourse</p> <p>2. Express confidence in practicing safe sex in difficult situations</p>
3.5 Use condoms correctly	<p>1. Describe that, every time they have sexual intercourse, they have to use a condom from start to finish of the sexual act</p>	<p>1. Express that they perceive themselves at risk for STI's/HIV and pregnancy due to incorrect condom use</p>	<p>1. Express positive attitude towards using condoms correctly</p>		<p>1. Explain in four steps how to put on and remove a condom correctly</p>

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
	<p>2. Describe how to put on, take off and dispose of a condom</p> <p>3. Explain that a condom should not be used after the expiry date and can only be used once</p>		2. List 2 perceived advantages and disadvantages of correct condom use		2. Express confidence that they can use condoms correctly
3.6 Store condoms correctly	<p>1. Explain the effect of heat, sunlight, moist, rough handling or keeping condom in a wallet for too long on condom</p> <p>2. Explain the importance of checking the expiry date of condoms</p>	<p>1. Perceive self at risk for STIs/ pregnancy due to consequences of incorrect storage</p> <p>2. Explain the potential consequence of incorrect storage (breakage of condom and consequently - pregnancy, STIs, HIV)</p>			<p>1. Explain others how to store condoms correctly</p> <p>2. Express positive belief in ability to store condoms correctly</p>

Behavioural outcome 4. Health seeking behaviour

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
4.1 Seek information about SRHR and sexuality	<p>1. Mention 3 places where they can obtain information about SRHR and sexuality (YFCs, health centres)</p> <p>2. Mention 3 kinds of materials they could obtain (materials, textbooks)</p>		1. Express positive attitude towards health services	1. Describe social norms as positively regarding seeking information at health services	
4.2 Visit SRHR services and Youth Friendly Centres in time	<p>1. Mention two places that provide YFSs (where, what services are provided, who are services providers, and when are the services provided)</p> <p>2. Explain that they have the right on non-judgemental youth friendly services</p>	1. Explain that they have health risks if they would not go to a clinic in case of SRHR problems	1. Express a positive attitude towards visiting SRHR services in case this is needed	1. Explain the norms of community members about young people who talk about sexuality and obtain condoms/ contraceptives	1. Provide a scenario for communicating and standing up for their rights in dealing with health service providers
4.3 Get HIV/STI testing and counselling	<p>1. Describe what happens in a health clinic if they go for STI or HIV testing</p> <p>2. Name one place where they can go for HIV and/or STI testing</p>	<p>1. List two consequences of untreated STIs</p> <p>2. Explain the health risk for themselves and that of the sexual partner on HIV-infection if HIV status is not known</p>	1. List the advantages of in-time examination, tests, and treatment of RTIs/STIs/HIV	1. Explain the norms of community members about young people getting tested for STIs or HIV	1. Express confidence to get tested on HIV or STIs

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
4.4 Use reliable and professional SRH services or YFCs for counselling	1. List 2 places where they can receive youth friendly counselling				1. Describe step by step to access and request health care services in YFCs and professional health centres

Annex 6.4 Examples Change Objectives - Environmental actors

Examples are provided for the four environmental conditions:

1. Parents and wider community support sexuality education for young people
2. Health care providers provide youth friendly health care to young people
3. Policy makers provide and implement legislation and policies that support young people's SRHR
4. School counsellors provide counselling to young people and refer them to health services

Environmental condition 1. Parents and wider community support sexuality education for young people

At the end of the programme, parents and community can ...

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
1.1 Allow/ encourage their children to participate in SRHR curriculum	<ol style="list-style-type: none"> 1. Explain that sexuality education does not increase sexual activity among youth 2. List 3 health risks of young people 	1. Explain that if their children do not get educated about SRHR-related topics, they are vulnerable for SRH problems	1. Express a positive view on sexuality education	1. Explain that other parents and community members also support youth to participate	1. Demonstrate how to resist pressure of other community members against sexuality education
1.2 Communicate with their children about sexuality and SRHR	<ol style="list-style-type: none"> 1. Explain the basic facts on SRH, rights, sexuality, reproduction and prevention 2. Explain that young people have the right on education and care, and the right to take their own decisions 	1. Explain that if their children do not get educated about SRHR-related topics, they are vulnerable for SRH problems	1. Express a positive attitude towards young people's sexuality	1. Explain norms in the community related to communication about sexuality with young people	1. Demonstrate how to communicate with their children about sexuality
1.3 Convince other community members of the need of SRHR education for young people	<ol style="list-style-type: none"> 1. Explain that sexuality education does not increase sexual activity among youth 2. List 3 health risks of young people in the particular community 	1. Explain that if their children do not get educated about SRHR-related topics, they are vulnerable for SRH problems		1. Mobilise support among other community members and parents	1. Demonstrate advocacy skills to communicate with community members on the need of sexuality education for youth

Environmental Condition 2. Health care providers provide youth friendly health care to young people

At the end of the programme, health care providers can ...

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
2.1 Approach young people in a non-judgemental way	<p>1. Explain their own values related to young people's sexuality and SRHR</p> <p>2. Explain that young people have the right on non-judgemental care</p>	1. Explain that if young people are approached in a judgemental way, they are less likely to accept support	<p>1. Express acceptance that young people are sexually active</p> <p>2. Explain the advantages of a non-judgemental approach</p>		1. Demonstrate skills to communicate with young people in a non-judgemental way
2.2 Provide confidential services and counselling	1. Explain that young people have the right on confidential care and counselling		1. Convince others that confidentiality is one of the key conditions of good health care provision		1. Explain how they keep what they hear from young people confidential
2.3 Provide care and counselling at convenient place and time	1. Explain that young people have the right on youth friendly care and support	1. Describe that if services are not provided at convenient times and places, young people are less likely to obtain services			
2.4 Provide condoms and other contraceptives or commodities	<p>1. Explain that all young people have the right to obtain condoms, contraceptives or other commodities</p> <p>2. Explain how condoms and contraceptives protect people from HIV, STIs or unintended pregnancy</p>	1. Explain that if young people have unprotected sexual intercourse, they risk HIV/STI-infection or unintended pregnancy	1. Express a positive view on young people using condoms and contraceptives to protect themselves	1. Express awareness of the norms in the community with regard to provision of condoms and contraceptives to young people	<p>1. Demonstrate condom demonstration skills</p> <p>2. Demonstrate skills to communicate with young people about sexuality and condom use</p>
2.5 Provide testing services and counselling for HIV, STI, pregnancy	1. Explain how they provide testing services to young people	<p>1. Explain that if young people are not aware of their HIV status or STI infection, they can easily infect others as well</p> <p>2. Explain that if young people are not tested on HIV or STIs, this may have severe consequences for themselves as well as their (future) sexual partners</p>	1. Express a positive view on testing services for young people	1. Express awareness of the norms in the community with regard to testing on HIV, STIs and pregnancy for young people	

Environmental Condition 3. Policy makers provide and implement legislation and policies that support young people’s SRHR

At the end of the programme, policy makers can ...

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
3.1 Conduct research to collect relevant argumentation and contextual information related to the need of SRHR education for young people	<ol style="list-style-type: none"> List 5 main topics to be explored in research Highlight the 5 major constraints in implementing SRHR/ sexuality education for young people 		<ol style="list-style-type: none"> Express acknowledgement of the need to explore barriers in sexuality education for young people 		
3.2 Write policies supportive to young people’s SRHR	<ol style="list-style-type: none"> Explain why sexuality education for young people is conditional for their health and rights 		<ol style="list-style-type: none"> Express positive attitude towards sexuality education of young people List three supportive arguments and three arguments against sexuality education of young people 	<ol style="list-style-type: none"> Express awareness of social norms in society with regard to sexuality of young people Demonstrate skills to refuse negative social influences or norms 	<ol style="list-style-type: none"> Demonstrate skills to convince other policy makers to write the policy
3.3 Monitor the implementation of policies by schools supportive to young people’s SRHR	<ol style="list-style-type: none"> Explain which people/ schools will be supportive and who not 			<ol style="list-style-type: none"> Express awareness of the norms in communities with regard to the implementation by schools 	<ol style="list-style-type: none"> Provide a plan how they monitor the implementation
3.4 Make funds available for young people’s SRHR	<ol style="list-style-type: none"> Explain why sexuality education is important in protecting young people from SRH problems, such as AIDS, unintended pregnancies and STIs 				
3.5 Speak in public or in parliament to support young people’s SRHR and sexuality education			<ol style="list-style-type: none"> Express the need for sexuality education for young people 	<ol style="list-style-type: none"> Explain social norms of relevant others with regard to sexuality education of young people 	<ol style="list-style-type: none"> Explain how they speak about this issue in a context with a lot of resistance against this topic
3.6 Talk informally with other policy makers (internal lobbying)	<ol style="list-style-type: none"> Explain the norms and values of other policy makers with regard to this subject 		<ol style="list-style-type: none"> List three supportive arguments and three arguments against sexuality education of young people 	<ol style="list-style-type: none"> Explain that they have good relationships with other policy makers 	<ol style="list-style-type: none"> Demonstrate good lobbying skills to talk with other policy makers

Environmental Condition 4. School counsellors provide counselling to young people and refer them to health services

At the end of the programme, school counsellors can ...

Performance objectives	Knowledge	Risk perception	Attitude	Social influence	Skills & self-efficacy
4.1 Provide confidential and non-judgemental counselling	<p>1. Express awareness of the educational programme</p> <p>2. Explain that young people have the right on confidential and non-judgemental counselling</p>	1. Explain that if young people are not approached in a confidential and non-judgemental way, they may not return to them to seek help	<p>1. Express acceptance of young people's sexuality and that some young people can be sexually active on a young age</p> <p>2. Express awareness of violation of rights of young people, e.g. related to gender, stigma on HIV/AIDS, rape and harassment</p>	1. Mobilise support of other colleagues and experts	1. Demonstrate
4.2 Refer young people to youth friendly health services	<p>1. List 4 youth friendly services to refer young people to in case of serious SRH problems</p> <p>2. Explain that young people have the right on youth friendly health care</p>	1. Explain that if young people are not referred to a clinic or specialised counselling facilities, this could lead to increased health problems	<p>1. Express acceptance of young people's sexuality</p> <p>2. Express positive attitude towards young people and talking with them about sexuality and SRHR related topics</p>	<p>1. Mobilise support amongst other colleagues, experts, counsellors</p> <p>2. Express awareness of norms in the community and school with regard to young people's sexuality and SRHR</p>	1. Express awareness of what they can deal with as a school counsellor and which problems need more or specialised support and care

7. IM Step 4. Evidence-Based Intervention Design

Where are we in Intervention Mapping?

In the previous step, programme planners have together with the target group (young people), educators, and relevant stakeholders, decided about the most relevant and most changeable outcomes and objectives of the intervention. The objectives are stated on the level of behaviour change, and change of environmental conditions, and specified in performance behaviours, and change objectives. These objectives as a whole provide the blueprint of the intervention programme.

In this step, planners design an intervention that is based on the objectives of Step 3, and is based on theoretical evidence. Planners are encouraged to use existing materials as much as possible, and if needed, design new materials and activities. They design one coherent programme and check whether the activities in the programme are based on theoretical principles. Finally, planners test the materials together with the target populations (young people, parents, community, etcetera) and the users of the intervention materials (i.e., educators, peer educators, lobbyists, etcetera), and produce a final version that can be piloted.

Steps in Intervention Mapping

1. Involvement
2. Needs Assessment/ Situation Analysis
3. Objectives
4. Evidence-Based Intervention Design
5. Adoption & Implementation
6. Monitoring & Evaluation

Intervention design is probably the most creative part of the development process, which means that is one of the most fun steps, but it also means that planners need to go ‘forward and backwards’ and have to be flexible in adapting their ideas and products. Often, these decisions, adaptations, and ideas get lost, because intervention planners do not document their experiences and decisions. However, to increase knowledge about good practices, and reasons why the intervention has become the way it is in the end, it is recommended to document the relevant decisions and ‘reasons why’ that are taken during intervention design.

IM Step 4 is also a way to ensure the quality of an intervention. The aim is to use existing experiences from theories and studies (evidence) to design intervention activities and materials that are effective in creating change by meeting the objectives: change in knowledge, risk perception, in attitudes, social influence, skills and in the end change in behaviour. To take that step, planners have to carefully think about the selection of the activities and materials they will provide to the target group(s). Generally, planners are good at designing these activities and materials. For example, if they want to give young people information about HIV/AIDS, they may provide them with a leaflet explaining the facts, or they may provide a lecture, or they may facilitate discussion about this topic in a group setting. In IM, these activities, means, and materials are defined as ‘strategies’.

However, many planners are not very much aware of the underlying processes: why does a leaflet, a lecture, or group discussion increase knowledge? And which of these activities is most effective in increasing awareness about HIV/AIDS among young people? IM defines these underlying processes as theoretical ‘methods’. The methods have to provide answers to the question ‘why does this strategy lead to a change in behaviour, in knowledge, risk perception, attitudes or skills?’ This so-called ‘justification’ helps planners to take conscious decisions about the strategies they include in the intervention.

In practice, it may be very difficult to think in terms of theoretical methods. Planners tend to be more comfortable to think in terms of educational strategies. Actually, this does not matter that much, as long as planners consider the change processes underlying educational strategies. So for each educational strategy, planners have to ask themselves ‘why would this particular strategy be effective in changing this particular objective?’. Subsequently they can look for theories or methods that can provide scientific support for effectiveness.

A challenge in this step is to ensure that the final program fits with both the target population(s) and the context (school) in which it will be delivered. To achieve this, involvement of both young people, relevant people in their environment, and educators from the start is crucial.

The end product of IM Step 4 consist of 1) a review of available programmes and a selection of a basic programme; 2) a description of how the objectives in IM Step 2 can be achieved by particular strategies; 3) a description of the justification of the link between objectives and strategies; and 4) an intervention that can be pilot-implemented in a small number of schools.

Tasks in Step 4

Task 4.1	Involve relevant stakeholders
Task 4.2	Draft Intervention plan and structure
Task 4.3	Select activities and materials (strategies)
Task 4.4	Provide methods and theories
Task 4.5	Design and pre-test the intervention

7.1 Task 4.1 Involve relevant stakeholders

Each step of Intervention Mapping starts with the involvement of relevant stakeholders. The table below shows an overview of relevant stakeholders to involve in evidence-based intervention design. If possible, planners should try to get experts in health promotion or behaviour change theories involved. They can assist planners in creating an intervention that is more likely to have effect on behaviour of the target population by applying existing experiences from theories and evidence. In some countries this may be a problem, as there are few experts in health promotion. This chapter gives at least some basic tips for increasing the effectiveness of sexuality education programmes for young people.

In intervention design, planners work together with various people, for example curriculum developers, writers, illustrators, who have the knowledge and skills to develop sexuality education programs. Thorough planning, briefing and good communication about expectations with especially creative consultants who collaborate in the design, writing, and creation of the intervention materials and activities, contribute to effective collaboration.

In this stage, it is recommendable to consult the student panel and teacher panel, as well as the linkage board. For example, after the program outline is finalised. There is still the opportunity for them to give comments, which can be reflected in the program. If intervention planners do not

consult the users and target population of the program, they run the risk of developing materials that will not be used at all, because they do not fit in the implementation setting or because the target population (students) are not interested. The steering committee and advisory board should be involved to get comments and create commitment to the programme.

Experience also shows that it may be useful to involve a representative of the ministry who is familiar with the national (or regional) educational objectives for young people in school (related to SRHR-related topics).

Table 7.1 Involved stakeholders in evidence-based intervention design

4	Evidence-Based Intervention Design	a. Planning group	<ul style="list-style-type: none"> · Select 'basic intervention programme' · Select methods & strategies · Involve experts in health promotion/ behaviour change theories · Organise involvement other relevant stakeholders · Design intervention programme in collaboration with curriculum developer · Clear communication to producers of programme materials
		b. Working group young people	<ul style="list-style-type: none"> · Provide feedback on the selected strategies (class activities and materials) · Provide feedback on content, scope, lay-out, tone, etc. of intervention
		c. Working group educators	<ul style="list-style-type: none"> · Provide feedback on the selected strategies (class activities and materials) · Feedback on feasibility of implementation of intervention
		d. Advisory board	<ul style="list-style-type: none"> · Provide feedback on methods and strategies · Feedback on intervention programme · Are committed to the programme
		e. Others	<ul style="list-style-type: none"> · Experts in 'health promotion'/ behaviour change theories · Creative consultants (including text writers, illustrators, graphic designers, photographers, video producers, etc.) · Representative of Ministry/Department of Education

7.2 Task 4.2 Draft the Intervention Plan and Structure

In step 3, planners come up with a large number of most relevant and changeable objectives. Planners have a rough idea of the various groups they will target in their intervention, and what to change among them. The next task is to create a draft structure of the intervention, indicating what the intervention could look like in the end.

In addition to decisions regarding scope and sequence of a program, in this task intervention planners have to take decisions about programme implementation. Who is going to deliver the program, or parts of the program? What media are going to be used? Which medium and which messenger would attract the attention of the target population, which are most useful in facilitating comprehension of the health promoting message? Brainstorming is a very important tool in this task.

The initial programme plan and structure give an overview of the target audiences of the intervention, the main topics to be addressed, communication messages for each target audience, channels and vehicles to communicate these messages, and finally the scope and sequence of the intervention, as well as the themes or entry points of the intervention.

7.2.1 Make list of target audiences

Based on the needs assessment/ situation analysis , planners have identified which groups of people have to be targeted to address the SRHR related problems young people face. These can be the young people themselves, but also people in their environment who, directly or indirectly, influence young people's behaviour.

Possible target audiences in sexuality education programmes for young people can include young people in school, young people not in school, parents, community members, health service providers, policy makers, school administrators, etcetera. Planners can identify the behavioural and environmental outcomes for each of the target audiences. The box below provides an example of how planners can structure this. The contents may be different for each project.

Box 7.1 Example - List of target audiences

Target audience	Expected outcomes
At risk group	Behaviour change young people
Young people in school	Change in behaviour and rights, in order to improve SRHR
Environmental agents	Environmental change
Parents	Are aware of and support sexuality education
Community members	Are aware of and support sexuality education
Health service providers	Are aware of sexuality education programme and able to provide youth friendly services to young people
Policy makers	Develop/ sustain supportive policies for sexuality education for young people

7.2.2 Identify 25 topics to be addressed among the target audiences

By clustering the objectives and goals, planners get a manageable list of topics that need to be addressed in the intervention. The topics can be based on the health goals (i.e., unintended pregnancy, HIV/AIDS, STIs, sexual abuse), behavioural outcomes (i.e., condom use, delayed onset of sexual intercourse), environmental outcomes (i.e., health service provision, involvement of parents), or change objectives (related to, for example, rights, sexuality, skills, and changes during adolescence).

It is recommended to start with extracting the 25 main topics out of the lists of goals and objectives. Different age groups might require different approaches and topics that can be addressed in sexuality education programmes.¹ The table below is an example, the contents can be different for each specific project.

Box 7.2 Example - 25 intervention topics

Target audience	Expected outcomes	Topics
At risk group	Behaviour change young people	
Young people in school	Change in behaviour and rights, in order to improve SRHR	<ul style="list-style-type: none"> · HIV/AIDS · Adolescence, growing up · Rights · Communication about sexuality · Pregnancy, reproductive health · Prevention of SRH problems · Gender
Environmental agents	Environmental change	
Parents	Are aware of and support sexuality education	<ul style="list-style-type: none"> · HIV/AIDS · Effects of and need for sexuality education
Community members	Are aware of and support sexuality education	<ul style="list-style-type: none"> · HIV/AIDS · Effects of and need for sexuality education
Health service providers	Are aware of sexuality education programme and able to provide youth friendly services to young people	<ul style="list-style-type: none"> · Non judgemental and confidential care for young people · Referral
Policy makers	Develop/ sustain supportive policies for sexuality education for young people	<ul style="list-style-type: none"> · Effects of and need for sexuality education

7.2.3 Create communication messages for each audience

The next step for planners is to brainstorm about communication messages to be conveyed to the target audience. In a Dutch awareness campaign for the Dutch public about condom use as prevention method, the communication message was ‘have safe sex or no sex’. The communication message explains in a nutshell what planners want to achieve among the target audiences.

7.2.4 Identify channels and vehicles

Based on the list of 25 topics and communication messages to be addressed in the intervention, planners start brainstorming to generate ideas about how to communicate the messages and address the objectives among the target audiences. Planners should throw away all preconceived notions and restraints and ask themselves ‘If we could do anything that comes into our mind, what would we do?’

Box 7.3 Teachers and/or peer educators as implementers of sexuality education

Many interventions among young people use the method of peer education to provide education to others. According to the Webster dictionary a peer is: ‘one that is of equal standing with another; one belonging to the same societal group especially based on age, grade, or status’. Thus, the term ‘peer education’ indicates ‘peer-to-peer education’ or those of the same societal group or social standing educating each other.²

Peer adolescents deliver many programs targeting either in school or out of school youth. An adolescent peer group is usually defined not only by age, but also by shared interests, such as participation in shared social characteristics (i.e., sports or school activities).

For the purpose of peer education, it is important to identify the group and select individuals who are willing to act as ‘peer educator’ and are acceptable in this role by that group. A peer educator is someone who belongs to such a group as an equal participating member, and receives special training and information so that this person may bring about or sustain positive behaviour change among group members.

Effectiveness of peer education

Despite the widespread use of programs, evaluations of programs including peer education components are rare.³ In the area of HIV/STD prevention and sexual and reproductive health, only a few published studies have shown that these programs are effective in changing the targeted behaviours, while other studies show that peer education frequently fails, among other reasons because of implementation constraints.⁴

It has been frequently argued that peer education can be a very effective strategy to promote sexual and reproductive health among youth^{5;6} reported work in this area was found to be diverse in terms of aims, objectives, methods, findings and levels of evaluation.⁷

Advantages and disadvantages

The *advantages* of peer education programs are the lower costs, relative to the ones of professionally trained staff; beliefs that people, particularly youth, are likely to rely on peers for information; beliefs that peer educators can act as role models for behavioural outcomes; peers use youth language and real life situations familiar for the target group; and the opportunity for volunteers to experience personal growth and perhaps career development.^{8;9;10 ;11}

Disadvantages of peer education, however, are that sometimes targeted youngsters do not trust the information that they receive from peer educators,¹² the possibility of change in young people’s relationships with the peer educator or inconsistencies in the peer-educator’s own behaviour.¹³ Another disadvantage is that effective peer education depends on the selection of the ‘good peers’.

Peer education can have some positive outcomes if the programs are well designed. For example, in various school-based-programs trained peer educators support teachers in specific tasks. These peer educators need appropriate information, preparation and training so that these peer educators are credible and effective in convincing their peers. More information about peer education can be found on the Internet.^{14;15;16;17;18;19}

Planners select channels and vehicles: a communication *channel* can be interpersonal or mass-medial, or a combination of both; a *vehicle* is more specifically how a message is actually packaged and delivered (for example, teachers, newspapers, entertainment television).

Planners can use information from the needs assessment/ situation analysis (IM Step 1) about preferred channels and vehicles, as perceived by the target audience. Their needs and preferences have to be balanced with logistics and budget. See Annex 7.3 for an overview of advantages and disadvantages of channels and vehicles.

Box 7.4 Target audiences and channels and vehicles

Target audience	Expected outcomes	Topics	Channel	Vehicle
At risk group	Behaviour change young people			
Young people in school	Change in behaviour and rights, in order to improve SRHR	<ul style="list-style-type: none"> · HIV/AIDS · Adolescence, growing up · Rights · Communication about sexuality · Pregnancy, reproductive health · Prevention of SRH problems · Gender 	<ul style="list-style-type: none"> · School curriculum · Movie · Interpersonal channels 	<ul style="list-style-type: none"> · Teacher · Peer educators · Computer · Paper version of the curriculum
Environmental agents	Environmental change			
Parents	Are aware of and support sexuality education	<ul style="list-style-type: none"> · HIV/AIDS · Effects of and need for sexuality education 	<ul style="list-style-type: none"> · Mass media awareness raising 	<ul style="list-style-type: none"> · Awareness meeting organised by school headmaster · Exhibition at the end of implementation · Leaflet with explanation about programme
Community members	Are aware of and support sexuality education	<ul style="list-style-type: none"> · HIV/AIDS · Effects of and need for sexuality education 	<ul style="list-style-type: none"> · Mass media awareness raising 	<ul style="list-style-type: none"> · Awareness meeting organised by school headmaster · Leaflet with explanation about programme
Health service providers	Are aware of sexuality education programme and able to provide youth friendly services to young people	<ul style="list-style-type: none"> · Non judgemental and confidential care for young people · Referral 	<ul style="list-style-type: none"> · Mass media awareness raising 	<ul style="list-style-type: none"> · Awareness meeting organised by school headmaster · Leaflet with explanation about programme
Policy makers	Develop/ sustain supportive policies for sexuality education for young people	<ul style="list-style-type: none"> · Effects of and need for sexuality education 	<ul style="list-style-type: none"> · Interpersonal channels 	<ul style="list-style-type: none"> · Meetings with policy makers and representatives of young people, school, advisory board

For a long time, schools have particularly focused on the transfer of knowledge to students (i.e., courses on Language, Mathematics, Biology), and less on acquiring skills, developing attitudes or building self-esteem. However, malaria, tuberculosis, and AIDS and other sexual health problems such as STIs, unintended pregnancy and forced sex cause major problems in many developing countries. There is a need to educate and enable young people to prevent these diseases and impairments of their quality of life. The school setting seems to be one of the most appropriate settings to provide such education.

A number of studies has demonstrated that health education administered through schools (including involvement of parents, health professionals and community leaders) has a significant impact on health behaviour of school-age children.^{20;21;22}

There are a number of advantages when reaching young people with sexuality education in schools:

- In most countries large numbers of young people attend schools and are thus easily accessible for interventions
- Contrary to outside-school settings, school-based interventions are more easily structurally embedded and usually encompass a process instead of the usually short-term, ad hoc interventions outside school
- The existing infrastructure, facilities and the capacity of personnel at schools can be used for health education and health promotion activities
- As there are substantial barriers to receiving health services for poor and marginalised groups in the developing world and many poor and marginalised adolescents can be reached via school-based interventions (as opposed to clinic-based), schools can contribute to reducing inequities in access to public services
- As much risk behaviour in adolescence takes place under the influence of social networks, many of which are located in the school, school-based interventions have the potential of intervening in the social ecology of adolescents by directly addressing the norms characterizing such networks
- Schools can serve as gatekeepers for access to other community groups such as parents, youth centres and sports organisations as well as health services and community (including religious) leaders
- Educational and health outcomes are inextricably linked. Unhealthy or addicted adolescents, for example, are unlikely to achieve their educational potential. Likewise, a student who is failing at school is at risk for adverse health outcomes such as depression, being suicidal and sexual acting out. It is thus necessary to improve health outcomes if one is to improve educational outcomes, and vice versa.

7.2.5 Decide about the scope and sequence of the intervention components

To be able to bring all single programme components together, planners decide about the scope and sequence of the intervention components. *Scope* is the breadth and amount of an intervention, whereas *sequence* is the order in which interventions, or intervention components, are delivered across time.

Scope

In sexuality education programmes, the scope of the intervention relates to the comprehensiveness of the intervention, addressing topics ranging from love and sexuality to safe sexual behaviour, and focusing on young people. The scope shows the general structure of the content, target groups and implementation of the intervention.

When deciding about the scope of the intervention, planners need to take the implementation setting into account. Who is going to deliver the program, or parts of the program? When implementation takes place in schools, teachers may deliver the intervention. Do the intervention components fit with the school environment (i.e., activity that requires lot of personal attention from teachers might not be useable in a class setting with 70 students)?

Box 7.6 Topics in sexuality education

In each setting and culture, and for each particular target group, particular topics need to be addressed in sexuality education. However, experience shows that to a large extent young people of all cultures and backgrounds need the same kind of information and do experience the same kind of challenges. The topics of the intervention 'The World Starts With Me'²³ are listed below:

Lesson	Topics/ activities
Lesson 1: The World Starts With Me	Introductory lesson to make young people familiar with the programme and create a safe environment. Participants need to have fun and get excited about the programme.
Lesson 2: Emotional Ups and Downs	Young people get introduced to emotional change during adolescence through a digital presentation, role play activities and by identifying emotions for themselves and others.
Lesson 3: Is Your Body Changing Too?	Young people go through presentation about body changes during adolescence, both for boys and girls, get information about hygiene.
Lesson 4: Friends and Relationships	This lesson makes young people aware of the important social relations they have, including their parents, friends, others. In an exercise they draw the most important people, and why they are important to them. They are also introduced to friendships with people from the opposite sex.
Lesson 5: Boys and Girls, Men and Women	The focus in this lesson is on gender, equal rights for men and women. Through a digital presentation, an exercise on gender roles, and group work, young people are triggered to get aware of their own opinion about this.
Lesson 6: Fight for your Rights!	In this lesson young people learn about young people's sexual and reproductive rights and through a poster making exercise stand up for their own rights in their own communities.
Lesson 7: Sexuality and Love	Young people learn about the topics of sexuality, sexual intercourse, love, enjoying sexuality, through a presentation and making their own storyboard.
Lesson 8: Pregnancy: 4 Girls and 4 Boys!	In this lesson, students deal with the issue of pregnancy and will come to understand that pregnancy is a beautiful thing if it happens at the right time and in the right circumstances. Students gain knowledge and facts through the interactive presentation and explore these issues in a role play exercise.
Lesson 9: Protect Yourself: STIs and HIV/AIDS	The aim of this lesson is to help students be aware of the real and present dangers of unsafe sex because of STIs and HIV/AIDS, using a presentation, a quiz to test their knowledge, a group discussion and role plays to practise negotiation skills.
Lesson 10: HIV/Aids: U have a role 2 play 2	This lesson about HIV/AIDS contains a presentation about HIV/AIDS, short interviews with people who are infected with or affected by HIV/AIDS, group work, and postcard making. Optional are a visit to a health clinic, or a visit of people affected by HIV/AIDS.
Lesson 11: Love shouldn't Hurt	This lesson deals with sexual harassment and abuse, through a presentation and skills building exercise on refusal skills of unwanted sex.
Lesson 12: Your Future, Dreams and Plans	Young people focus on their future, dreams and plans. Students do a goal setting exercise, and an exercise to explore their positive characteristics.
Lesson 13: My Top peer book	This refresher lesson gives students a moment of reflection on the whole course and prepares them for sharing their knowledge with their peers. They translate their personal highlights of the course into tips they feel are important to share with peers and develop a small pocket book with their top tips.
Lesson 14: Exhibition	Students prepare an exhibition and a public presentation of The World Starts With Me, to show their parents and community what they have done, by giving presentations, and exhibition of their work.

Sequence

After planners have decided on the scope of an intervention, they have to decide on the sequence of topics and activities within this scope. A logic sequence of issues and themes contributes to the efficacy of HIV/AIDS and SRH programs.²⁴ Within the scope of school based sexuality education, planners map out the sequence of the lessons that are delivered to the students, as well as other activities that the students are exposed to.

How do planners get to a logical sequence? This process is influenced by various factors and sources. The sequence of a school based sexuality education intervention can for example be based on an existing curriculum or intervention. It can also be influenced by the experience of the curriculum developer or researcher, who has her/his particular way of modifying interventions.

To a large extent the sequence depends on the list of topics, and on knowledge derived from scientific theories or from experiences of the stakeholders (for example, students, teachers, linkage board or experts). When they decide about the sequence of the topics and activities, planners also take into account the implementation possibilities and limitations. For example, the number of lessons and time needed for implementation is based on the time that is available in the school setting.

Box 7.6 provides an overview of the sequence of topics and activities of *The World Starts With Me*, a computer based sexuality education programme, implemented in Uganda, Kenya, Thailand and Indonesia. Various factors and sources contributed to the content and sequence of the topics that are addressed in the intervention:

- Theory and evidence indicate that in order to change behaviour, people should first be provided with information, get aware of their personal risks and attitudes, and only in a later stage providing knowledge, before skills-training is proven to be more effective than the other way around.²⁵
- Particular information, for example, about adolescence and self-awareness should be provided to young people before they are exposed to skills training, for example, on negotiation skills. The reason for that is that self-awareness and attitudes determine to a great extent also the attitude towards sexuality and why they should get negotiation skills anyway
- The sequence proved to be effective and logic to the people who had to work with it (mainly teachers and students)

7.2.6 Interventions to improve young people's SRHR

To address young people's sexual and reproductive health and rights, different categories of interventions can be distinguished. Depending on the context, needs, and resources available, one or a combination of interventions can be developed and implemented to address young people's rights and needs.

Educational interventions

Educational interventions aim to improve young people's sexual health by supporting them in making well-informed decisions with regard to their sexual behaviour, i.e., postponing sexual activity or practicing safe sex. To enable them to take these decisions, young people are made aware of the long-term impact of their decisions and the importance of planning their futures. Educational interventions can focus on all young people, both in school and outside the school setting (for example in youth centres, or through mass medial education).

Ideally, comprehensive educational interventions provide complete, accurate and age-appropriate sexual health information; support value development and coping with social influences; assist

young people in understanding a positive view of sexuality; and incorporate skills-building exercises to help young people improve their self-esteem, develop their communication skills about sexuality, and strengthen their ability to be assertive, refuse unsafe sexual practices and to negotiate safer sexual practices.²⁶ It depends on the channels and vehicles whether this is attainable or not. Educational interventions can be divided into three categories:

- **Mass media interventions** traditionally focus on behaviour change, spreading health messages on a large scale to reach groups of people. Mass media interventions, such as television or radio programs, are effective in raising awareness on health risks and increasing knowledge. Behaviour change can usually not be expected due to their ad hoc character.^{27;28} They are most opportune in targeting outside-school youth and particularly difficult-to-reach youth, being a cost-effective means to raise awareness at a large scale.²⁹ Mass media can also be used for advocacy, progressing beyond narrow interpretations of behaviour change and focus on shaping supportive policies related to health promotion.
- **Outreach interventions** provide information and services through face-to-face contact between outreach workers and individual people. These programs focus on youth in settings outside the school, particularly on difficult-to-reach youth, including street children, drug users and sex workers. Outreach is often site-specific, based on where members of the target population might gather, such as a street corners, institutions (such as youth centres, prisons, canteens of sport clubs), places where youth events are organised, internet cafe's or social gathering spots. Outreach may be a one-on-one encounter or take place in small groups. It may be a one-time event, regular event or as part of a relationship between a specific worker or program and a specific client or members of a target population.
- **School-based interventions** are usually set up in such a way that they include structurally embedded SRHR education through a curriculum or program after school hours for school youth.

Interventions on reproductive health services

Reproductive health services for young people can be combined with educational interventions and aim at offering access to effective, affordable, confidential and non-judgmental counselling and health care. These programs aim to support youth (especially sexually active young people) to cope with threatening or existing sexual health problems.

Today's reproductive health services usually include advice and counselling on various SRH topics. These include family planning services; decisions about contraception; pregnancy testing; post-pregnancy care and nursing care in the hospital and at home; STI diagnosis, testing and treatment and (in endemic countries) HIV testing and treatment. Other services that can be provided include emergency contraception (EC); condom provision and education; and websites with information and support.³⁰ In some settings, health care providers provide post-abortion care; outreach work; and operating telephone help lines.

In many developing countries, youth friendly reproductive health services are scarce, limited and sometimes not available or accessible. One of the important factors is the opinion of health services providers about sexual activity of young people. Providers often do not accept young people's sexuality, do not take them seriously or are judgmental when they provide counselling and care. As a result, young people may not come back, do not to adhere to treatment or do not notify partners in case of STIs. Some ways to increase the availability and friendliness of services for young people:

- *Make regular reproductive health services* also accessible for young people. Disadvantages include that the range of facilities offered and the design of the health service (location,

building) are often not youth-friendly,^{31;32} and that many health service providers are not or hardly aware of the real needs of young people. Training can be provided to service providers to make them aware of this to effectively meet their needs with respectful behaviour in often very sensitive situations.

- Set up *specific youth services*, meaning that facilities are tailored at young people's needs, being secure and 'safe' (privacy should be guaranteed when entering the building or when helped) and easily accessible for young people (not too much travelling, a welcoming reception). Youth-friendly services should offer confidentiality, privacy, trustworthy staff whose attitudes are non-judgemental and respectful toward youth, convenient hours of operation, convenient location(s), inexpensive or free services, youthful waiting room décor, and casual dress among staff.^{33;34}

Health service providers may also make condoms and other contraceptive commodities available and affordable to young people (condom social marketing, the promotion and sale of condoms at subsidised prices)³⁵. Young people often say that they prefer private-sector sources (especially retail outlets) as their source of condoms.

Advocacy interventions

Developing and implementing advocacy strategies and materials and related training for advocacy professionals

In most cultures, young people's sexuality is a sensitive subject. Programs that offer sexual and reproductive health information and services to adolescents can expect to encounter resistance from the community. An enabling environment, however, improves the effectiveness of interventions targeting youth. This environment should facilitate appropriate and affordable supplies (condoms, contraceptives), facilities (information sources, educational programs, health services, counselling, et cetera); supportive regulations such as laws and policies; and supportive community norms on young people's sexuality and SRH.

Advocacy can be a tool to change this social environmental, aiming at removal of environmental constraints that discourage programs that meet the needs and rights of young people.³⁶ Advocacy programmes can consist of lobbying among policy makers or working with mass media at (inter)national or local level.^{37;38} Media advocacy programs are successfully applied by stimulating community action and promoting changes in the physical and social environments.³⁹ Media advocacy can model terminology and tactics that make discussion in interventions that directly focus on the target group more probable and comfortable.⁴⁰

7.2.7 Select a programme theme

A programme theme is a general organising construct for a programme. A programme often has a theme as well as several recurring visual and linguistic sub themes or ideas. A theme provides structure to an intervention and comes back in all programme components and materials.

In sexuality education interventions, the theme can for example be exploring oneself in relation to the environment: 'the world starts with me'. Themes are not necessarily related to the content of the intervention. The most important reason to choose a particular theme is whether it will aid attention, awareness and comprehension.⁴¹

7.3 Task 4.3 Select activities and materials (strategies)

When the initial programme plan and structure are created, the next task for planners is to identify materials, means and activities for the various interventions that have to be developed, either targeting young people or targeting people who are responsible for a supportive environment (environmental agents).

In the Intervention Mapping vocabulary, *strategies* are defined as the practical activities, means and materials that together make up an intervention programme. Examples of strategies include group discussions, presentations in written materials, skills building exercises, lectures, leaflets, etcetera. The terminology is sometimes confusing, as in other areas, a strategy is defined as ‘a plan for actively doing something’, or ‘a long term view mostly described as a high level framework on where a department/ organisation wants to be in about 2 years or how it wants to be perceived in that time frame’. In IM, a strategy is not a high-level plan, but a detailed, practical activity or material.

Most planners are familiar with *strategies*, the practical activities and materials that are used to change people’s behaviour and determinants. For example, when programme developers are asked how to increase knowledge, they are able to come up with a number of creative examples of how to give information, ranging from lecturing to exercises where people have to actively search for the information. Strategies can be selected for changing knowledge, attitudes, skills and the other determinants. Some strategies focus on one determinant only, others include a number of determinants.

Planners have to be aware of the conditions for the use of particular strategies. Not all strategies can be used to communicate with every target group. For example, a target group needs to be literate when planners want to use written materials; to be able to do a role-play, the implementation setting requires sufficient space and the facilitators need to have the skills to guide a role-play; social modelling, for instance in videotaped role model stories, is most likely to be effective when the target population can identify with the model; and when aim to educate young people on correct condom use, they have to take into account that not all teachers feel comfortable enough to do a condom demonstration in a classroom setting.

To come up with a list of strategies that cover all the objectives of IM Step 3, planners can accomplish the following tasks:

- Brainstorm about strategies
- Use existing interventions
- Link the strategies to the objectives
- Design new strategies
- Provide justification for the strategies

7.3.1 Brainstorm about strategies

In the previous task, the general intervention structure is created. Planners can now start thinking about a more detailed description of the intervention: which activities or materials are needed to achieve the goals and objectives? And what can be done to do this as effective as possible?

Brainstorming is a very important tool in this phase. When brainstorming gets stuck, planners can try a paradoxical approach: if we wanted to have the opposite effect, what would we do? Another

way is to ask them for solutions: if you were going to (for example) increase safe sexual behaviour of young people, what would you do?

This exercise results in a list of optional strategies to be included in the intervention programme. This list will guide the analysis of existing programmes and if needed, the design of new materials and activities. Scientific literature hardly provides information about the effectiveness of specific strategies. For the selection of strategies we often have to rely on the experiences in health education and health promotion practice.

7.3.2 Use existing interventions

One of the principles of this manual is to concentrate on the use of existing programme materials, exercises, practices and activities. Many materials or descriptions are already available, and generally it is a waste of money and time to start from scratch with intervention development. Planners are encouraged to select and review existing intervention materials, and retrospectively explain to what extent the intervention materials address the objectives of IM Step 3.

Collect existing programmes

First, planners collect one or more available sexuality education programmes that can be used as the basis for the intervention. Depending on the specific context, life skills programmes, HIV/AIDS prevention programmes, or reproductive health programmes may be available, either from the own country or region, or from elsewhere. Planners should select a programme that addresses as much as possible the identified objectives, and ideally is developed according an evidence- and theory-based approach. Materials do not necessarily have to be designed for the exact target group of the program. For example, very useful activities can also be collected from materials developed in other countries. We then suggest however to carefully check the materials on culture-specific aspects.

Planners can collect complete programmes, but they can also collect specific activities from any kind of programme, educator instructions only, other useful parts of manuals (i.e., fact sheets), or descriptions of activities, exercises, approaches, or materials that have proven to be useful and/or effective. In addition to sexuality education programmes, planners can also collect good practices related to advocacy, mobilisation of community support, training of health workers, etcetera. Programme planners should find as many existing materials and activities as possible that can cover the lists of objectives as identified in IM Step 3. To understand the rationale underlying the various activities and programmes, it is suggested, if possible, to also collect the description of materials and decisions of programme developers why the materials and activities are the way they are. Planners can find out whether the programme was implemented and evaluated, and if so when, for which period, the extent to which the programme is sustainable, as well as the intensity level of the programme (e.g., once a week or once a month).

At first sight it might be difficult to get hold of the materials. Experts and stakeholders (e.g., in the Advisory Board) may be able to provide suggestions on where to find materials. Another way is to consult colleagues and search the Internet.⁴² When the materials are collected, planners need to find out whether it is possible to use the materials of other organisations in their own program. They have to find out its costs, whether there are copyrights, whether the initial designers have particular conditions to be allowed to use the materials, or whether planners have to ask permission before using them.

Analyse existing programmes

After the collection of programmes, planners conduct an analysis of the existing materials and activities.⁴³ The checklist that accompanies this manual is a planning and support tool for school based sexuality education programmes for youth in schools. The criteria of this tool are listed below. The full tool can be obtained from the Internet.⁴⁴

Box 7.7 Characteristics of effective school based sexuality education programmes

A. Approach

1. Planners use a logic model approach to develop the intervention programme
2. Planners include SRR in design and content of the intervention

B. Involvement (Step 1)

3. The intervention programme is developed by a multidisciplinary planning team (programme planners) as part of a larger linkage system
4. Planners involve young people and educators at relevant moments during intervention programme development
5. Planners involve relevant authorities to secure support for the intervention programme
6. Planners identify the target group and the implementation setting of the intervention programme
7. Planners include gender in the design and content of the intervention programme

C. Analysis of needs and capacities (IM Step 2)

8. Planners assess relevant needs, capacities, strengths and assets of young people
9. Planners assess community values and available resources and capacities

C. Objectives (IM Step 3)

10. Planners tailor the intervention objectives to the specific target group
11. Planners specify the health goals of the intervention
12. Planners state clear objectives related to behavioural outcomes
13. Planners state objectives related to performance behaviours (specific actions to use condoms, delay sexual intercourse, avoid violence)
14. Planners state objectives related to multiple risk and protective factors influencing sexual behaviours
15. Planners identify objectives related to a supportive environment for young people's SRHR

D. Evidence-Based Intervention Design (IM Step 4)

16. Planners include small group work in the intervention programme
17. Planners provide factual information and encourage young people to actively obtain, share and personalise the information
18. Planners always combine risk information with solutions and skills to reduce risks; the intervention programme is not fear-based
19. Planners address attitudes and values in the intervention programme
20. Planners include activities in the intervention programme to learn how to cope with negative social influences
21. Planners include skills training in the intervention programme
22. Planners include options for individual support in the intervention programme
23. Planners encourage parent involvement
24. Planners explicitly communicate about sex, condom use and contraceptive use in the intervention
25. Planners encourage educators to create a safe setting for youth to participate
26. Planners cover topics in a logical sequence
27. Planners pilot-test (parts of) the intervention

E. Adoption & implementation (IM Step 5)

28. Planners select educators with desired characteristics
29. Planners train and support educators
30. Planners encourage educators to implement all activities as designed
31. Planners undertake actions to improve continuation of implementation

F. Monitoring & Evaluation (IM Step 6)

32. Planners have a plan for effect evaluation
33. Planners have a plan for process evaluation

7.3.3 Link the strategies to the objectives

After the collection and analysis of existing programmes and strategies, planners make an overview of the activities and materials and identify which objectives are covered by these strategies. This also shows an overview of the objectives that are not (yet) covered by the selected materials.

If new strategies are designed, planners also include the new strategies in their final matrix. This provides them with a total overview of strategies and gives insight whether all relevant and changeable change objectives are addressed in the programme.

These matrices with change objectives can be used for the educator's manual, so that they know what each participant is supposed to learn in each lesson.

Strategies and change objectives young people

In the previous task planners have analysed the existing materials and programme descriptions and may have selected a number of strategies that are useful for their own programme. For each of the relevant strategies, they describe which objectives are addressed on the levels of knowledge, risk awareness, attitude, social influence and skills & self-efficacy.

For example, one of the strategies in *The World Starts With Me* is a role play exercise where young people need to practice negotiation skills. See the box 'Negotiation skills exercise'.

For each strategy, planners can identify which objectives of IM Step 3 are covered by that particular activity. The table below shows some objectives, derived from the matrix of change objectives in the previous chapter. It shows that the activity covers objectives on the level of all determinants. In practice, not all activities address all determinants. Some focus particularly on skills, others on risk awareness and others on knowledge.

This overview of objectives for each strategy is the foundation for the design of the final intervention materials. It will give educators a clear overview of what students need to know, think, and be able to do at the end of that particular exercise.

Negotiation skills exercise

step 1

Use the Negotiation skills to do the role play.

1. Timing - Choose your time well
2. Give a clear message
3. Be Firm
4. Stick to your decision

step 2

Divide students into pairs. Each pair practises the negotiation skills in a brief role play, using all guidelines. For each pair, the story is the same: a boy and girl are on a date. One of them wishes to have unsafe sex with the other. But the other does not want to have sex at all or only wants to have safe sex. Each pair decides on the exact story. The story itself has little importance; it is more important that each student gets to practise the negotiation skills. The students can all be in the same room, playing at the same time.

step 3

When all pairs have completed their role play, ask a few students to demonstrate the negotiation skills in front of the class. Lead the class discussion: how did it go? What have they learned? Will they put this into practice? What difficulties do they think will arise?

Box 7.8 Example - linking change objectives to strategies young people

Activity/ material	Knowledge	Attitude	Risk perception	Social influence	Skills & self-efficacy
<i>At the end of the programme, young people can...</i>					
Negotiation skills exercise (The World Starts With Me)	Explain that sexual expectations in boys and girls can be different	Express own attitude towards the possibility of having sex with boy/girl friend when alone	Write down risks (health, emotional and social) associated with sexual activity	List four arguments often used by young boys or young girls to pressurize another person into having sexual intercourse	Explain why they believe they have mastered the ability to successfully negotiate alternative safer sexual practices with a sexual partner
	List five ways of being intimate or of having sex with a loving partner, as an alternative to sexual intercourse	Explain that lovers should communicate with each other about sexuality	Mention of each sexual technique the risk on STIs/HIV and pregnancy	Argue why young people pressure each other into sexual intercourse	Explain negotiation, assertiveness and refusal skills step by step

Strategies and change objectives environmental agents

Planners can also use existing activities or materials that focus on the relevant environmental agents, including parents and the wider community, health care providers, and policy makers. The change objectives for each of the groups of environmental agents are related to the existing activities and materials.

For instance, strategies for the involvement of parents in sexuality education of their children mainly aims at turning their hesitance towards the programme into allowing their children to participate in the programme, or even getting their support. An example of a strategy is the provision of a booklet or leaflet explaining about the programme and the need for it.

Another strategy can be a group discussion during a parent awareness meeting in order to clarify values and provide arguments that support the need of sexuality education for young people. The table below shows how the change objectives of Step 3 can be linked to this strategy. Planners can link the change objectives for each selected strategy for each environmental agent.

Box 7.9 Example - linking change objectives to strategies environmental agents

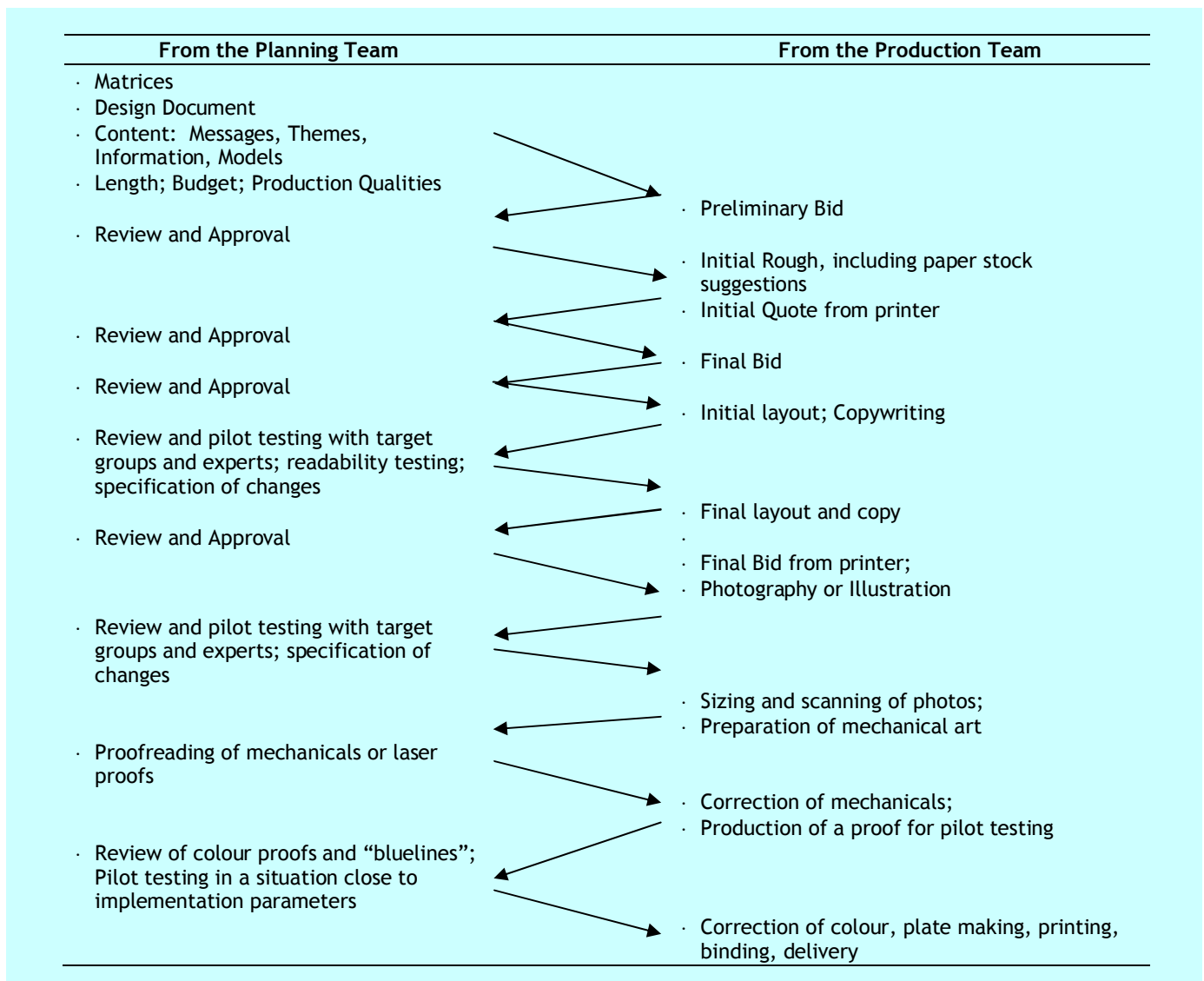
Activity/ material	Knowledge	Attitude	Risk perception	Social influence	Skills & self-efficacy
<i>At the end of the programme, parents can...</i>					
Group discussion about need for and risks of sexuality education (Parent awareness meeting)	1. Explain that sexuality education does not increase sexual activity among youth	1. Explain that if their children do not get educated about SRHR-related topics, they are vulnerable for SRH problems	1. Express a positive view on sexuality education	1. Explain that other parents and community members also support youth to participate	
	2. List 3 health risks of young people				

7.3.4 Design new strategies

Most likely, existing interventions address part of the objectives but not all. As a result, new activities have to be designed or existing materials have to be adapted to fit in the intervention. For example, there might be an intervention available with a lesson about ‘physical changes during puberty’, with two activities. Intervention planners have to check whether these two strategies meet (all) their objectives and whether the strategies will be effective (e.g., in line with theoretical principles). When existing materials do not optimally cover all the objectives, new materials have to be developed.

For example, an organisation in Kenya used a sexuality education programme that was developed in Uganda. The needs assessment revealed that it was necessary to address specific Kenyan cultural factors in the programme. However, these issues were not addressed in the Ugandan version. As a result, change objectives related to ‘culture’ were identified and used to guide the design of a specific lesson about culture.

Figure 7.10 Tasks for Producing a Print Piece⁴⁵



It is beyond the scope of this manual to provide specific instruction on every task for the production of the wide variety of programme materials. The figure below provides an example of how the communication between the planning team and the production team may occur, from explanation about the ideas, up to the final production of materials. The actions to be taken by planners and producers to produce for example videotapes or computerised programmes can also be drawn like this.

Collaborate with creative consultants

In the design of new strategies and materials, planners may collaborate with creative consultants: specialists such as text writers, graphic designers, video producers, and so on. The major task of the planner is to safeguard the theoretical underpinnings of materials, as well as the program structure and unity. To accomplish this task, program guidelines have to be specified in briefings, storyboards and script outlines. These documents have to cover a full description of all program components to facilitate the transfer of the program theory to the producers of specific program components.

Apart from their technical skills, openness to collaborate with intervention planners and researchers should be a central criterion for the selection of creative consultants. Creative consultants should be willing to accept research and theory as a basis or starting point for their work. For instance, they should be willing to accept the outcomes of pre-test activities.

Involve target audience and implementers

Planners can gain a lot in the design of new strategies when they involve the target audience and educators (for example teachers) in the design. The target audience can provide direct feedback on the quality and attractiveness of the materials, and feedback of the educators can help planners in designing materials which are appropriate for teachers to use for teaching.

7.3.5 Provide justification for the strategies

Health promotion planners are often good at identifying strategies (practical activities and materials), but they are often not consciously aware of the reasons why these strategies would be effective in changing behaviour. For example, planners decide to increase knowledge of young people by providing them a lecture and a group discussion about changes during adolescence. But why would a lecture help in increasing knowledge? And why would a group discussion improve people's knowledge? What are the processes that take place so that people learn? And what would be the best way to give information: a lecture or a group discussion?

These underlying processes of learning are referred to as 'justification'. Planners are encouraged to critically think about the selected activities and materials and ask themselves how these strategies would contribute to a change in knowledge, attitudes, skills. And to ask themselves whether the selected strategies would be the most effective in doing so.

Justification describes the underlying processes of behaviour change: 'how does this activity increase young people's knowledge?'; 'how does this activity change young people's attitudes towards equal opportunities for boys and girls?'; 'how does the skills training improve young people's negotiation skills?'

There are some advantages in describing justification. First, it can help planners to take conscious decisions about all the activities and materials they include in the intervention, and make sure that they use activities and materials that are effective in changing behaviour.

Secondly, the description of justification is useful for future programmes. When planners know which processes have influenced the effectiveness of educational programmes, they can apply this

again in future programmes. If planners find out that active involvement of the target group has improved the programme, this is something programme developers can use again in future interventions.

According Intervention Mapping, planners should provide justification for all activities and materials that are used in the intervention, both the programme for young people, as well as the activities that are conducted to change the environment. When we look again at the example of the ‘negotiation skills exercise’ of The World Starts With Me, we have provided justification why this exercise would address the objectives. See the Table in Box 7.11.

Box 7.11 Example - justification for strategies

Activity	Determinant	Objectives	Justification	Method (theory)
Negotiation skills exercise (The World Starts With Me)	Knowledge	Explain that sexual expectations in boys and girls can be different	Young people gain information by experiencing or observing that boys and girls deal in different ways with communication and social pressure	Modelling (Social Cognitive Theory ⁴⁶)
		List five ways of being intimate or of having sex with a loving partner, as an alternative to sexual intercourse	Actively obtaining information activates young people’s thinking and it is therefore more likely that they will remember the information.	Active learning (Elaboration-Likelihood Model ⁴⁷)
	Attitude	Express own attitude towards the possibility of having sex with boy/girl friend when alone	Young people get aware of their own attitude towards negotiating sexual intercourse and may change their attitude based on what they experience or observe how others respond in the exercise	Modelling (Social Cognitive Theory ⁴⁸) Active learning (Persuasion Communication Matrix ⁴⁹)
		Explain that lovers should communicate with each other about sexuality		
	Risk perception	Write down risks (health, emotional and social) associated with sexual activity	By doing it themselves, young people become aware of the risks of lack of negotiation skills	Active learning (Persuasion Communication Matrix ⁵⁰)
	Social influence	List four arguments often used by young boys or young girls to pressurize another person into having sexual intercourse	Young people hear or observe the reasons of others why they would or would not negotiate safe sex with a partner	Modelling (Social Cognitive Theory ⁵¹)
	Skills & self-efficacy	Explain why they believe they have mastered the ability to successfully negotiate alternative safer sexual practices with sexual partner	Young people learn step by step how they can negotiate sex with a sexual partner	Modelling skills & guided enactment (Social cognitive theory ⁵²)
		Explain negotiation, assertiveness and refusal skills step by step		

7.4 Task 4.4 Identify methods and theories

Many programme planners find the identification of methods and theories a difficult step, partly because they lack knowledge about behaviour change theories, whereas they generally do have a reason for conducting particular activities or using materials. In this section we will provide planners with some examples of theories that have proven to be useful in sexuality education programmes.

Several reviews of HIV interventions have identified characteristics that appeared to distinguish between effective and ineffective school-based programs.^{53;54;55} As far as change methods and theories are concerned, these characteristics include being based upon 1) a social cognitive and social influence approach, 2) the use of interactive strategies to personalise the risks of unprotected sexual intercourse, and 3) the use of interactive, observational and rehearsal strategies to develop communication and negotiation skills.

This implies that effective programs cover risk communication, attitude change, clarification and exchange of values and norms, norm setting, and skill enhancement. Strategies usually include interactive teaching, group discussion, small group work, creative assignments, entertainment activities, demonstrations, instructions, and role-play activities.

More specifically, effective intervention programmes:

- 1) match the stages-of-change of the target population
- 2) actively involve learners in information transfer
- 3) use modelling techniques (e.g., role-play activities, peer-model stories, role model simulation, peer educators)
- 4) provide non-fear based, personalised risk information combined with clear instructions for risk reduction
- 5) use persuasive messages that are tailored to current attitudes
- 6) link health recommendations to important values
- 7) provide information about social norms
- 8) initiate an exchange of thoughts, feeling, values and opinions, with a special focus on gender-role perspectives
- 9) set social norms in favour of health recommendations
- 10) include training in specific sub-skills, with an special focus on communication, negotiation, refusal, and assertiveness skills, and on planning and decision-making skills regarding sexual-risk reduction

7.4.1 Identify methods

After describing justification ('logic thinking'), planners attach theoretical methods to the justification. Intervention Mapping defines a theoretical method as a process of change derived from scientific theory.

Different strategies can have the same justification. For example, a game and a group discussion aim at the active involvement of young people. The justification for these activities is that active involvement enhances the chance that a student will have attention for certain information, and will remember the information. This justification can be translated into theory: active involvement (or active learning) is described in the 'Elaboration-Likelihood model'.

Other examples of strategies include role plays, stories of two young people on a videotape, or a story about young people in a brochure. The justification for these three activities ('why does it work?') is that young people can learn values or skills when they see other people doing it. 'Seeing others doing it' can be translated in the theoretical method 'modelling'.⁵⁶

7.4.2 Identify theories

Methods are derived from various *theories*, including socio-psychological, psychological, organisational, and anthropological theories. Theory in health promotion planning falls into two broad categories of use:

1. To understand the **problem**, both its behavioural and external or environmental causes (*theory of the problem*)
2. To understand the possible mechanisms for **change** (*theory of action*)

The latter category of theories is useful in thinking about behaviour change mechanisms, which is the focus of this section.

Behaviour change theories give us insight in how to guide a target population (e.g., young people) from being unaware to maintained behavioural outcome. Behaviour change is a comprehensive process in which one passes through the stages of being unaware, being aware, concerned, knowledgeable, motivated to change, practicing trial behaviour change and sustained behaviour change.⁵⁷

Using theories in practice means that planners can design sexuality education programmes that are more likely to create a change in behaviour by changing the determinants of behaviour. We briefly explain the various concepts below.

The importance of theory

Effective health promotion programmes help people maintain and improve health, reduce disease risks, and manage chronic illness. They can improve the well-being and self-sufficiency of individuals, families, organisations, and communities. Usually, such successes require behaviour change at many levels, (e.g., individual, interpersonal, organisational, and community).

Not all health programs and intervention are equally successful, however. Those most likely to achieve desired outcomes are based on a clear understanding of targeted health behaviours, and the environmental context in which they occur. Practitioners use strategic planning models to develop and manage these programs, and continually improve them through meaningful evaluation. Health behaviour theory can play a critical role throughout the program planning process and its implementation.⁵⁸

What is theory?

A theory presents a systematic way of understanding events or situations. It is a set of concepts, definitions, and propositions that explain or predict these events or situations by illustrating the relationships between variables. Theories must be applicable to a broad variety of situations. They are, by nature, abstract, and don't have a specified content or topic area. Like empty coffee cups, theories have shapes and boundaries, but nothing inside. They become useful when filled with practical topics, goals, and problems.⁵⁹ An example of a well-known theory in health promotion is the Social Cognitive Theory of Bandura.⁶⁰

Concepts are the building blocks—the primary elements—of a theory. And **constructs** are concepts developed or adopted for use in a particular theory. The key concepts of a given theory are its constructs. **Variables** are the operational forms of constructs. They define the way a construct is to be measured in a specific situation. **Models** may draw on a number of theories to help understand a particular problem in a certain setting or context. They are not always as specified as theory.

Most health behaviour and health promotion theories were adapted from the social and behavioural sciences. Health behaviour and health promotion theories draw upon various disciplines, such as

psychology, sociology, anthropology, consumer behaviour, and marketing. Many are not highly developed or have not been rigorously tested. Because of this, they often are called *conceptual frameworks* or *theoretical frameworks*.

Box 7.12 Social Cognitive Theory

The Social Cognitive Theory is relevant to health communication. First, the theory deals with cognitive, emotional aspects and aspects of behaviour for understanding behavioural change. Second, the concepts of the SCT provide ways for new behavioural research in health education. Finally, ideas for other theoretical areas such as psychology are welcome to provide new insights and understanding.

Core Assumptions and Statements

The social cognitive theory explains how people acquire and maintain certain behavioural patterns, while also providing the basis for intervention strategies.⁶¹ Evaluating behavioural change depends on the factors environment, people and behaviour. SCT provides a framework for designing, implementing and evaluating programs.

Environment refers to the factors that can affect a person's behaviour. There are social and physical environments. Social environment include family members, friends and colleagues. Physical environment is the size of a room, the ambient temperature or the availability of certain foods. Environment and situation provide the framework for understanding behaviour. The situation refers to the cognitive or mental representations of the environment that may affect a person's behaviour. The situation is a person's perception of the place, time, physical features and activity.

The three factors environment, people and behaviour are constantly influencing each other. Behaviour is not simply the result of the environment and the person, just as the environment is not simply the result of the person and behaviour. The environment provides models for behaviour. Observational learning occurs when a person watches the actions of another person and the reinforcements that the person receives. The concept of behaviour can be viewed in many ways. Behavioural capability means that if a person is to perform a behaviour he must know what the behaviour is and have the skills to perform it.⁶²

Concepts of the Social Cognitive Theory⁶³

- Environment: Factors physically external to the person; Provides opportunities and social support
- Situation: Perception of the environment; correct misperceptions and promote healthful forms
- Behavioural capability: Knowledge and skill to perform a given behaviour; promote mastery learning through skills training
- Expectations: Anticipatory outcomes of a behaviour; Model positive outcomes of healthful behaviour
- Expectancies: The values that the person places on a given outcome, incentives; Present outcomes of change that have functional meaning
- Self-control: Personal regulation of goal-directed behaviour or performance; Provide opportunities for self-monitoring, goal setting, problem solving, and self-reward
- Observational learning: Behavioural acquisition that occurs by watching the actions and outcomes of others' behaviour; Include credible role models of the targeted behaviour
- Reinforcements: Responses to a person's behaviour that increase or decrease the likelihood of reoccurrence; Promote self-initiated rewards and incentives
- Self-efficacy: The person's confidence in performing a particular behaviour; Approach behavioural change in small steps to ensure success
- Emotional coping responses: Strategies or tactics that are used by a person to deal with emotional stimuli; provide training in problem solving and stress management
- Reciprocal determinism: The dynamic interaction of the person, the behaviour, and the environment in which the behaviour is performed; consider multiple avenues to behavioural change, including environmental, skill, and personal change.

The original Intervention Mapping book,⁶⁴ and also the Internet provide a lot of resources related to behaviour change theories and methods^{65;66;67;68;69;70;71;72} and to a social psychology glossary.⁷³ In the sections below, we present a summary of a number of theories and refer for more information to relevant resources.

Suggestions

This section provides a summary of relevant theories, as well as some basic suggestions that may help planners to improve the effectiveness of sexuality education programmes. Each of the suggestions is based on a particular theory and for each suggestion we provide examples of how to apply the suggestion in practice. See the box below for a summary of the suggestions.

Box 7.13 Suggestions to improve effectiveness of strategies

General (including knowledge)

1. Focus on all relevant and changeable determinants of behaviour
2. Actively involve the target group
3. Tailor the intervention to the target group
4. Reinforce positive actions or change
5. Repeat important messages
6. Use 'learning by observation' (modelling)

Risk awareness

7. Provide the target group with information about personal risk
8. Combine fear arousal with increasing confidence
9. Let the target group imagine the consequences of risk behaviour

Attitudes

10. Use persuasive arguments to convince the target audience
11. Encourage target audience to compare 1. what they want, and 2. what they do

Social influence

12. Make target group aware of actual social influence
13. Include training of resistance skills
14. Encourage target group to mobilise social support

Skills & self-efficacy

15. Include step-by-step skills-training
16. Encourage target group to attribute failure and success in a constructive way
17. Encourage target group to set achievable goals

Environment

18. Use lobby and advocacy
19. Increase social support for target group
20. Mobilise the community

7.4.3 General suggestions on methods and theories (including increase of knowledge)

The summary starts with some general suggestions on methods and theories that apply to behaviour change in general and to the various behavioural determinants, including knowledge.

1. Focus on all relevant and changeable determinants of behaviour

A number of theories^{74;75;76} suggest that behaviour is not only influenced by knowledge, but is also determined by a number of other factors, such as attitudes, risk perception, social influence, skills, and confidence related to the particular behaviour.

For example, whether a teenager will visit a clinic does not only depend on his knowledge about the kind of care that is offered by the clinic, but also by his perception whether he will be taken seriously by the caregivers, confidentiality, or his fears of being open about his health problems. Changing behaviour therefore can usually not be achieved by providing information only, but planners should also take into account other behavioural factors, such as social influence, skills and attitudes.

Knowledge is an essential element when we want to change behaviour: without an understanding of health risks and their relation to behaviour, without knowledge about risk reduction, no one will be motivated to change and no one will be able to change. Increasing knowledge is a logical first step in behaviour change, but in most cases knowledge does not directly lead to behaviour change. Usually more is needed to motivate people to change their behaviour, and to support them with behaviour change. Health promotion programs without knowledge components are unthinkable. See the Internet for more information.⁷⁷

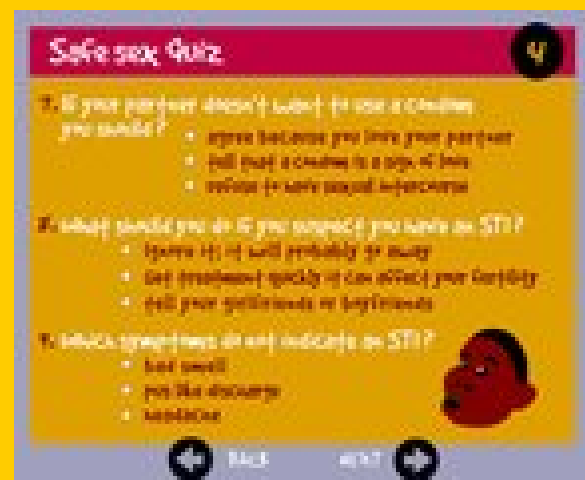
2. Actively involve the target group in learning

A key indicator for effective sexuality education programmes for young people is whether the target group is actively involved in learning.^{78;79} In many countries, teachers are used to frontal teaching and learners receive their information by means of lectures, acting as only recipients of programmes. Active involvement of young people in the learning process however increases the chance that they will remember the information they have received. The underlying process (method) is that active participation in the acquirement of information generally leads to a more elaborate processing of the information, which, in turn, leads to more stable and sustainable changes in knowledge, attitudes and beliefs. The quality of message elaboration generally depends on people's interest, their motivation, and their capability.

In sexuality education programmes, young people can actively be involved for example through classroom discussions, small group discussions, and various exercises in which students have to apply the information that is provided, such as, completing a quiz or questionnaire (see Box 7.14). Also inquiry teaching (using questioning to elicit information) is a strategy that is often used to enhance active processing of information. Conditions for these kind of activities are that educators have sufficient time (within their sometimes tight teaching schedules) and space (e.g., class rooms), as well as facilitation skills.

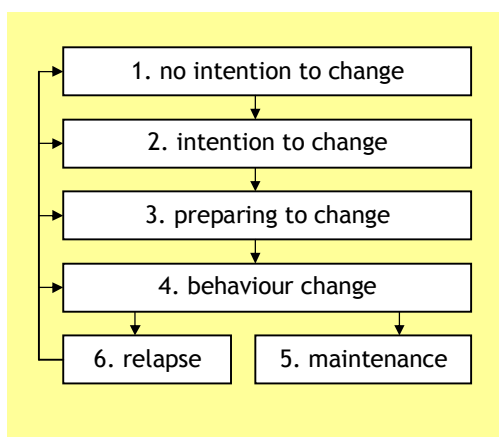
Box 7.14 Example - active learning

In the 'Safe Sex Quiz', students are encouraged to actively obtain information and think about the risks of unsafe sexual intercourse. After finishing the quiz, they receive feedback about the correctness of their answers.



3. Tailor the intervention to the target group

An intervention is most likely to be effective when it is tailored to the specific problems, needs, rights, wishes and background of the target group. If planners have done a needs assessment and have specified objectives, the intervention is likely to be addressing the actual needs and rights. Adapting health messages and intervention activities to the knowledge, beliefs, circumstances and prior experience of a learner, may create relevance, and thus may enhance effectiveness.⁸⁰



The problem is, that we cannot easily deliver health messages that are tailored to each individual of large populations, which also holds for school-based sexuality education. One way to individualise behaviour change communication is the provision of opportunities for learners to have personal questions answered, for instance by means of a question box in the classroom or a telephonic help line. Another method to individualise is, for instance, a self-help guide. By means of a simple ‘intake’ questionnaire, people can be guided to health messages that are relevant to them. For example, print materials on sexuality education may include separate chapters

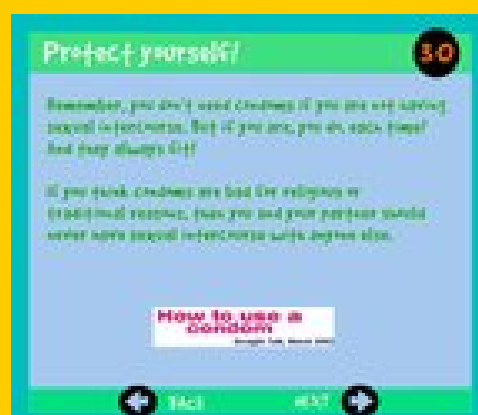
for boys and girls.

The intervention can also be tailored to the **behavioural stage** the target group is in. Looking at groups of young people worldwide, often, some of them are sexually active (either before, within or outside marriage) and some of them are not. Among the sexually active young people, some use condoms during sexual intercourse, others don't. This means that the target group of an intervention consists of people with different behaviours. To make sure that the programme is tailored to all individual participants, planners have to take into account the different behavioural stages.

The Transtheoretical Model^{81;82;83} gives insight in the phases of behaviour change. It acknowledges that behaviour change is a process and not a one-time event. For instance, most people won't be able to dramatically change their sexual behaviour all at once. The model presents 6 stages of behaviour change, going from not having the intention to change behaviour towards maintained behaviour change:

Stage 1. No intention to change; In the first stage, people do not have the intention to change their behaviour within the next 6 months. Someone is either unaware that his/her behaviour places him/her at risk, refuses to acknowledge his/her risk, or has decided for some other reason not to adopt the behavioural outcome. For example, young people may not have the intention to use a

Box 7.15 Example - Tailoring



Example of a presentation where young people in different behavioural ‘stages’ are addressed: both young people who are not sexually active, as well as young people who are sexually active are informed about the use of condoms.

condom, because they do not see themselves being at risk of STIs, although they change partner due to serial monogamy. To change their intention towards condom use, planners can make people aware of the risks and prevention methods, and try to change their attitudes.

Stage 2. Intention to change; In the second stage, people have the intention to change behaviour within the next six months. People often remain at this stage for a long period of time. For example, young people may be aware of their health risks, but are hindered by the social norms of others related to condom use. People in this phase need to be motivated and to get aware of their own capabilities and confidence, and need support from others. They need to set specific goals in this stage.

Stage 3. Preparing to change; An individual makes a decision to change behaviour within thirty days, and has taken some steps in this direction. Although some particularly resolute individuals are able to adopt new behaviours immediately and consistently upon making a decision to change, this is not the case for most people. For young people to use a condom, it requires detailed planning how to do this and building confidence that they can do it, e.g., buying condoms, negotiating with the sexual partner, and correctly using a condom during sexual intercourse. Skills building therefore is an important activity for people in this stage.

Stage 4. Behaviour change; In stage 4, people begin performing the behaviour consistently for less than six months. In our example, this is the stage in which the individual actually buys and uses condoms during sexual intercourse. To maintain correct condom use, young people need to be rewarded for their healthy behaviour.

Stage 5. Maintain change; If people maintain performing behaviour for more than 6 months, they are in the maintenance stage. People need assistance to perform routine behaviour by receiving feedback and if possible, rewarding.

Stage 6. Relapse; Relapse may occur at any part of this sequence and may or may not be followed by a resumption of progress through the stages of change. For example, after getting a new relationship, someone may stop using a condom. In case of relapse, people have to get aware of how they attribute their failure: if they think it is because of an external, stable cause (e.g., condoms are not available), they are less likely to use condoms again. If they attribute it to an internal instable cause (e.g., I just had a bad day and was not in the mood), they are more likely to use a condom during the next sexual encounter. Social support may encourage people to try and perform the behaviour again. See the Internet for more information.^{84;85}

4. Reinforce positive behaviour or change

One of the suggestions from social theories is to reinforce positive behaviour or change, instead of punishment of negative behaviour, as reinforcement is more effective than punishment. This is also referred to as operant conditioning: reinforcement of a behaviour, resulting in more or less frequent occurrence of the behaviour.⁸⁶

Applying reinforcement is difficult when health promoters have no direct contact

Box 7.16 Example - modelling

In WSWM, modelling is used by quoting a young girl who became pregnant and advises other young people not to do the same if they are not ready for it.

with the target population. One way to solve this problem is to include self-rewards in the educational messages (e.g., ‘when you have managed to ..., buy yourself something nice’). When health promoters have direct contact with the target group, they can build in feedback in an educational programme,⁸⁷ by giving information to the learner about his/her performance. For example, by giving feedback when learners exercise skills.

5. Repeat important messages

Repeating important messages in behaviour change communication increases the acceptance of the message by the target group and it increases the chance that the target group will remember the message. For example, if one of the key messages in sexuality education is that young people should use a condom when they have sexual intercourse, this message may be repeated in a number of lessons, in various activities and through different channels. Theory shows that people become more positive about stimuli the more times they are exposed to them, even if they are not consciously aware of the process.⁸⁸

6. Use ‘learning by observation’ (modelling)

Modelling can be defined as ‘learning by observing other people’s behaviours’ and whether their behaviour is rewarded. This concept is described in the Social Cognitive Theory.⁸⁹ By observing others, a person can form rules for his/her own behaviour; and on future occasions this coded information can serve as a guide for action.

By observing other people, an individual can learn that some behaviour is reinforced and other behaviour is not. Modelling can be effective when someone:

- Has attention for and perception of the relevant aspects of the modelled activity (for example, condom demonstration in a video clip or instruction in a classroom)
- Can remember the modelled information
- Has skills to translate the modelled information into adequate action (for example, skills to use a condom)
- Can identify with the model; a model who first struggles but succeeds in the end is more representative and easier to identify with than a ‘mastery model’ (someone who is doing everything right)
- Observes that the model is rewarded for the (positive) behaviour

In sexuality education, modelling can be used in, for example, role model stories (and pictures) in print material, by means of role-play in videotape or role-play in drama. In Box 7.16, an example is provided in which modelling is used to change attitudes and skills of young people. See the Internet for more information.^{90;91}

7.4.4 Suggestions to increase risk awareness

One of the determinants found to be relevant in determining sexual behaviour is the level of risk awareness related to HIV/AIDS, STIs, and pregnancy. In sexuality education, planners can include a number of activities and messages to increase risk awareness.

SUGGESTION	HOW - EXAMPLES (STRATEGIES)	WHY (JUSTIFICATION)	METHOD	THEORY	CONDITIONS
1. Focus on all relevant and changeable determinants of behaviour	Combine: <ul style="list-style-type: none"> · Lectures (knowledge) · Group discussions (attitudes) · Role plays (skills) 	If all relevant behavioural determinants are addressed, the intervention is more likely to change behaviour		Theory of planned behaviour (TPB) ⁹²	Time Space Skills of educators
2. Actively involve the target group	<ul style="list-style-type: none"> · Ask questions · Knowledge quiz · Crossword puzzle · Interview · Questionnaire · Information brochure · Interview classmates/others · Exams · (Small) group discussions · Write song/rap · Poster making 	Active participation in the acquirement of information generally leads to a more elaborate processing of the information, leading to more stable and sustainable changes in knowledge, attitudes and beliefs	Active learning	Elaboration-Likelihood Model (ELM) ⁹³ Persuasion Communication Matrix ⁹⁴ Social Cognitive Theory ⁹⁵	Time Space Skills of educators
3. Tailor the intervention to the target group	<ul style="list-style-type: none"> · Telephonic help line · Personal feedback · Self help guides · Intake questionnaires · Print materials with specific messages for sexually active and inactive young people, and/or for boys and girls, etc. · Question box 	Tailoring the intervention to the needs, culture, behavioural stage, age, gender, etc. of young people, increases young people's attention and recognition, and is more likely to address those aspects of behaviour change that are most relevant to them at that point of time	Tailoring	Transtheoretical model (TTM) ⁹⁶ Precaution Adoption Process Model (PAPM) ⁹⁷	Resources Knowledge of needs of different sub-target groups Time
4. Reinforce positive actions or change of the target group	<ul style="list-style-type: none"> · Feedback and compliments provided by the educator · Suggest self-rewards in print materials 	Positive feedback and encouragement results in positive behaviour and is more effective than punishment	Feedback Operant conditioning	Social Cognitive Theory ⁹⁸	Kind of reinforcer
5. Repeat important messages	<ul style="list-style-type: none"> · Same message in different activities 	Repetition of a message leads to increased remembering by the target group	Repeated exposure	Theories of learning ⁹⁹	
6. Use modelling in educational activities or materials	<ul style="list-style-type: none"> · Role model stories in print material · Role play in drama or videotape 	When the 'models' meet particular criteria, people can identify with them and 'copy' the behaviour, attitudes, skills	Modelling/ observational learning	Social Cognitive Theory ¹⁰⁰	Convincing role models

Table 7.2 General suggestions

7. Provide target group with information about personal risk

An adequate perception of health risks is generally not sufficient to change people's risk behaviour. Various empirical studies conducted in Africa, report that many adolescents do not perceive

themselves as being susceptible to HIV despite their AIDS-knowledge.^{101;102;103} Acknowledgement that one is personally at risk, is also needed to change behaviour in order to reduce health risks.

Some suggestions to personalise risks:

- **Use risk statistics.** People’s capability to make adequate risk assessments is in general rather low. For instance, people tend to overweigh small probabilities and underestimate large ones,¹⁰⁴ and they all think that the risk they run is lower than people on average (*unrealistic optimism*).¹⁰⁵ Planners can therefore include actual risk statistics for a particular group of people.
- **Mention risk behaviour instead of risk groups.** Planners should explicitly link risk to behaviour (e.g., unprotected sexual intercourse during serial monogamy, casual sex) instead of risk groups.¹⁰⁶
- **Use feedback and confrontation.** Messages should focus on self-evaluation regarding the risk behaviour,¹⁰⁷ by providing feedback and confrontation with personal health risks.

Information about personal risks can be provided in print materials, including exercises such as questionnaires or quizzes to encourage the target group to apply the information to themselves.

8. Combine fear arousal with increasing confidence

Fear arousal is a method that is frequently used in health education. With their strong focus on the negative health outcomes of sexual activity, many of the reproductive health education programs in sub-Saharan Africa are fear-based. Theories on fear appeals, as well as empirical evidence suggest that fear usually is a strong motivator to individual action, but not necessarily to risk reduction.¹⁰⁸

Research shows that in order to increase risk awareness, planners can provide risk information, but always have to make sure that the target audience also has the confidence that they can do something about it and prevent the risks.

When people are afraid but are not convinced of the effectiveness of the alternative behaviour, or do not feel confident regarding behaviour change, the resulting behaviour may be defensive, more avoidance oriented than action oriented. In other words, reactions to fear appeals and fear-reducing recommendations are mainly dependent on people’s outcome expectations regarding the recommendations ('what will happen if I follow the recommendations') and their self-efficacy expectations ('how confident am I that I can follow the recommendations').

Box 7.17 Example - Combine fear arousal with increasing confidence

In a digital presentation¹⁰⁹ about risks on STIs, students are informed about the symptoms of STIs, the risk of not noticing its occurrence, and some slides later, what students can do about it: by preventing it and by testing in case of symptoms or doubt.



Thus, to encourage risk-reducing behaviour, AIDS education should include information that students may be personally vulnerable to the AIDS threat, that there exist highly effective strategies for coping with this threat (ABCD: Abstinence, Being faithful, Condom use, Delay of sexual intercourse), and that they possess the necessary skills to implement these strategies.

Fear-arousing communication should always go together with adequate recommendations for adaptive coping behaviour. It should not only make very clear what the negative consequences are of HIV infection, but should also provide adequate guidelines and suggestions for how the target group can reduce the risk of HIV infection, by protecting themselves and their partner. To enhance arousal of moderate levels of fear (*fear appeals*)¹¹⁰ in such a way that the risk information attracts students' attention, the information should be personalised. For instance, only providing information about the health consequences of AIDS to make people scared, generally does not lead to change in intention for safe sexual behaviour. Planners also need to include examples of how people can prevent it, and give people confidence that they are actually able to do something about it. Research has shown that this method has been effective in communicating HIV/AIDS-risks.¹¹¹

Box 7.18 Theory - Health Belief Model

Health Belief Model

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviours, including sexual risk behaviours and the transmission of HIV/AIDS.

Core Assumptions and Statements

The HBM is based on the understanding that a person will take a health-related action (i.e., use condoms) if that person:

1. feels that a negative health condition (i.e., HIV) can be avoided,
2. has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., abstaining from sexual intercourse, using condoms will be effective at preventing HIV), and
3. believes that he/she can successfully take a recommended health action (i.e., he/she can abstain from sexual intercourse or use condoms comfortably and with confidence).

The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived *susceptibility* (one's opinion of chances of getting a condition), perceived *severity* (one's opinion of how serious a condition and its consequences are), perceived *benefits* (one's belief in the efficacy of the advised action to reduce risk or seriousness of impact), and perceived *barriers* (one's opinion of the tangible and psychological costs of the advised action). These concepts were proposed as accounting for people's "readiness to act." An added concept, *cues to action* (strategies to activate "readiness"), would activate that readiness and stimulate overt behaviour. A recent addition to the HBM is the concept of *self-efficacy*, or one's confidence in the ability to successfully perform an action.

See for more information the Internet.^{112;113;114;115;116} And an example where the HBM is applied to HIV prevention and STI screening and HIV testing.¹¹⁷

Protection Motivation Theory

The Protection Motivation Theory (PMT)¹¹⁸ was originally proposed to provide conceptual clarity to the understanding of fear appeals. A later revision of Protection Motivation Theory extended the theory to a more general theory of persuasive communication, with an emphasis on the cognitive processes mediating behavioural change. The PMT is comparable to the HBM, but has included additional factors.

The Protection Motivation Theory proposes that the intention to protect one self depends upon four factors:

- 1) The *perceived severity* of a threatened event (e.g., AIDS)
- 2) The *perceived probability* of the occurrence, or vulnerability (e.g., perceived vulnerability to get infected with HIV)
- 3) The *efficacy of the recommended preventive behaviour* (e.g., efficacy of condoms to prevent HIV infection)
- 4) The *perceived self-efficacy* (i.e., the level of confidence in one’s ability to use a condom)

9. Let the target group imagine the consequences of risk behaviour

Theories suggest that people base their risk judgements on information about the ways in which a particular outcome may occur: *risk scenarios*.¹¹⁹ Risk scenarios are stories describing *how it happened*; they describe a process that underlies the occurrence of an event.

Precaution Adoption Process Model

The Precaution Adoption Process Model¹²⁰ is a same kind of model as the Stages of Change model (also referred to as Transtheoretical model).¹²¹ The difference between the two models is that in the PAM an additional earlier stages is added, when individuals may be unaware of the need for behaviour change. There is an emphasis on awareness raising.

Risk scenario’s may reduce perceptions of invulnerability because they give people an ‘easy-to-imagine’ explanation for, for instance, getting infected with an STI.¹²² Risk scenario’s can be included in sexuality education programmes through peer model stories or testimonies in print materials, and through videotaped or real-life models. See Box 7.21 for an example.

A testimony of a teenage boy in South Africa was printed in a students’ workbook:¹²³

I am a 15-year-old boy and have been going out with a girl for 3 months. We really love one another and therefore decided to have sex. We have had sex a couple of times, but I feel this is wrong. Our parents and friends do not know that we are sleeping together and having sex. Last month her period came late and we were worried that perhaps she was pregnant. She went to the clinic to have a test. It turned out that she isn’t pregnant, but we had a real scare. What would we have done if she had been pregnant? We are a bit more careful now and have started to use condoms. Should I stop having sex? What will she think of me?

I also sometimes see another guy talking to her and am scared that he will want to have sex with her. What if he sleeps around and has sex with other girls and has some kind of infection, like HIV? Should I ask her if she is having sex with anyone else?

SUGGESTION	HOW - EXAMPLES (STRATEGIES)	WHY (JUSTIFICATION)	METHOD	THEORY	CONDITIONS
7. Provide information about personal risk	<ul style="list-style-type: none"> · Risk-information in print material · Questionnaire, quiz 	When people are aware of their personal risk, they are more likely to undertake action, than when they are not aware or think that others have higher risks than they have.	Information about personal risk	Transtheoretical model (TTM) ¹²⁴ Precaution Adoption Process Model (PAPM) ¹²⁵	<ul style="list-style-type: none"> · Should be presented as individual, undeniable, on same dimension, congruent with actual risk, and cumulative rather than for one occasion · Should be presented with qualitative and quantitative examples
		When people are confronted with themselves, they are more likely to become aware of their own ideas and level of risk awareness.	Self-evaluation and re-evaluation	Transtheoretical model (TTM) ¹²⁶	<ul style="list-style-type: none"> · Individual · Specific
8. Combine fear arousal with increasing confidence	<ul style="list-style-type: none"> · Inquiry teaching (ask questions) · Peer-led teaching · Role model stories in textbooks · Videotaped role modelling 	When people are aware of their personal health risks and they feel confident that they can do something about it, this will increase behaviour change.	Fear arousal	Fear appeals ¹²⁷ Health Belief Model ¹²⁸ Protection Motivation Theory ¹²⁹	<ul style="list-style-type: none"> · Requires high self-efficacy expectations rather than high outcome expectations alone
9. Let the target group imagine the consequences of performing risk behaviour	<ul style="list-style-type: none"> · Testimony, peer model stories in print materials · Videotaped or real-life models 	Target group is confronted with what could happen after they perform particular behaviour	Risk scenarios	Precaution Adoption Process Model (PAPM) ¹³⁰	<ul style="list-style-type: none"> · Plausible scenario with cause and outcome · Imagery

Table 7.3 Suggestions to change risk awareness

7.4.5 Suggestions to change attitudes

Attitudes are frequently referred to as the result of balancing the expected advantages and disadvantages of an object, person or specific action. Balancing is not only based on logical reasoning and rational considerations, but also on ingrained habits and ‘irrational’ beliefs. This section provides some suggestions for changing attitudes.

10. Use persuasive arguments to convince the target audience

One way to change attitudes is by using persuasive arguments in communication with the target group.

Persuasive communication

The Elaboration Likelihood Model of persuasion¹³¹ is a model of how attitudes are formed and changed through information processing. Central to this model is the elaboration continuum, which ranges from low elaboration to high elaboration. Depending on the extent of elaboration, different processes can mediate persuasion.

Routes to persuasion

The ELM distinguishes two ways we make decisions and hence get persuaded:

- When we are motivated and able to pay attention, we take a logical, conscious thinking, *central route* to decision-making. This can lead to permanent change in our attitude as we adopt and elaborate upon the speaker's or written arguments.
- In other cases, we take the *peripheral route*. Here we do not pay attention to persuasive arguments but are swayed instead by surface characteristics such as whether we like the speaker or brochure. In this case although we do change, it is only temporary (although it is to a state where we may be susceptible to further change).

One of the best ways of motivating people to take the central route is to make the message personally relevant to them. Fear can also be effective in making them pay attention, but only if it is moderate and a solution is also offered. Strong fear will just lead to fight-or-flight reactions (oppose the arguments or ignore them).

Motivational and ability factors

Which route is taken is determined by the extent of elaboration. Both motivational and ability factors determine elaboration. *Motivational* factors include (among others) the personal relevance of the message topic, accountability, and a person's need for cognition (their innate desire to enjoy thinking). *Ability* factors include the availability of cognitive resources (e.g., the presence or absence of time pressures or distractions) or relevant knowledge needed to carefully scrutinize the arguments. Under conditions of moderate elaboration, a mixture of central and peripheral route processes will guide information processing.

Suggestions for persuasive arguments include:¹³²

- **Introduce, reinforce or build on existing beliefs.** A message can try to change beliefs, reinforce beliefs, or introduce new beliefs.^{133;134} It is far easier to introduce, reinforce or build on existing beliefs than to change existing attitudes. The best campaigns are those that are framed to fit within acceptable beliefs, attitudes and behaviours.
- **Change a set of beliefs.** Changing single beliefs towards a topic is less effective than changing the whole set of beliefs. For instance, if a young person thinks that 'only prostitutes get AIDS', 'having sex with a condom is not real sex', and 'I do not need to use condoms because my partner is faithful', all these opinions should be changed in order to change his attitude towards condom use.^{135;136} Supportive beliefs should be reinforced and inhibiting beliefs should be countered.^{137;138}

- **Encourage active elaboration of information.** The reception of information may be enhanced by motivating for instance young people to engage in elaborate or systematic processing of the information.^{139;140} This implies that a strategy should preferably not be based upon a passive one-sided transfer of information, but that young people should be motivated to actively elaborate the information that is presented, for example, through discussion.

- **Provide new, short-term consequences.** Young people usually have a very short awareness of time. Therefore, short-term consequences (e.g., pregnancy) of behaviour are more convincing than long-term consequences (e.g., AIDS).^{141;142;143}

- **Moderate discrepancy between message and existing attitudes.** Argumentation is most effective if there is a moderate discrepancy between attitudes of the target population and the recommendations that are given in a message.¹⁴⁴ For instance, when planners want to encourage young people to take their own decisions about whether to be sexually active or not, or whether to use a condom or not, this may be more difficult in communities with an abstinence-only approach. Moderate message discrepancy may cause the highest attitude change, whereas extreme levels of discrepancy may even result in boomerang change and having an opposing effect. Messages that take abstinence into account as one of the effective options may have more effect than messages that put a lot of emphasis on condom use.

Box 7.23

Example - Persuasive communication

This game encourages young people to think about gender roles and tries to change the attitude of young people towards these roles. For instance, young people have to decide whether 'doing domestic work' is the responsibility of either a woman, a man, or both. When they drag the statement to one of the three options, they get feedback on their decision.



11. Let target audience evaluate themselves

Self-evaluation is a concept whereby a person compares his or her current performance to a personal standard.^{145;146;147} Planners can encourage people to evaluate themselves by asking them to set goals and provide feedback on their performance in achieving the goals. Another way to encourage self-evaluation is by asking people to imagine how they would feel after performing a risk behaviour (*anticipated regret*), for instance after having unsafe sex. The underlying assumption is that when people are encouraged beforehand how they would feel, that they may expect negative feelings or regret, and that they are more likely to perform health behaviour.

People are encouraged to think about 1) what they want and expect of their life, and 2) what they do. For instance, 'I want to finish school and then...', but also 'I am sexually active and may get pregnant and I may get expelled from school'. Youth have to get aware that what they think not necessarily is coherent with their future plans and their norms and values. This should motivate them to change their ideas and their behaviour.

Examples of strategies to initiate people's evaluation of their own performance are group or classroom discussions, modelling stories in print materials or videotaped modelling.

Box 7.24 Example - Clarify sexual values

Students in Dar es Salaam (SATZ) were encouraged to get aware of their own values with regard to abstinence and delay of sexual intercourse.

III. - Clarifying your sexual values

Read your sexual values carefully choosing "YES" or "NO" to the following statements

Can you abstain from sex for a long time?	
Can you delay sex until you are ready to get married?	
Can you respect your partner's wishes to not get married?	
Can you delay sex if you are not ready?	
Can you abstain from sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	
Can you delay sex until you are ready to get married?	

Box 7.25

Example - Anticipated regret

In the sexuality education programme 'Today's Choices' in South Africa, anticipated regret is included in a digital presentation.

Sexual decision making

Decision making steps

When making important decisions such as these, you can follow the decision making steps below. It may be a good idea for you and your partner to write your thoughts down and think about these issues on your own before you discuss them with each other. Remember that communication is the foundation of any relationship. Only when both parties agree, your decisions will be stable.

Think of an example when reading these steps, like having a partner who waits for you, while you do not wait for her.

Step 1 Identify the problem **Step 2 Gather information**
Step 3 Think up the various options **Step 4 Make your decision**

Example: You are thinking about having sex with your partner. You are not sure if you are ready to have sex. You are not sure if your partner is ready to have sex. You are not sure if you are ready to have sex. You are not sure if your partner is ready to have sex. You are not sure if you are ready to have sex. You are not sure if your partner is ready to have sex.

SUGGESTION	HOW - EXAMPLES (STRATEGIES)	WHY (JUSTIFICATION)	METHOD	THEORY	CONDITIONS
10. Use persuasive arguments to convince the target audience	<ul style="list-style-type: none"> · Print material · Peer-model stories · Video-taped role models 	When people are approached with persuasive arguments, they are more likely to sustainably change their attitudes	Use of persuasive arguments	Elaboration-Likelihood Model (ELM) ¹⁴⁸ Persuasion Communication Matrix ¹⁴⁹	<ul style="list-style-type: none"> · New information · Reinforce acceptable beliefs · Change set of salient beliefs and not single beliefs · Active elaboration of information · Two-sided message · Moderate discrepancy · Consideration of source, message, channel and receivers
11. Let the target group evaluate themselves	<ul style="list-style-type: none"> · Inquiry teaching Classroom discussion · Print materials · Video 	When people evaluate their own attitudes and imagine consequences of future behaviour, they are more likely to be aware of the advantages and disadvantages and consequently more likely to perform behavioural outcome	Self-evaluation - Anticipated regret	Social cognitive theory ¹⁵⁰ Transtheoretical model ¹⁵¹	<ul style="list-style-type: none"> · Better to stimulate both cognitive and affective appraisal of self image

Table 7.4 Suggestions to change attitudes

7.4.6 Suggestions to change social influence

Social influence has two components: 1) the actual influence (support, pressure) of others, and 2) the perceived influence by the target group. For example, young people may be pressured by their peers into sexual intercourse or alcohol abuse, or they perceive that they are pressured by their peers. In this section, we provide suggestions to address perceived social influence.

The exercise 'Me and my world' (WSWM) encourages young people to get aware of the people in their social environment and how they influence them, by mapping relevant others in a range of close and wider circles.



12. Make the target group aware of social influence

Planners can inform people about the *actual* social norms or expectations, in order to change their perception of social influences. For instance, young people hardly communicate about sexuality and sexual risk reduction, and most adolescents may only have vague ideas about what their peers think and do. Their perceptions of group norms regarding safe sex might be cleared by providing information about the way peers respond to sexuality and AIDS prevention, and by enhancing communication among young people about sexuality and AIDS prevention. For example, using information from the situation analysis to show that “not everybody is having sex”.

Such an exchange of information can be accomplished by, for example, class-room discussion, small-group discussion, peer-model stories in print material, videotaped peer models, peer education, and a variety of exercises aimed at the anonymous exchange of attitudes and values.

When planners decide to use classroom discussions as a strategy to provide information about group norms, they have to be aware of the risk of group polarisation.¹⁵² The discussion may lead to an unfavourable shift when the average opinion of the group favours for instance unsafe sex. Educators should be well trained in guiding discussions to be able to end less fruitful group discussions or by supporting arguments and views favouring safe sex, and by presenting support from other reference groups.

Because of the taboo on sexuality and discussing sexuality, it can be difficult to get a group of students to share their thoughts and feelings. One way of initiating an exchange of values and attitudes can be an exercise in which students anonymously have to respond to statements about safe sex on paper, which are the basis of subsequent group discussion.

The **Social Comparison Theory**¹⁵³ is the idea that there is a drive within individuals to look to outside images in order to evaluate their own opinions and abilities. These images may be a reference to physical reality or in comparison to other people. People look to the images portrayed by others to be obtainable and realistic, and subsequently, make comparisons among themselves, others and the idealized images.

Upward and downward social comparison

We learn about our own abilities and attitudes by comparing ourselves with other people and their opinions. Mostly, we seek to compare ourselves with someone against whom we believe should have reasonable similarity. In the absence of such a benchmark, we will use almost anyone. *Upward social comparison* occurs where we compare ourselves with people who we deem to be socially better than us in some way. *Downward social comparison* acts in the opposite direction.

13. Include training of resistance skills

Planners can reduce social pressure by building resistance skills. For example, young people's skills can be trained by confronting them¹⁵⁴ with various levels of peer pressure and they can be taught a repertoire of skills to resist different levels of peer pressure:¹⁵⁵

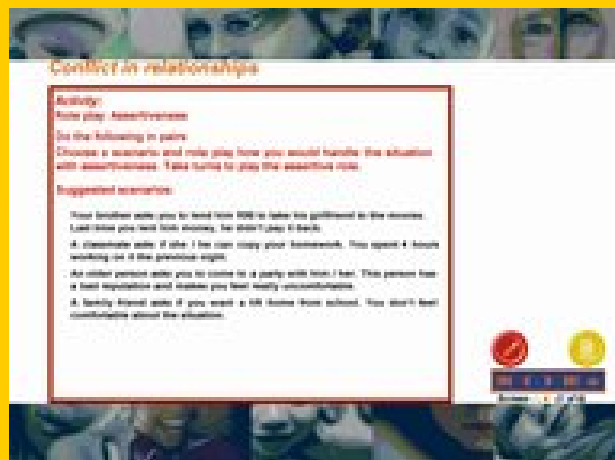
- 1) **mild** peer pressure - simple refusal ('just say no'),
- 2) **moderate** peer pressure - repeated refusal, use of counterarguments, express feelings
- 3) **strong** peer pressure: persistent refusal, providing alternatives, counter-pressure; and
- 4) **extreme** peer pressure: extreme counter-pressure and avoidance.

Important in refusal skills training is the use of counterarguments in a discussion (psychological inoculation).^{156;157} In a programme for young people, planners can give examples of situations where their attitude (i.e., towards use of a condom) will be challenged. Facilitators should provide young people with counterarguments and offer training to use these counterarguments.

Counterarguments can be provided by means of peer models in print materials or on videotape, and by means of small group or classroom discussion. It may also be useful to use pencil-and-paper exercises to elicit counterarguments. Useful strategies for practising the use of counterarguments are debates, role-playing activities combined with feedback or modelling by using videotapes showing peer models who negotiate safe sex in difficult situations.

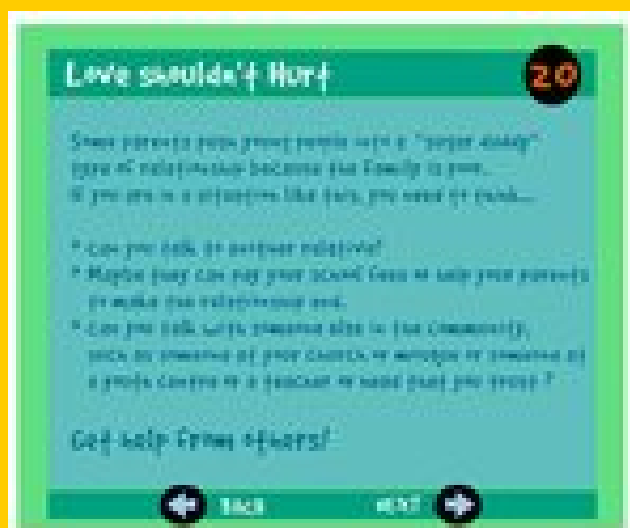
Box 7.27 Example - Role-play assertiveness

Students who participate in Today's Choices in South Africa are encouraged to do role-plays on assertiveness and resisting peer pressure.



Box 7.28 Example - Mobilise Social Support

A presentation in a computer-based programme encourages students to get support from others in difficult situations.



14. Encourage target group to mobilise social support

Another way to let the target group deal with social influence is encourage them to mobilise *social support*,¹⁵⁸ i.e., helping relationships that combine caring, trust, openness, and acceptance, as well as support for the change of behaviour or the maintenance of behaviour change.

Planners can encourage young people to mobilise a group of friends who support them in difficult situations. Social support can be encouraged in numerous ways, either official (rapport building, therapeutic alliances, counsellor calls, and buddy systems) or non-official (mobilise support from friends or family members).

The mobilisation of *social support* can be enhanced by 1) teaching young people that they can mobilise their own support group, for instance by explicitly asking when and

why to provide support, and 2) teaching young people that they can provide support, and convincing them that it is important that they do that. Various techniques may facilitate this process, among which peer-model stories in print material.

SUGGESTION	HOW - EXAMPLES (STRATEGIES)	WHY (JUSTIFICATION)	METHOD	THEORY	CONDITIONS
12. Make the target group aware of social influence	<ul style="list-style-type: none"> Small group discussion Peer model stories print materials Video taped peer models 'Famous' role models in classroom 	When people are aware of actual social influence, they are more likely to respond to that in a constructive manner	Provide information on group norms	Social Comparison Theory ¹⁵⁹	Avoid negative group polarisation
13. Include training of resistance skills	<ul style="list-style-type: none"> Counterarguments provided by educators, experts or peers Peer models in print material or video tape Small group or class discussion Role-playing activities & feedback 	When people get trained in resistance skills, they are more likely to resist social pressure when this is needed and as a result, are better able to perform the behaviour they want to perform.	Enhance refusal skills	Social inoculation theory ¹⁶⁰ Social Cognitive Theory ¹⁶¹	Skill building for refusal skills; commitment to earlier intention; relating intended behaviour to values; psychological inoculation against pressure
14. Encourage target group to mobilise social support	<ul style="list-style-type: none"> Peer model stories in print material Case studies 	When the target group is able to mobilise social support, they are more protected in risk situations.	Mobilise social support	Transtheoretical model ¹⁶² Theories of Social networks/ Social support	Must combine caring, trust, openness, and acceptance as well as support for behaviour change

Table 7.5 Suggestions to change social influence

To assist young people in improving their skills to use a condom when they have sexual intercourse, planners can use the following steps:

- 1) Divide the desired behaviour 'use of condom' into sub-skills: e.g.,
 - * buy a condom
 - * carry a condom
 - * bring up the issue of safe sex
 - * negotiate use of condom with a partner
 - * put on and remove a condom
- 2) Take one sub-skill and give instruction how to practice the skill, e.g., put on and remove a condom
- 3) Show how to put on and remove a condom, e.g., by a demonstration on a banana or dildo - either in the class room or by preparing a video fragment
- 4) Students can practice in the class situation on a dildo or banana, or the finger of a classmate
- 5) They can get feedback on their performances and reinforcement of good behaviour
- 6) Students can practice in a real situation, by themselves



7.4.7 Suggestions to change skills and self-efficacy

Skills and people's belief that they have control over their behaviour (*self-efficacy*) are crucial determinants of many (health) behaviours. When people have low self-confidence in their ability to change their behaviour (self-efficacy), they may not be motivated to give it a try, regardless their actual skills. Methods to enhance self-efficacy usually go together with methods to enhance skills. In this section we provide some suggestions to increase self-efficacy skills in sexuality education programmes.

15. Include step-by-step skills-training

According to the Social Cognitive Theory (SCT),¹⁶³ people learn new behaviours by observing the behaviour of others (*observational learning*) and by trying new behaviours people learn about the consequences of these behaviours (*enactive learning*). Most behaviour is learned through a combination of observation and enactment, reinforced by feedback and incentives.

Skills training can be done step by step:

- 1) break down complex behaviours into more easy sub skills,

- 2) verbal instruction,
- 3) modelling and observation,
- 4) guided enactment in easy situations, combined with feedback, and
- 5) guided enactment in more difficult situations, combined with feedback.

This learning process can easily be combined with the identification of barriers (i.e., difficult situations) and the planning of solutions.

This step by step skills training can be done by means of role model stories in print materials, photo novellas, role-playing activities and videotape and demonstration and instruction. Conditions for use are that the target needs to have the capability to remember the skills that are modelled and must be able to identify with the models. They also should have the skills to copy the behaviours of the models, while the modelled behaviour has to be reinforced. Guided practice should include a demonstration of sub skills, clear instruction and enactment with feedback.

The underlying concept of skills building is to try and keep people motivated in training the skills. By breaking down complex behaviour into sub skills, people are more likely to perceive positive outcomes and success. And positive outcomes and success will enhance people's self-efficacy expectations, which, in turn may enhance their self-esteem.

16. Encourage target group to attribute failure and success in a constructive way

Attribution training is based on the process of attributing success and failures in behaviour.¹⁶⁴ For instance, someone may have the intention to use a condom during sexual intercourse, but fails. Whether or not this person will try again to use a condom, will depend on his explanation for his failure: is it because he/she is not performing well, or because of factors in the environment?

Especially when people attribute their failure to an internal, stable and uncontrollable cause ('I'm responsible for my failure, and this is beyond my control and will never change'), they will not be motivated to give safe sex another try. When people attribute success to an internal, stable and controllable cause, this will enhance their self-efficacy, self-esteem and motivation to try it again.

The most important implication of attribution for health education is that health promoters should prevent people to attribute failure to internal, uncontrollable and stable causes. One way to do this is to warn people that the behaviour (change) may be not that easy, and that it is not unlikely that they will have some failure experiences.

Anticipating possible future failure experiences, people can be taught how to cope with failure. One component of such a learning process can be attributional training, to help people reinterpret previous failures in terms of unstable attributions ('You were in a very difficult situation there') and previous successes in terms of stable attributions ('You are the type of person who has been able to go to health clinics for various times when this was needed'),¹⁶⁵ through for instance role model stories in video or print material, or by exercising reattribution in role-playing activities.

According to the Attribution Theory,¹⁶⁶ we can distinguish three dimensions in the explanations people give for their successes and failures: locus of control, stability, and controllability.

Locus of control	Stability	Controllability
Internal	Stable	Can control
External	Instable	Cannot control

The *locus of control* dimension has two poles: unique to the person (internal) versus situational or external locus of control. For example, personal characteristics or skills versus capacities or actions of others. The *stability* dimension captures whether causes change over time or not. For instance, ability can be classified as a stable, internal cause, and effort classified as unstable and internal. *Controllability* contrasts causes one can control, such as skill/efficacy, from causes one cannot control, such as attitude, mood, others' actions, and luck. See the Internet for more information about attribution.¹⁶⁷

Box 7.30 Example - Goal setting

In the program *The World Starts With Me*,¹⁶⁸ students are assisted in thinking about their future by setting concrete goals.

SETTING OBJECTIVES

1. My objective is:
2. I will meet this objective by (date) :
3. The personal strengths I have are:
4. The challenges I may face are:
5. Things I have to do to meet the objective:
6. I will need the assistance and support from the following people:



17. Encourage target group to set achievable goals

Another way to increase skills and self-efficacy among the target audience is goal setting.^{169,170} When people set challenging but feasible goals, this has a beneficial effect on people's effort, persistence, and concentration, and thus will encourage them to try harder and for a longer period of time, with less distraction from the task at hand.

Conditions for using goal setting techniques include that (a) people should be committed to achieve the goal, (b) the complexity of the task should fit with the abilities of the individual (and his or her self-efficacy), and (c) the target group should have access to natural or organised feedback.

During a goal setting training in a classroom setting, students can be facilitated in setting their personal goals by asking them when, where, and how they intend to achieve their goals. A way to do this is by giving students the assignment to fill in an outline for self-monitoring. See the example 'Worksheet setting objectives' that is used in the *World Starts With Me*, to guide students in thinking about their future goals. See the internet for more information about goal setting theory.¹⁷¹

SUGGESTION	HOW - EXAMPLES (STRATEGIES)	WHY (JUSTIFICATION)	METHOD	THEORY	CONDITIONS
15. Include step-by-step skills building	<ul style="list-style-type: none"> · Role model stories in print materials · Photo novellas · Role playing activities · Videotaped role models · Demonstration and instruction 	The underlying concept of skills building is to try and keep people motivated in training the skills.	Modelling skills Guided enactment	Social cognitive theory ¹⁷²	<ul style="list-style-type: none"> · Attention from audience · Capability to remember skills · Identification with role models · Copy behaviour of role models · Reinforcement of behaviour
16. Encourage target group to attribute failure and success in a constructive way	<ul style="list-style-type: none"> · Role models in video, print material · Role play · Case study 	When people attribute failure to instable, controllable causes, they are more likely to try again; when people attribute success to stable, internal causes they are more likely to perform the skills and behaviour again.	Reattribution training	Attribution theory ¹⁷³	<ul style="list-style-type: none"> · Anticipating future failure
17. Encourage target group to set achievable goals	<ul style="list-style-type: none"> · Outline for self-monitoring 	When people set practical and achievable goals, they are more likely to achieve these than when they set long-term, difficult goals.	Goal setting and feedback	Goal setting theory ¹⁷⁴	<ul style="list-style-type: none"> · Commitment to goal · Abilities and task complexity fit · Provision of feedback

Table 7.6 Suggestions to change skills and self-efficacy

7.4.8 Suggestions to change the environment

This section presents suggestions to change external determinants, or the social environment of the target population, also referred to as those factors outside the individual that influence either health behaviour or environmental conditions. These factors include social influences such as norms, social support, and reinforcement, and structural influences, such as access to resources, organisational climate, community norms, and policies. Barriers to performing health behaviour are often structural, such as lack of health insurance, inconvenient clinic hours, lack of transportation, and high cost of health services.

As is stated before, one way to change the environment is by identifying the responsible people for the environmental issues and change their behaviour and determinants. For example, planners can identify the attitudes of policy makers who are responsible for the availability of condoms. Policy makers may for example fear that if they would advocate for lower condom prices for young people, they would be disliked by the religious community they are part of and who believe that young people should not have sex when they are not married, and thus do not need any condoms. This may influence their attitude towards the provision of condoms to young people. Planners can use theories on attitude change to use in advocacy in order to change the attitudes of policy makers. Literature, however, also gives us specific tools and suggestions to influence social and organisational changes and community mobilisation.

In all situations in which we want to teach people ways to change their behaviour, we have to provide them with the means to do so. In addition, we have to reduce those barriers that hinder behaviour change by means of facilitation. Usually this implies a change in the environment. This chapter also addresses methods to change environmental conditions. Every method designed to change individual behaviour is most effective when simultaneously environmental conditions are optimised. For instance, programs promoting condom use will only be effective when condoms are also made available.

18. Advocate among policy makers, decision makers, general public

Planners can use lobby and advocacy to influence relevant policy makers or decision makers. Advocacy can be defined as the set of skills used to create a shift in public opinion and mobilise the necessary resources and forces to support an issue, policy or constituency.¹⁷⁵ Advocacy ensures that the rights of disenfranchised individuals are protected, that institutions work the way they should, and that legislation and policy reflect the interest of the people. It addresses attitudes and policies at all levels, from organisational, through community and state, to the national or international arena. A list of 20 rules of etiquette, drawn from the experiences of a number of advocates, provides guidelines for advocacy.¹⁷⁶

Related to sexuality education, planners can advocate for acceptance of young people's sexuality and SRHR, including the provision of youth friendly services, funding for sexuality education, provision of condoms to young people, etcetera. See the Internet for more information and tools related to advocacy on HIV/AIDS and SRHR related topics.^{177;178}

The advocate needs excellent communication skills to convince others, and he/she needs factual information to underpin the evidence-based arguments he/she is using, and needs to advocate at the right time.

To enhance tactical efforts, six principles can be applied:¹⁷⁹

1. *presence*; remind people of the issue by doing something about it frequently
2. *generosity*; praise others for their strengths and actions, to gain goodwill, and to reinforce their actions
3. *shaping*; reward small steps of those who change toward your goals
4. *escalation*; continue to mobilise more people and increase the intensity of the tactics if the first efforts are unsuccessful
5. *accuracy and honesty*; be scrupulously accurate to maintain credibility and to keep opponents from successfully arguing against the issues raised
6. *consistency*; distribute praise and criticism fairly; if one group is criticised for its position, other groups should be treated the same way

Guidelines for Effective Advocacy: Rules of Etiquette

1. accentuate the positive
2. plan for small wins
3. begin by assuming the best of others
4. do your homework and document your findings
5. take the high ground
6. reframe the opponents' definitions of the issue
7. keep it simple
8. be passionate and persistent
9. be willing to compromise
10. be opportunistic and creative
11. don't be intimidated
12. maintain focus on the issues
13. make it local and keep it relevant
14. be broadly based and non-partisan from the beginning
15. develop an independent public identity
16. try to stay within the experiences of individuals in your group
17. whenever possible, go outside the experience of your opponent
18. make your opponents live by their own rules
19. tie advocacy group efforts to related events
20. have a good time

Two types of advocacy are media advocacy and policy advocacy. *Media advocacy* consists of a set of strategies for using the media to promote health. Mass media provide the forum for the surfacing and discussion of issues, setting the agenda for policy makers and the public. Media advocacy seeks to influence the selection of topics by the media and the way they are presented in order to set and achieve an agenda that addresses the topics advocates would like to address.

Media advocacy is based on three steps:¹⁸⁰ 1. setting the agenda, 2. shaping the debate, and 3. advancing the policy. In setting the agenda, the goal is to get the media to select the story. Shaping the debate involves shifting the view of health from the individual to the societal level and dealing with the complexity of health and social problems so that the debate is defined by the public health perspective. Advancing the policy includes making sure the content reaches the key decision makers.

Policy advocacy relates to agenda setting. Two types of policy agendas can be identified:¹⁸¹ a systematic agenda that includes the issues perceived by the political community as meriting consideration and as within the jurisdiction of governmental authority, and the institutional or governmental agenda that is the set of issues that are explicitly up for active consideration by governmental decision makers.

19. Create social networks that can support people and make them less vulnerable

Social norms are the expectations of behaviour that others in a social group hold for a person. Norms are transmitted to individuals starting in childhood through the family and then is continued through institutions, such as churches, voluntary associations and schools. Although shifting social norms is a difficult process which often requires a long time, a number of theories provide suggestions to do that by using role models.

Edutainment, or enter-education combines education and entertainment to transmit social norms and culture.¹⁸² In edutainment, mass media portrayals of role models are provided and reinforced. In for example soap operas, popular music, films, and comic books, popular characters may model health behaviour. For example, in Nigeria, family planning was introduced in a popular television series in which characters began to use family planning and were reinforced or were socially punished for resisting adoption. This led to increased family planning clinic visits.¹⁸³

Another way is by using mass media role model stories of community members and advice from experts to increase adoption of behaviours (*behavioural journalism*). News stories, talk shows, feature stories in newspapers, and cartoon-style newsletters have been used as media vehicles. The media materials use models that are perceived as attractive and similar to members of the at-risk population, and these models give their reasons for adopting the new behaviour, demonstrate skills used or acquired in adopting the behaviour, and state the perceived reinforcing outcomes they received.

20. Increase social support

Increasing social support for the target population, will increase their ability to perform healthy behaviour. Social networks link individuals together and are the basis for community. The function of social networks is determined by both *structure* (such as pattern of linkages) and *interaction* (such as the nature of relationships and the benefits individuals receive from them).

It is possible to enhance a social network, by training network members to more effectively provide social support.¹⁸⁴ People get skills training in how to contact social network members in person, by

telephone, and by letter. Training can also include how to listen, express empathy and concern, provide information and suggestions, and offer help with tangible needs.

Another way of enhancing social networks is by mobilising respected and popular people in a particular community to adopt protective sexual practices and persuade acquaintances to follow their example. A similar intervention in the Netherlands among gay men not only led to change in individual behaviour but also to increased norms supportive of protective behaviour.¹⁸⁵

SUGGESTION	HOW - EXAMPLES (STRATEGIES)	WHY (JUSTIFICATION)	METHOD	THEORY	CONDITIONS
18. Advocate among policy makers, decision makers, general public	<ul style="list-style-type: none"> · Fact sheets 	When lobby and advocacy are done according guidelines, this may influence policies, social movements & norms	Advocacy, such as information, persuasion and negotiation	Stage Theory of Organisational Change Agenda-Building Theory Policy Window Theory	Form of advocacy varies by environmental level, nature of issue being addressed, nature of power relationships; must match style and tactics of the collective
19. Create social networks that can support people and make them less vulnerable	<ul style="list-style-type: none"> · Video clips in mass media campaigns · Soaps, comic books, music stars · Women's groups, youth groups 	When people are part of a group, they are more likely to get supported and less vulnerable for social influences or pressure	Mass media role models Behavioural journalism	Diffusion of Innovations Theory ¹⁸⁶ Social Cognitive Theory ¹⁸⁷	Conditions for modelling; conditions for persuasive communication
20. Mobilise the community	<ul style="list-style-type: none"> · Poster-making · Meetings with community · Exhibition 	By mobilising the community, they get to know more about a project or issue, which may reduce fears or misconceptions, which may increase commitment and support, leading to a supportive environment	Mobilise social networks	Theories of social networks and social support	<ul style="list-style-type: none"> · Presence of a network that can potentially support health behaviour

Table 7.7 **Suggestions to change external factors**

7.5 Task 4.5 Design, pre-test, revise and produce the intervention

The final task is the design and production of all programme materials. One way of increasing the effectiveness of the programme, is by conducting a relatively small pre-test of all strategies. After adaptation, the final intervention materials can be produced.

7.5.1 Design a coherent intervention programme

At the end of programme design, planners take the final decisions about the scope, sequence and approach in activities, and intervention components. If no decision has been taken yet about the title of the programme, planners do that in this phase, and they decide about the length of activities and interventions.

In sexuality education programmes, planners produce a draft programme including teacher instructions and possibly student materials. See the box below for contents of a teacher manual. The internet also provides tips for planners, curriculum developers and teacher trainers on the development of life skills curricula for HIV prevention in Africa.¹⁸⁸

Instructions for teachers in a teacher manual

1. *Acknowledgements.* A teacher manual starts with acknowledgements of all people who have contributed to this manual. It can also function as a way to attract teacher's attention by mentioning certain institutions or people that make teachers confident in using the manual. E.g., mentioning the Ministry of Education.
2. *Contents.* The second aspect is to show the contents of the teacher manual, including page numbers. This increases the user friendliness of the manual.
3. *Introduction.* In the introduction planners explain teachers the why, for whom, how, etc. of the manual. To introduce the teacher how to use the manual and why this manual is useful and necessary.
4. *Lessons.* For each lesson, planners include objectives on the levels of knowledge, attitudes, and skills; a lesson outline explaining the sequence and length of each activity; and a detailed explanation for teachers what they have to do in each activity with tips.
5. *Background information.* Planners may include background information for the teachers on particular topics and/or lessons.

7.5.2 Pre-test the intervention

An essential element in programme development is pre-testing, for it allows the reactions of experts and members of the target population to be gauged at an early stage in a program's life. Pre-testing in this chapter means a small scale test of the draft materials. It is often confused with pilot implementation. The latter however, is a subsequent step in which the final intervention programme is implemented by the intended educators among a number of beneficiaries.

A pre-test is generally valuable to test an intervention's attractiveness, comprehensibility, relevance, credibility, acceptability, undesired side effects, and workability. The need for pre-testing is strongest when (a) little is known about the target population, and (b) the content of the program is controversial.

Materials can be pre-tested with young people, educators, parents, health professionals and educational professionals. Planners can build in several evaluation activities, such as pre-tests of prototype written materials and illustrations, video scripts, an 'off line montage', a 'home video'-version, and outlines of educational sessions. Whenever possible, intervention planners should pre-test low-budget draft versions of all program materials and activities. The internet provides documents with guidelines for pre-testing.¹⁸⁹

To plan and conduct concept tests and materials pre-testing, complete the following steps:¹⁹⁰

1. Determine test objectives
2. Choose methods; e.g., focus groups, consultation teams, feedback panels, and pilot group sessions
3. Secure vendors, facilities, and moderators or interviewers (if required)
4. Identify, screen, and recruit respondents
5. Draft test instruments (discussion guides, questionnaires)
6. Conduct pre-testing
7. Analyse results
8. Make the best use of results

Materials can be tested with members of the intended audience to accomplish the following:¹⁹¹

- *Assess comprehensibility*—Does the intended audience understand the message?
- *Identify strong and weak points*—What parts of the materials are doing their job best—for example, attract attention, inform, or motivate to act? What parts are not doing their jobs?
- *Determine personal relevance*—Does the intended audience identify with the materials?
- *Gauge confusing, sensitive, or controversial elements*—Does the treatment of particular topics make the intended audience uncomfortable?

7.5.3 Produce final programme materials

After pre-testing, programme planners adapt the programme and produce the final materials. Often this requires more time than expected, depending on the kind of materials that have to be produced. Production of print materials (including leaflets, posters, teacher and student books) generally includes lay-outing and printing and can be adapted relatively easily. Production of a video-tape obviously requires a whole other kind of timeframe.

An important aspect in production of the materials is to make very clear agreements with the people who will be responsible for the production. It is important for them to know that there is a thinking underlying the way the materials are now. Make sure they contact you if they want to change certain aspects in the materials.

Annexes

Annex 7.1 Worksheets IM Step 4. Evidence-Based Intervention Design

WORKSHEET 4.1 Strategies/ activities

WORKSHEET 4.2 Justification, Methods and Theories

Annex 7.2 Outline Documentation Step 4. Evidence-Based Intervention Design

Annex 7.3 Communication Channels and Vehicles

WORKSHEET 4.1

Strategies/ activities

Instruction

- Describe how the objectives of IM Step 3 are linked to the activities and materials in the selected programme (components), both for the at risk group (young people) and the environmental agents (i.e., parents, community, health service providers, policy makers, etcetera)

Worksheet

Activity/ material	Change objectives				
	Knowledge	Attitude	Risk perception	Social influence	Skills & self-efficacy
<i>At the end of the programme, ... [target group] can ...</i>					
1. ...					
2. ...					
...					

WORKSHEET 4.2

Justification, Methods and Theories

Instruction

- Describe for each activity or material the justification of particularly that activity or material.
- Link this to methods and theories
- Describe the conditions for use

Worksheet

Activity	Determinant	Objectives	Justification	Method (theory)	Conditions
1. ...	Knowledge				
	Attitude				
	Risk perception				
	Social influence				
	Skills & self-efficacy				

Annex 7.2 Outline Documentation Step 4. Evidence-Based Intervention Design

This report includes the documentation of the original IM Step 3 Methods & Strategies, and the original IM Step 4 Intervention Design.

General suggestions:

- Keep the final report short (max. 40 pages excluding references and tables & figures) and provide additional information as much as possible in annexes to the report - this makes the report easier to read by others
- Keep record of references to literature/articles/publications/reports and provide a list of references at the end of the document

1. Introduction

Approximately 4 pages

2. Involve relevant stakeholders

- Which stakeholders (working group, advisory board, ...) were involved in this step? Why?
- Did you involve experts in Health Promotion?
- What were constraints in involvement of stakeholders?

	Who	When	How
1. Review of available intervention programmes			
2. Use of behaviour change theories			
3. Selection of activities and linkage to objectives			
4. Justification, Methods and Theories			

3. Review of available intervention programmes

- Describe the decisions taken in the identification of available programmes
- Describe the decisions taken in the selection of programme (lessons/ activities/ components)
- The table below can assist planners to document the existing materials¹⁹²

	Title	Author (/ publisher)*	ISBN	Date of publication	Target population	Aim of programme	Topics covered	Format of materials **
1								
2								

** If relevant, include contact details of organisation that developed materials*

*** For example, Comic book, Poster, Flipchart, Advocacy guidelines/manual, Fact sheets, Community Sensitisation guidelines, Teacher manual/ Educator Guide, Learner workbook/ Learner Guide, Activity Book, Pamphlet, Peer Educator Manual, Video production, Television programme, Newspaper article series, etcetera.*

4. Use behaviour change theories

- To what extent were theories used? Were they applicable?
- Were (external) researchers/ health promotion planners involved in applying theories?

5. Strategies

- Describe how the objectives of IM Step 2 are linked to the activities and materials in the selected programme (components), both for the at risk group (young people) and the environmental agents (i.e., parents, community, health service providers, policy makers, etcetera)
- List the objectives that are not yet covered by (existing) activities and materials; this can be done by using the matrices of IM Step 2

Activity/ material	Change objectives				
	Knowledge	Attitude	Risk perception	Social influence	Skills & self-efficacy
<i>At the end of the programme, ... [target group] can ...</i>					
1. ...					
2. ...					
...					

6. Justification, Methods, Theories

- Describe for each activity or material the justification of particularly that activity or material.
- Link this to methods and theories
- Describe the conditions for use

Activity	Determinant	Objectives	Justification	Method (theory)	Conditions
1. ...	Knowledge				
	Attitude				
	Risk perception				
	Social influence				
	Skills & self-efficacy				

7. Reflection

Max. 1 page

Briefly describe the quality of the information in IM step 3. What were constraints in this step?

8. References

Provide references to the literature/reports/documents that were used in the identification of Methods and Strategies.

9. Annexes

Provide tables and background information in the annexes of the report.

Annex 7.3 Communication Channels and Vehicles¹⁹³

Channels and Vehicles	Typical Uses, Methods and Strategies	Advantages	Disadvantages
<i>Interpersonal:</i> Community volunteers Peer leaders	<ul style="list-style-type: none"> · Skill training · Social reinforcing · Modelling · Tutoring · Small group discussion 	<ul style="list-style-type: none"> · Powerful source of influence and persuasion · Inexpensive · Involve community and enhance capacity 	<ul style="list-style-type: none"> · Difficult to train and motivate multipliers
<i>Interpersonal:</i> Teachers	<ul style="list-style-type: none"> · Mastery learning · Tutoring · Small group discussion · Lecture · Modelling 	<ul style="list-style-type: none"> · Expert in teaching techniques · Fits organizational context of school 	<ul style="list-style-type: none"> · Can be resistant to truly interactive techniques · Can be crippled by curriculum time constraints
<i>Interpersonal:</i> Health Care Providers	<ul style="list-style-type: none"> · Skill training · Social Reinforcement · Modelling · Counselling 	<ul style="list-style-type: none"> · Powerful source of influence and persuasion · Expert in patient assessment and counselling · Captive audience interested in personal health issues 	<ul style="list-style-type: none"> · Difficult to train and motivate · Lack of time · Have difficulty integrating counselling techniques if they are used to a more directive “medical model” · Can be perceived as too dissimilar from the patient
<i>Circulating Print:</i> Newspapers	<ul style="list-style-type: none"> · Letters to the editor · Editorial commentary · Role Model Stories · Information · Persuasion · Vicarious reinforcement 	<ul style="list-style-type: none"> · Inexpensive · Wide audience · Extends expertise · Detailed · Very flexible · Positive consumer attitudes about vehicle · Can be niche based 	<ul style="list-style-type: none"> · Depends on literacy · Reaches only certain segments · Short life span · Clutter, i.e., many vehicles on the market compete attention · Not for demonstration · Poor visual quality
<i>Circulating Print:</i> Magazines	<ul style="list-style-type: none"> · Editorial commentary · Role Model Stories · Information · Persuasion · Vicarious reinforcement 	<ul style="list-style-type: none"> · Good audience segmentation · High audience receptivity · Credibility and prestige · Long life span · Visual quality 	<ul style="list-style-type: none"> · Lack of flexibility · Lack of control of distribution
<i>Circulating Print:</i> Newsletters	<ul style="list-style-type: none"> · Letters to the Editor and editorial commentary · Role Model Stories · Information · Persuasion · Vicarious reinforcement 	<ul style="list-style-type: none"> · Good audience segmentation · High audience receptivity · Strong possibility for tailoring · Control of distribution 	<ul style="list-style-type: none"> · Requires cultivation of relationship with gatekeepers such as health reporters at the newspaper · Requires ability to capitalize on short media attention span for issues · Requires high degree of novelty
<i>Display Print:</i> Billboards Posters	<ul style="list-style-type: none"> · Attention · Awareness · Cue to action 	<ul style="list-style-type: none"> · Can be very effective in calling attention to a campaign 	<ul style="list-style-type: none"> · Can only effect limited learning and change objectives (e.g. knowledge and awareness) · Expense can be significant
<i>Display Print:</i> Brochures Flip-Charts	<ul style="list-style-type: none"> · Skill Training · Modelling · Information with 	<ul style="list-style-type: none"> · Can effect a variety of learning and change objectives 	<ul style="list-style-type: none"> · Distribution must be considered because no standard routes exist as they

Channels and Vehicles	Typical Uses, Methods and Strategies	Advantages	Disadvantages
	<ul style="list-style-type: none"> extensive detail · Persuasion · Vicarious reinforcement 		<ul style="list-style-type: none"> do for circulating print
<i>Radio:</i> News Items Interviews PSAs	<ul style="list-style-type: none"> · Information · Awareness · Role Model Stories · Persuasion 	<ul style="list-style-type: none"> · Good audience segmentation · High audience receptivity 	<ul style="list-style-type: none"> · Requires cultivation of relationship with station gatekeepers · Requires ability to capitalize on short media attention span for issues - also short life span · Requires high degree of novelty · Role model stories cannot be supported by visuals
<i>Television</i> News stories Talk shows Interviews	<ul style="list-style-type: none"> · Skill Training · Modelling · Information with extensive detail · Persuasion · Vicarious reinforcement 	<ul style="list-style-type: none"> · Wide distribution · Possibility for segmentation 	<ul style="list-style-type: none"> · Lack of control over content · Requires cultivation of relationship with station gatekeepers · Requires ability to capitalize on short media attention span for issues - also short life span · Requires high degree of novelty · Competition with broadcast clutter
<i>Television:</i> Entertainment TV	<ul style="list-style-type: none"> · Intense role model stories 	<ul style="list-style-type: none"> · Wide distribution · Natural segmentation · Norm changing capabilities 	<ul style="list-style-type: none"> · Requires relationships with producers · Can be very long
<i>Television:</i> PSAs	<ul style="list-style-type: none"> · To stimulate awareness 	<ul style="list-style-type: none"> · Wide distribution · Natural segmentation 	<ul style="list-style-type: none"> · Channel surfing cuts down on audience · Must have excellent production qualities · Often used at off-peak or not used
<i>Television:</i> Informercials	<ul style="list-style-type: none"> · Product awareness and persuasion 	<ul style="list-style-type: none"> · Can provide large amounts of detail 	<ul style="list-style-type: none"> · Channel surfing is a problem here too
<i>Computer Assisted Instruction</i>	<ul style="list-style-type: none"> · Skill-training 	<ul style="list-style-type: none"> · Has a very wide and quickly expanding repertoire of vehicles, e.g., CD ROM, decision-support, simulations, games, learner-controlled instruction 	<ul style="list-style-type: none"> · Can be costly to develop · Programming skills are in high demand and can be difficult
Videotape: Training Documentary Story	<ul style="list-style-type: none"> · Just about anything 	<ul style="list-style-type: none"> · Control over content 	<ul style="list-style-type: none"> · Can be costly · Distribution systems must be planned

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8. IM Step 5. Adoption and Implementation

Where are we in Intervention Mapping?

The 'product' of IM Step 4 (evidence-based intervention design) consists of the final programme materials, based on feedback of the target group and educators, consent of other relevant stakeholders, and based on evidence and theory.

Having such a 'product', does not automatically mean that the programme is implemented the way programme planners have planned it.

Intervention Mapping Step 5 therefore focuses on specific actions that planners need to take, to make sure that the programme 1) is adopted and 2) is implemented by schools and the community. These actions can include the planning of a teacher training and other teacher support, or organising awareness meetings for the wider community, health workers and/or the school management.

Steps in Intervention Mapping

1. Involvement
2. Needs Assessment/ Situation Analysis
3. Objectives
4. Evidence-Based Intervention Design
- 5. Adoption & Implementation**
6. Monitoring & Evaluation

The introduction of sexuality education programmes in the school system can be regarded as the introduction of an innovation (an idea, practice, or product that is new to the adopter, which may be an individual or an organisation). This usually demands changes in teachers' behaviour, pedagogic and didactical skills, and the school management.

In this manual we make a distinction between the pilot implementation (full implementation on a small scale) and the up scaling/ regular implementation of the programme. Both kinds of implementation require different approaches in planning its adoption and implementation, and also require different monitoring and evaluation.

In our experience with a number of projects, we have found out that it is usually preferable to first do a small pilot implementation to test out the programme, and only after that disseminate the programme on a larger scale. The advantage of doing so is that planners can carefully plan in a detailed way, and make the programme as effective as possible. An other advantage is that the implementation can be carefully monitored.

For a long time, the diffusion of health promotion programmes has been regarded as an automatic process, and intervention planners did not actively interfere with the adoption and implementation of their programme. It is only since recently that health promoters acknowledge that programme adoption usually needs agenda setting and active persuasion, and that programme implementation needs active support, encouragement and reinforcement. Programme planning should include theory- and evidence-based strategies to facilitate that target populations and organizations adopt and implement the programme.¹

In this chapter we mainly focus on planning the adoption and implementation of sexuality education programmes in school settings. Even effective health promotion programmes have little impact if they are not used, inadequately used, or prematurely discontinued.² When no attention is given to the systematic planning of adoption and implementation, programme developers run the risk that the number of programme users turns out to be very low. A Dutch study concluded that a systematically designed innovation strategy has the potential to produce significant changes in classroom-based sexuality education practices.³

Diffusion of Innovation Theory

The 'Diffusion of innovation theory'^{4,5} provides a framework for how to get (sexuality education) programmes adopted, implemented and maintained over time. According to this theory, programme diffusion is thought of as moving from awareness of a programme, through decisions to adopt a programme, to initial and sustainable programme use. It is described as a three-staged process: a. Adoption, b. Implementation and c. Sustainability. Usually, successful programme diffusion requires an active strategy that focuses on these diffusion phases.⁶ When no attention is given to these processes, programme developers run the risk that the number of programme users may decrease with each phase.

a. Adoption

Adoption refers to the uptake of a programme by potential users and depends on knowledge of a programme, awareness of an unmet need, and the assumption that the programme may meet the perceived need. Programme adopters move through the stages of awareness, interest, trial and adoption.

For example, school administrators and staff have to be aware that the sexuality education programme exists, they need to have an interest in using the programme, and they have to decide to give it a try. All adopters go through these stages, but the time required to complete these stages depends on characteristics of both the adopters and the programme.⁷ Some people are more open-minded regarding innovations than others, and some are more easily convinced of the need of the innovation; some innovations are more easily diffused than others.

Adopters adopt at different times following the introduction of the innovation into their social system, and the population can be segmented into innovators, early adopters, early majority, late majority, and laggards based on the point at which they adopt the innovation. These categories of adopters have different characteristics. For example, innovators are venturesome, early adopters are opinion leaders, the early majority are deliberators, the late majority are sceptical, and the laggards are traditional.

Innovators (2,5%) Early adopters (13,5%) Early majority (34%) Late majority (34%) Laggards (16%)

b. Implementation

Programme adoption is by no means a guarantee for quality implementation. In health promotion practice, programme users frequently only implement parts of a programme, or implement activities in a wrong way. Another observation is that programme users adapt programmes to their own situation and capability, varying from small changes to major revisions. Such reinvention may foster programme ownership and commitment, which is not just important for programme implementation but also for sustainability. However, programme reinvention may also reduce programme effectiveness.

Programme implementation refers to questions about completeness and fidelity. *Fidelity* refers to the degree to which a programme is implemented with its methods and strategies intact; *completeness* to the proportion of programme activities and components that are actually delivered.⁸

c. Sustainability

Sustainability refers to the maintenance and institutionalization of a programme as part of routine educational practice.^{9,10} Even when an effective intervention is effectively disseminated, often institutionalisation is rare.^{11,12}

Institutionalisation means incorporating a program, for example sexuality education, into organisational routines so that it survives in the long run. Institutionalisation can be described as routinisation, the progression of an innovation to an indistinguishable part of the individual or organisational routines.¹³

The step of adoption and implementation does not start after intervention planners have completed programme design. Planners should start anticipating programme implementation as early as possible in the development process, preferably early in the needs assessment. Only then it is most likely that the programme will get community support, and support of the stakeholders and decision-makers that are involved. This implies that intervention planners should link with teachers, school administrators, school health decision-makers (e.g., Ministry of Education), parents and community leaders as early as possible.

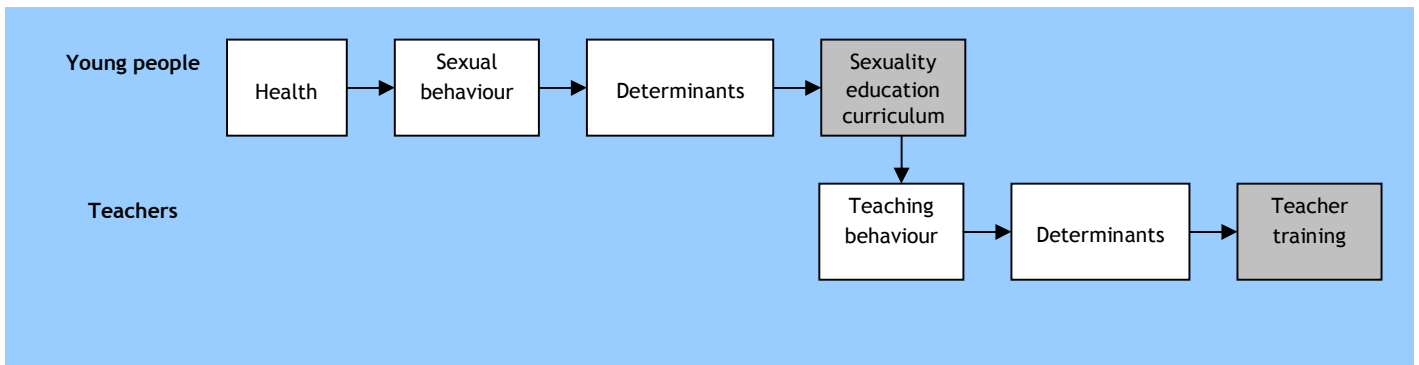


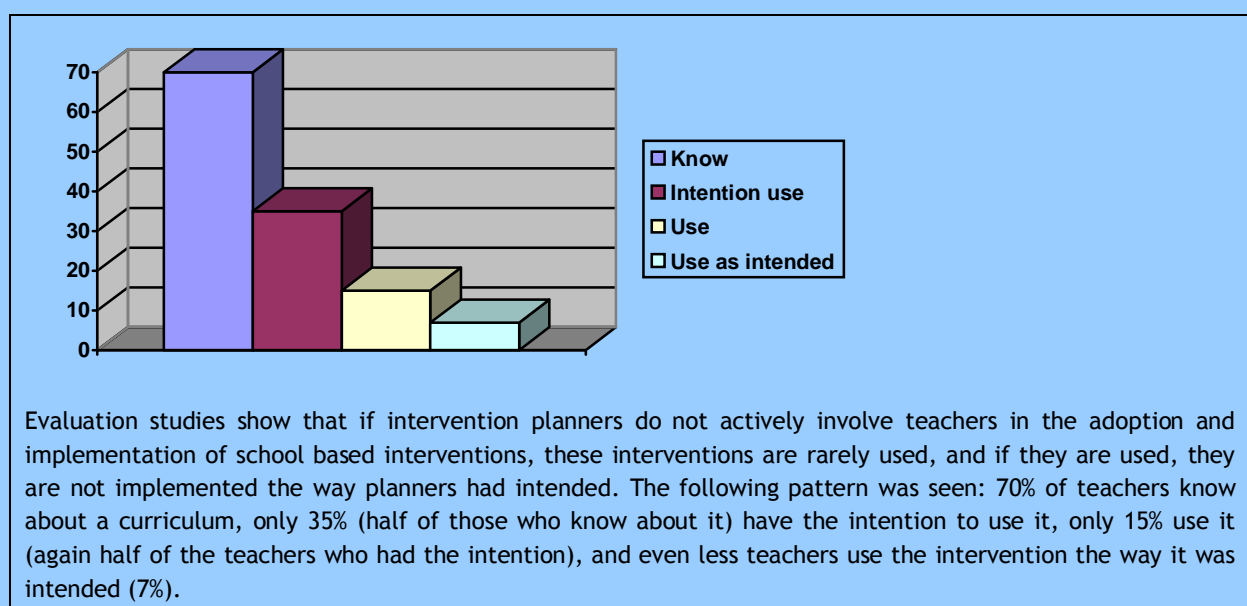
Figure 8.1 Different levels of Intervention Mapping

Systematically applying the Intervention Mapping model regarding adoption and implementation issues results in a theory- and evidence-based adoption and implementation strategy: interventions that facilitate the diffusion of the sexual health programme. In this step, planners go through the Intervention Mapping steps again, now focusing on the level of adoption and implementation by the implementers (i.e., teachers) and not on the level of the target group (i.e., students). See Figure 8.1.

This means that in Step 4, intervention planners focus on behavioural change among the potential programme users and relevant stakeholders, asking questions such as: ‘What should school administrators do to accomplish the programme implementation?’, ‘What are the factors that promote or inhibit programme adoption?’, and ‘What should teachers learn to be able to deliver the programme?’

Planners should specify programme objectives focused on the delivery of the sexual health promotion programme. This also means that, when planners encounter opposition to for example comprehensive sex education from key decision-makers, they should try to reduce this opposition instead of adapting their programme.

Box 8.2 Adoption and implementation of school based sex education by teachers



The adoption of the programme by teachers, as well as facilitation of teachers to be able to implement the programme are perhaps the most important factors in sexuality education for young people. To plan the adoption and implementation of school based sexuality education, planners can accomplish a number of tasks. An important step is already taken at the start of the project by involving all relevant stakeholders in the design of the intervention.

Teachers should be involved from the start in the preparation, planning and design of the programme, especially in the teacher panel that reviews the various stages in programme development, which increases the chance that the intervention is made together with teachers and consequently owned by teachers.

By embedding the programme objectives in the national education goals, teachers do not feel as if they have to do something additional, but they do get tools to achieve the goals they have to achieve anyway with their students. By taking into account the practical considerations during the design of the programme, the activities are more likely to fit with the number of students in a class room, and the time available for the lessons.

In addition to the involvement of the stakeholders from the start, the other tasks planners accomplish in planning the adoption and implementation:

Tasks in Step 5

- | | |
|----------|---|
| Task 5.1 | Involvement of relevant stakeholders |
| Task 5.2 | Assess possibilities and barriers for adoption and implementation |
| Task 5.3 | Set objectives for adoption and implementation |
| Task 5.4 | Design theory-based adoption and implementation interventions |
| Task 5.5 | Design an implementation plan |
| Task 5.6 | Plan for sustainable adoption and implementation |

8.1 Task 5.1 Involvement of relevant stakeholders

This step also starts with the involvement of relevant stakeholders to be able to design effective adoption and implementation interventions. First, the working group of teachers has to be involved in the planning of the teacher training. This is necessary to design a training and support activities that are addressing the needs of the teachers. Another person key in this step is the trainer of the teachers. And all others who may be involved in the adoption and implementation of the programme, including peer educators, school administrations, etc.

PLANNING PHASE	STAKEHOLDERS	TASKS
5 Adoption & implementation	a. Planning group	<ul style="list-style-type: none"> · Organise teacher training · Organise other adoption & implementation activities · Organise involvement other stakeholders (e.g., teacher trainer)
	b. Working group young people	<ul style="list-style-type: none"> · Involved in activities to convince other stakeholders/ schools to implement the intervention programme
	c. Working group teachers	<ul style="list-style-type: none"> · Involved in activities to convince other stakeholders/ schools to implement the intervention programme · Feedback on planned adoption and implementation activities
	d. Advisory board	<ul style="list-style-type: none"> · Involved in activities to convince schools to implement the intervention programme
	e. Others: Parents Teacher trainer Health service providers Researchers	<ul style="list-style-type: none"> · Informed about or involved in implementation · Training teachers in communication sexuality; participatory teaching; content & activities SRHR curriculum · Informed about or involved in implementation · If needed assist in design of adoption and implementation activities and materials

Worksheet 5.1 provides planners with an outline for documenting decisions about the involvement of relevant stakeholders in planning the adoption and implementation.

8.2 Task 5.2 Assess possibilities and barriers for adoption and implementation

Intervention planners start with an assessment of the reasons why organisations/ people do or do not want to adopt the sexuality education programme, and whether they feel they have the skills and knowledge to teach it. Are they aware of the programme (knowledge) and of the need among students for information about growing up and sexuality? Besides knowledge or addressing the needs of their students, other reasons may also be important, for example, social status and social influence and structures.

To be able to prepare a teacher training and other kinds of support to improve effective implementation by teachers, planners assess the behaviour and determinants of teachers and other stakeholders who are important in the adoption and implementation of the intervention. What are the determinants of intentions of teachers to provide sexuality education? Why do schools adopt or refuse sexuality education? Why are government officials supportive or not to sexuality education?

Policy-makers, teachers, community leaders and parents may object to the introduction of AIDS-prevention/ sexuality education programs because they feel that the topics covered by these programs are too sensitive and may encourage young people to have sex. Teachers may feel uncomfortable with teaching their students about safer sex, and countries may still lack policies that are supportive of school-based AIDS education.

One approach to decline the sensitivity of the issues regarding sexuality, as perceived by communities, teachers and school administrators, has been to modify programs being less explicit in

their sexual content. However, this may reduce the effectiveness that is demonstrated in evaluation studies. Another approach is to provide additional training for teachers and administrators to increase their understanding of sexuality and to address attitudes and values that can help them to be more comfortable with the sexual materials in the programs.

An important aspect of planning for the adoption and implementation of sexual health promotion programs is to assess sexual attitudes and values of the community, especially teachers and school administrators, related to prevention, and to take the prevailing norms into account when designing interventions to influence program adoption and implementation.

8.2.1 Topics for data collection

At first, planners identify what they would like to assess. It is possible that these topics are already analysed in the Needs Assessment/ Situation Analysis (IM Step 1). If not, some examples of topics for data collection include:

A. Analysis of the stakeholders in the school system

Planners can start with an analysis of the school system, by identifying the relevant actors within the school system, their responsibilities, and how they relate to each other. The actors can vary from the teachers to school counsellors, to the Ministry of Education, and school administration.

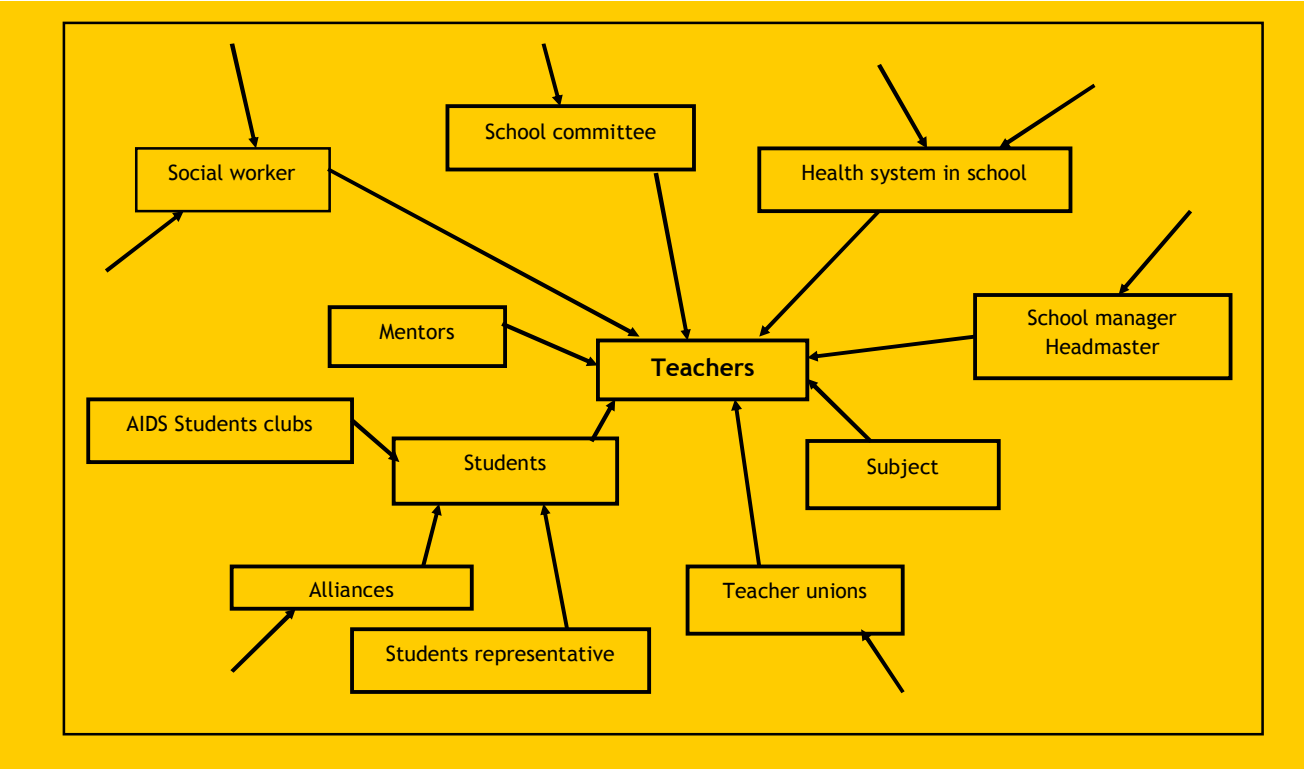


Figure 8.2 Organisational map of a school-based sexuality education intervention

B. Are schools willing to implement the programme (adoption)?

In the analysis of relevant stakeholders, planners identify who are responsible for and have power to take decisions about the adoption of the programme, and who have the mandate to decide about the content of the curriculum in the school. Sometimes teachers or a team of teachers decide. In other cases the official responsibility is in the hands of the school management (the board and/or headmaster of a school). They have to give consent for the implementation of sexuality education in the school. Intervention planners should therefore get an idea of the structure and decision-making processes in the schools, as well as the ideas and expectations of these decision makers, and the policy of the management-team of the school.

When the responsible persons are identified, planners analyse the determinants of their behaviour. Why do some head teachers adopt the programme and others not? What is the level of their knowledge, what are their values and attitudes, what skills do they lack or what is the social context they operate in?

In this context, it is also advisable to assess other constraints and possibilities. For instance, planners can assess the support and needs of parents and the wider community. What are the reasons why particular parents oppose against the programme and others do not?

C. Are schools able to implement the programme (implementation)?

In the analysis, planners also assess whether the implementers are able to use the programme. They identify the implementers, often teachers. What is the level of knowledge, attitudes, skills and social context that influences their performance in implementing the programme? For example, implementing a sexuality education programme often implies that teachers have to communicate with their pupils about sensitive issues, such as sexuality and relationships. In the assessment, planners identify the needs of teachers and their requirements to be able to implement the programme as intended. Do the teachers feel comfortable to use interactive teaching? Are they supported by other teachers and the school management when they provide sexuality education?

Box 8.3 Evidence from the Netherlands

Research in the Netherlands shows that the most important reasons for teachers to either implement the curriculum or not, were:

1. *Instrumentality*; e.g., procedural clarity (step by step explanation in a teacher manual what teachers have to do and how students are involved)
2. *Perceived personal benefits*; e.g., learning innovative teaching methods is also applicable in other classes or teaching other subjects
3. *Social influences* (colleagues, students); teachers are more likely to implement the curriculum if he/she feels supported by colleague teachers
4. *Self-efficacy* concerning teaching skills; the extent to which teachers feel confident to manage the students in the class while discussing sensitive topics, and talking frankly about these topics. This stresses the importance of teacher training to train skills and improve self-efficacy.

It also showed that in order to promote adoption and implementation of sexuality education programme, planners have to:

- provide procedural clarity (material development)
- combine mass-media and face-to-face contacts with teachers and school administration (adoption)
- provide solid training: demonstration and in-person assistance during implementation (implementation)
- prevent teachers from feelings of failure. They need to experience success (measure among teachers!)
- promote school level support (continuation)
- empower the local linkage system

8.2.2 Methods of data collection

Planners first collect existing information (secondary data), for example from reports, literature, or existing practices. And if they identify that particular information is still lacking, they can collect new (primary) information through for example interviews, focus group discussions or social mapping.

Secondary data collection

In secondary data collection, planners collect existing literature and existing interventions. For example, they collect existing training modules to train the teachers, or existing counselling tools that can be used to train the teachers. They also analyse literature about the requirements of teachers and the effectiveness of implementation by teachers. Or about the most important determinants of teaching behaviour in a particular context.

And they also look at what is already known about convincing the responsible people for adoption of sexuality education programmes. They assess the determinants of their behaviour.

Primary data collection

New information can be collected through interviews, focus group discussions and social mapping, to name a few. In the SATZ project, it became clear that schools are not always the easiest setting to get access to. The Cape Town research team, for example, experienced a lot of resistance and difficulty in getting access to the right people in the school, and to make appointments with them, even only to conduct interviews with them. Some examples of data collection methods are described in this section.

Social mapping

See Figure 8.2 for an example of a ‘social map’ with a number of relevant actors in the school system that are in one way or another involved in the provision of school based sexuality education. The map shows the different actors and whether and how they are related to each other. For example, teachers in a particular school setting may receive support from the school administration. In another school setting, the health care or referral system is a weak point in the system and may need improvement. In the assessment, planners can create social maps with the schools where they will implement the intervention.

Interviews

Planners can collect information through interviews among teachers to get insight in their reasons to either adopt the programme or not and their reasons to either implement the programme or not. In depth interviews can provide planners with a lot of information. Planners can also conduct interviews with others who are responsible for the adoption and implementation of the programme.

Focus group discussions

In addition to the interviews, planners can also conduct focus group discussions to collect the new information. This may generate more discussion and therefore other information than is generated in the in-depth interviews.

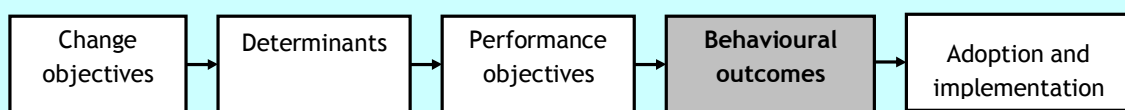
Questionnaire

In the SATZ project, a study was conducted among teachers about the reasons for them to either adopt the sexuality education programme or not.¹⁴ In most projects however, planners do not have resources to spend a lot of time on conducting such a study.

8.3 Task 5.3 Identify objectives for adoption and implementation

Based on the analysis of barriers and opportunities in adoption and implementation, planners identify objectives. The same steps are taken in defining these objectives than is done in Step 2, when the objectives for students were identified. Planners first set the behavioural outcomes on the level of adoption and implementation. Then they make these more specific by identification of performance objectives. And then they set the change objectives for each of the performance objectives. These levels are further explained in this section.

Figure 8.3 Where are we in the objectives?



8.3.1 Adoption and implementation behavioural outcomes

Planners first state the behavioural outcomes on the level of adoption and implementation of the sexuality education programme. They ask themselves the questions: ‘Who are responsible for the adoption and implementation of the programme?’ and ‘Which behaviours should they perform in order to increase adoption and implementation of the programme?’

For the adoption and implementation, planners can identify a number of behavioural outcomes:^{15;16}

- *Teachers* involve young people in the learning process so that they are able to make and act out healthy decisions about sexuality
- *Teachers* teach the new programme according to guidelines provided by the development team
- *Peer educators* teach the programme according to guidelines provided by the development team
- *Parents and the wider community* support their children to participate in the programme
- *School administration* supports the implementation of the programme

It depends on the context and evidence, what is possible in the adoption and implementation of sexuality education programmes in school. In some settings it is possible to involve parents in such a way that they are willing and able to discuss sensitive issues with their children. In other settings, the highest achievable outcome can be that parents do not resist against the involvement of their children in such programmes.

In many countries, sexual and reproductive health education consists of didactic lectures about basic anatomy and physiology. This is hardly surprising, because most training programmes fail to prepare future teachers of sexual and reproductive health to teach the subject effectively. As a result, many teachers complete their training with critical gaps in their knowledge of reproductive health. Some have judgmental attitudes or religious, legal or moral objections to teaching young people about sex, contraception, or condom use. Others feel uncomfortable talking about such subjects or using the interactive teaching methods that appear to be most effective in promoting

healthy sexual behaviour. When they move to the classroom, these teachers are often expected to use teaching materials that omit key information and encourage the "chalk and talk" approach.

Box 8.4 Requirements of educators

Within the school setting, teachers are often the primary implementers of sexuality education, either or not assisted by peer educators and/or health service providers. One of the major advantages of teachers as implementers is that they are available in the school and that they can incorporate the specific content of a SRH&R programme into the broader curriculum.

After the programme has ended, they can still continue providing education on SRH&R and support to students, making sexuality education and care an integral part of the school curriculum. Most teachers, external health service providers, or peer educators often cannot do that. Research shows that a school-based educational programme, exclusively led by teachers has longer-lasting effects in preventing risky sexual behaviour than a programme led by peers (peer education).¹⁷

However, teachers may not feel equipped and comfortable to teach young people about sexuality. Usually they are not experienced in talking about the sensitive issues as they are presented in SRHR programmes or to discuss these issues with students in an interactive way. Participatory approaches imply a new and innovative education style for many teachers. Equipping teachers with these skills is crucial for expecting programmes being implemented the way they are intended.

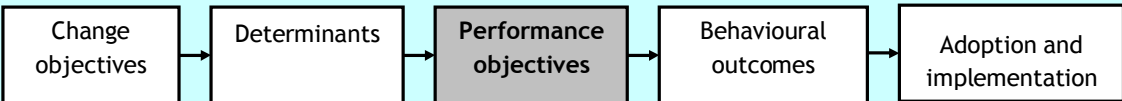
Generally, this requires a different role of teachers:

subject centred	→	person centred
expert	→	facilitator/enabler/guider
discipline/authority	→	trust/acceptance/encouragement
focus on output	→	focus on process and output
frontal education	→	participatory education

In the scope of this manual, the implementers of the intervention (sexuality education) are the teachers, sometimes assisted by peer educators, by other colleagues, health care providers, or school management. However, the teachers are the primary implementers of the programme. To make sure that teachers implement the programme well, it is often necessary to design an implementation intervention, with the core component being a teacher training.

After teachers (and schools) have adopted the curriculum, the next step is to make sure that teachers actually use the programme, and that they use it in a correct way. All activities that are done to improve the implementation, are part of an 'implementation intervention', generally being a teacher training as core activity.

Figure 8.4 Where are we in the objectives?



8.3.2 Performance objectives

After the specification of behavioural outcomes, planners identify performance objectives for each of the outcomes. See Chapter 6 about objectives for a more detailed description of stating performance objectives. In Table 8.1 we provide an overview of performance objectives for various examples of behavioural outcomes on adoption and implementation.

For example, one of the behavioural outcomes for teachers is that they involve young people in the learning process so that they are able to make and act out healthy decisions about sexuality. If we try to make this behaviour more specific, one of the actions teachers can take is to create a safe environment for students so that they feel free to talk openly about personal issues. This includes that they feel free to voice their opinions and to express their feelings; that they are respected and their contributions are treated with confidentiality; and that there are clear rules and boundaries that govern the interactions in the classroom.

Box 8.5

Participatory teaching approach

Open and frank communication about sexuality means more than providing biological information in lectures and class discussions. Communication is a mutual, interactive process, which includes listening, understanding and convincing in mutual respect. In the classroom, this takes place between the teacher and the students. Efficacy of communication is related to equity between partners, awareness of each other's rights, and a respectful and positive approach.

In group or classroom education, a participatory approach is an appropriate way of working and adds to the effectiveness of teaching.¹⁸ A participatory approach improves self-confidence and supports the development of one's own attitudes and skills. In life skills education that aims at the protection of young people's sexual and reproductive health and rights (SRHR), a participatory approach is very important.

This approach requires from teachers that they are willing and have the skills to descend their traditional throne of authority and knowing-it-all to become a process guider and trust agent, encouraging students to have their input in their own learning process in a safe atmosphere.

Participatory teaching in educating SRHR to young people, takes a positive perspective towards young people's decision and sexuality into account. Teachers can encourage students to share knowledge, dispel myths and allow them to be involved in their own learning process, becoming owners of this process.

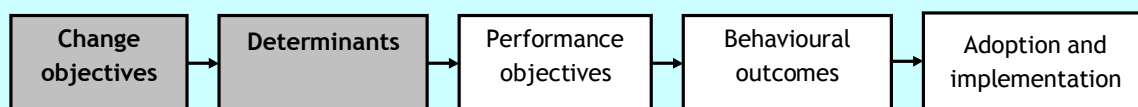
Teachers can combine both individual and group attention, providing the opportunity to value the input of all students, while they allow students to simultaneously shape their individual learning process. Participatory teaching optimises the *own and unique input* of all students and promotes their identification with the curriculum objectives. Students learn from each other (modelling¹⁹), which to a certain extent relieves teachers from their difficult task to initiate and address discussions on sensitive issues.

Table 8.1

Performance objectives adoption and implementation

Behavioural outcome	Performance objectives
Teachers involve young people in the learning process so that they are able to make and act out healthy decisions about sexuality	<ol style="list-style-type: none"> 1. Teachers express support of the programme 2. Teachers discuss sexuality in an open and explicit way 3. Teachers create and maintain a safe environment 4. Teachers teach in a non-judgemental manner 5. Teachers apply participatory learning principles in classroom
Teachers teach the new programme according to guidelines provided by the development team	<ol style="list-style-type: none"> 1. Teachers read the instructions for each session of the programme in the teacher manual 2. Teachers also teach the more difficult activities in the programme 3. Teachers seek help when they find particular activities difficult to teach
Peer educators teach the programme according to guidelines provided by the development team	<ol style="list-style-type: none"> 1. Peer educators discuss sexuality in an open and explicit way 2. Peer educators seek help when they find particular activities difficult to teach
Parents and the wider community support young people to participate in the programme	<ol style="list-style-type: none"> 1. Parents allow young people to attend the sexuality education sessions 2. Parents discuss sexuality related issues with their children
School administration supports implementation of the programme	<ol style="list-style-type: none"> 1. School administration encourages teachers to implement the programme 2. School administration provides resources (time, venue, funds, ...) for implementation of the programme 3. School administration encourages/ organises teacher support meetings

Figure 8.5 Where are we in the objectives?



8.3.3 Change objectives

The third task in setting the objectives for adoption and implementation is defining the change objectives. These objectives describe on the level of determinants (such as knowledge, attitude, skills) what planners want to achieve among the various actors in adoption and implementation.

See Annex 8.2 for examples of change objectives. These objectives were stated by project teams in Cape Town (SATZ) and/or Lokmitra (India MAIN PHASE project). Planners can use these examples and check to which extent these fit with their own analysis of needs of teachers and others involved in implementation.

personal level

- seeing young persons as human beings with human rights = taking young persons serious
- aware of own norms and values
- aware of own sexuality
- aware of restrictions in the area of sexuality and strong points (boundaries, insecurity)
- role model = practise what is preached
- respectful and confidential
- aware of interaction of own gender
- good listener
- flexible, tolerant
- approachable, open

pedagogical level

- alert on individual signals and a good referrer
- creates a safe climate
- uses all talents of up growing young persons
- facilitator not a controller
- utilises young peoples' context
- structures educational process in a developmental context
- uses child psychology and developmental sciences

didactical level

- reflect on own practise
- base on needs of young people (attractive, convincing)
- use a participatory approach
- familiar with various teaching methods, including role-play and drama
- uses young people's capacity
- rights-/ cultural-/ gender sensitive approach
- evidence based - behaviour change training and methods

management level

- uses feedback to management
- advocates for a. effective implementation, b. policy
- monitoring and evaluation and make adjustments
- lobby for supportive environment (staff, parents, community, health care)
- ask supportive management

8.4 Task 5.4 Design theory-based adoption and implementation interventions

Based on the objectives, intervention planners can design a number of interventions to enhance the adoption and implementation by teachers, school administration and the community. In practice, this will most likely result in the design of a teacher training and, if necessary, other activities to support the implementation of the curriculum. Similar to IM Step 4 (Evidence-Based Intervention Design), intervention planners have to look for theoretical methods that provide guidelines for the accomplishment of the objectives.

Planners attach to each of the interventions they decide to design, the objectives they want to achieve with this. They take the same steps as they did in the design of the theory-based intervention (IM Step 4). They also select methods that support the design of particular interventions.

The previous task provides planners with the objectives for support of teachers and other actors to be able to adopt and implement the programme. In practice this can lead to the design of a number of interventions targeting teachers, peer educators, school administrators, and the parents/ community. Table 8.2 provides an overview of options for adoption and implementation interventions. In this section we describe possibilities for interventions targeting teachers, school administrations, parents and the community, and others.

Table 8.2 Interventions for adoption and implementation

	Adoption interventions <i>All relevant stakeholders are willing to use the sexuality education programme</i>	Implementation interventions <i>All relevant stakeholders are able to use the sexuality education programme</i>
Teachers	Teacher training	Teaching materials Teacher training Support meetings
School administration	Information brochure/ one to one convincing	NA
Community/ parents	Awareness meeting	NA
School counsellors	Awareness meeting/ training of counsellors	Support meetings
Peer educators	Peer educator training	Peer educator training

8.4.1 Design interventions for teachers

As teachers are generally the implementers of sexuality education programmes in schools, we start with some interventions targeting the teachers, including the teacher manual, a teacher training and other forms of support.

Teacher manual

In Intervention Mapping step 4, the intervention materials are developed. Part of the materials may include the teacher materials, such as a teacher manual, posters, leaflets. Aim of the teacher manual is to provide teachers with sufficient information to be able to guide students through the lessons. The manual should preferably be developed in close collaboration with teachers. And if possible designed in the same kind of outline and layout they are used to in other curricula. This may make them feel more comfortable and as something that is part of their work and not an additional thing they have to do.

Planners can use an existing manual as a basis for their project specific teacher manual. And see whether the evidence shows any gaps that need to be filled with additional information or guidelines. Evidence shows that it is very important to provide very clear instructions for the teachers who implement the curriculum. The manual should describe exactly what they should do: how long the activity may take, which materials they may need, instruct them step by step what they have to do, provide examples and provide in depth background information.

A review conducted by Kirby and colleagues²⁰ of 83 evaluations of programmes in developing and developed countries, focused on pregnancy or HIV/STI prevention behaviours, revealed that programmes that had shown effect had particular features. The effective programmes were implemented by selected educators with desired characteristics (whenever possible), were trained and provided monitoring, supervision and support. While some programs were implemented by classroom teachers in whatever classes were appropriate, other programs hired their own educators and had more control over whom they hired. Commonly they hired people whom they believed could relate to youth and who had a background in health education and especially sex or HIV education.

Notably, most studies did not examine the impact of the characteristics of the educators on behaviour change. However, one study did randomly assign youth to different types of educators and found that matching the youths' race/ethnicity or gender with that of the educators did not have a significant impact on behaviour change.²¹ Similarly, two studies randomly assigned youth to receive either adult-taught or peer-taught sex and HIV education and found that the age of the educators did not affect program effectiveness.^{22;23} Qualitative evaluations of multiple programs have found that what is most important to young people is whether the educator can relate to youth, not the age of the educator.²⁴

Virtually all of the programs trained their educators in the implementation of the curriculum. This training varied considerably in length and approach. Some of the trainings were skill-based and provided practice teaching some of the activities, while others did not.

While all of the programs trained their educators, one study randomly assigned the educators to receive minimal training plus the well scripted curriculum, a three-day training plus the curriculum, or a three-day training plus video-taping of sessions and feedback on those video-tapes.²⁵ Notably, the level of training did not significantly affect the impact of the curriculum on subsequent behaviour change.

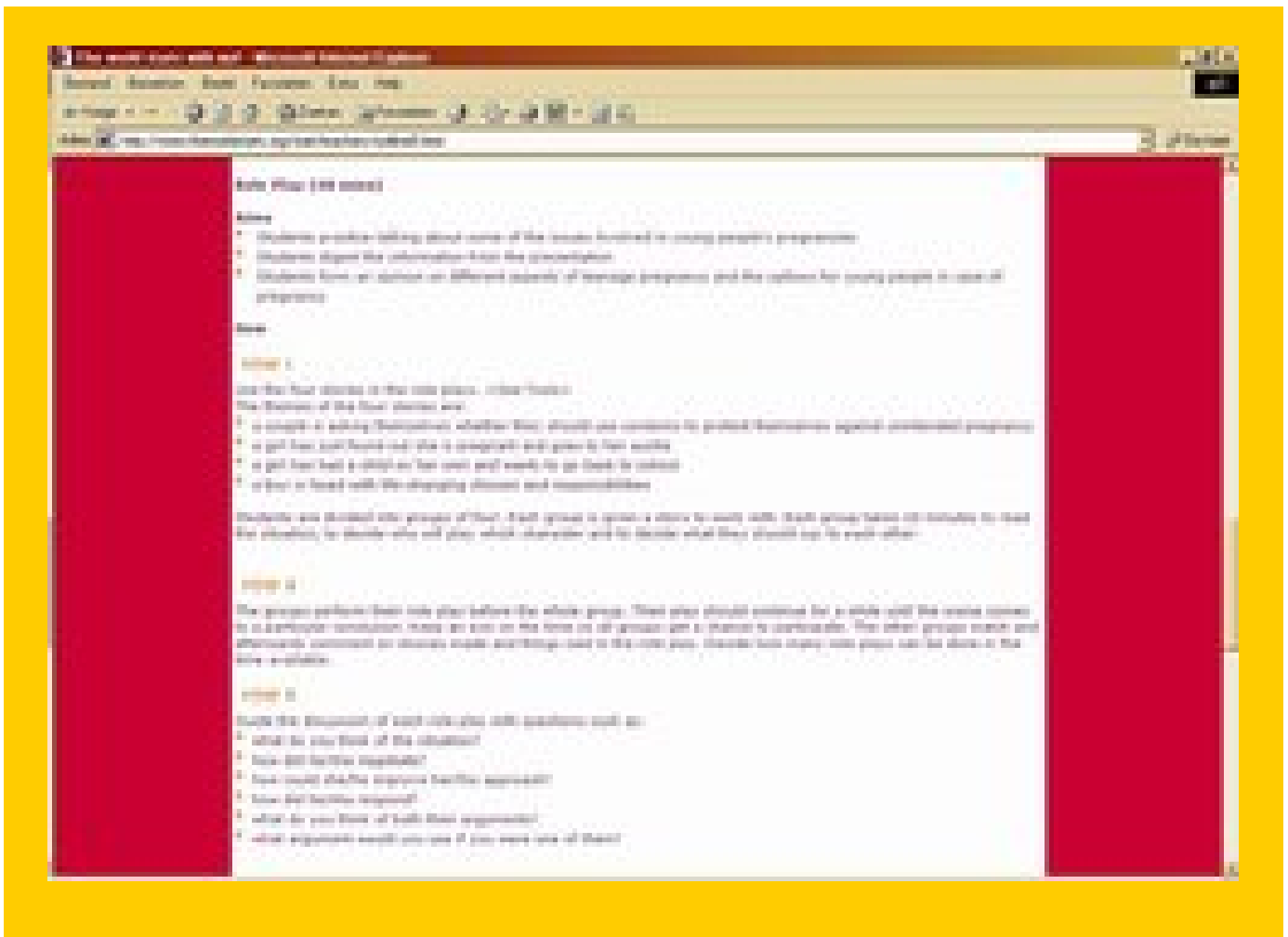
Most studies also provided at least minimal monitoring, supervision and support for the educators. Sometimes, the educators met periodically to discuss their experiences and solve common problems.

For example, if teachers should instruct students about a role play. Do not only say 'ask learners to do a role play on obtaining condoms from the clinic or pharmacy. After the role play, let the learners discuss about what they observe during the role play'. But also provide the teachers with instructions how they should organise the role play (how many students could be involved and when), provide an example of a 'story'. What could go wrong? And how can you as a teacher prevent this? See Box 8.8 for an example of *The World Starts With Me*. This is an exercise in the lesson about pregnancy, and students learn through role plays to practice talking about some of the issues involved in young people's pregnancies, and to form an opinion on different aspects of teenage pregnancy and the options for young people in case of pregnancy.

Teacher training

A training of teachers is generally very essential for effective programme implementation. A teacher training can provide teachers with awareness and confidence in teaching about health promotion issues, particularly about communicating sexuality in a youth-friendly way and applying an interactive and participatory approach.

In most sexuality education projects, the emphasis of the teacher training is on a) exercising and pre-testing the activities of the curriculum, b) provision of knowledge about SRH and the underlying approaches and objectives of the programme, and c) value clarification of the teachers themselves regarding sexuality and SRHR. Various documents on the Internet can assist in teacher training development^{26;27} and analyse existing teacher training materials.²⁸



Communicating about sexuality in the first place requires that teachers are aware of their own norms, values and attitudes towards sexuality in general and in particular towards sexuality and rights of young people²⁹. Part of the awareness includes the perception of the teacher on gender and gender differences.

In addition, as openly talking about feelings and opinions on sexuality is difficult for many adolescents, teachers have to be trained to act as role models, helping students to form and formulate their own opinions on sexuality and relationships. Teacher training has to provide teachers with skills to create safe settings in which young people feel free to talk openly about sensitive issues, to develop own opinions and learn to stand for them. In addition, exercising communication, refusal and negotiation skills in the classroom requires a setting in which students can freely act out roles in a controlled, safe situation.

Implementing a sexuality education programme requires a lot from teachers, at various levels. At a personal level, awareness of and coping with own norms and values in the classroom is needed. At pedagogical level teachers need skills to guide young people's development with a positive approach toward sexuality and young people's rights, being alert on individual problems and able to give support and adequately refer students.

At a didactical level, teachers need to be able to use a variety of teaching techniques in a participatory way. And at the management level, teachers have to contribute to a school policy in which students feel acknowledged and safe, are helped if needed and where misbehaviour is corrected in the case rights are violated. Training should address all teacher's contributions at these levels, but in particular their change of roles in the primary process, which is the process in the classroom.

Box 8.9 Open communication about sexuality

Understanding one's own sexuality and sexual development, as well as discussing sexual health risks are basic needs and concerns of young people worldwide. During puberty they discover their own sexual feelings towards others, and they are faced with questions such as how to cope with sexual excitement and sexual attraction and how these issues relate to starting a relationship, whether and when to become sexually active or not and in defining the boundaries in intimate contacts.

To address those issues in programmes for young people, open and frank communication about sexuality by educators (i.e., peer educators, teachers, counsellors or health service providers) is an inevitable prerequisite. Only then communication about sexuality can be modelled and learned and an understanding of the comprehensive concept of sexuality and the values and norms surrounding it, can be shaped.

Although research has shown that comprehensive sex education leads to a delay in the onset of sexual activity and safer sex among sexual active youth, many parents believe that an open discussion about sexuality provokes young people to become sexually active and encourages promiscuity. A review of 50 sexual health education programmes in different parts of the world revealed that young people were more likely to delay sexual activity when they had the correct information to make informed decisions and when sexuality and sexual health, including HIV, are openly communicated within a framework of comprehensive sexuality education.³⁰ The review also showed that comprehensive sexuality education promotes safe sex among sexually active youth.³¹

Other reviews also show that sex education or promotion of condoms does not lead to increased sexual activity among young people.^{32;33}

The misconception that sex education increases sexual activity may result in the belief that silence about sexuality can avoid sexual health problems among youth. This hinders communities to accept comprehensive sexuality education programmes and hinders educators to openly talk with young people about what sexuality can mean for them, including the range of sexual behaviours. As a result, millions of people, especially girls and women, remain ignorant about how to prevent sexual health problems, including HIV/AIDS, with potentially deadly consequences.³⁴

Open and frank communication about sexuality requires educators to be explicit about the broader range of sexual acts. Explicitness increases the insight of young people in sexual behaviour. For many (young) people, and particularly for boys, sexuality is often perceived as sex and sex as exclusively sexual intercourse. Other sexual or intimate behaviours, such as non-penetrative sex like kissing, touching, petting, mutual masturbation and oral sex are not perceived as 'real' sex.

If teachers are able to broaden the view on what sexuality is and explicitly communicate about the various sexual behaviours and ways to experience sexuality, young people will better understand what abstinence and sexuality can mean for them. In reality, many young people would like to delay sexual intercourse, but still like to be intimate with a sexual partner. However, they are often not taught about the range of sexual acts that are still safe and healthy to practice.

In addition, teaching alternatives in sexual behaviour can contribute to young people's 'stepwise development' of their sexual career, deciding which personal boundaries are most appropriate for them at what age. Finally, teaching options in sexual behaviours provides young people, and particularly young women, alternatives for negotiating safe sex with a partner.

In addition to training the abovementioned skills and awareness raising of own attitudes and values, the teacher training pays attention to the teacher training materials. During the training, parts of

the materials can be tested, by giving teachers the assignment to teach part of a lesson with other participants in the training session.

Support meetings

In addition to the training before implementation, support meetings can be organised to support teachers during implementation. During the implementation, they may face difficulties, and the support meetings can be a forum for teachers to share their experiences, give tips to each other, and plan new sessions.

For example, teachers in Uganda from a number of schools in a particular region gather once in a few months to exchange their ideas and concerns. These meetings are used to provide logistic instructions, but also to give space for the attendants to ask questions and feedback.

Box 8.10 Theory about creating change among the implementers

Concerns based Adoption model

The Concerns-Based Adoption Model (CBAM) is developed by Hall and his associates,^{35;36} which addresses seven stages of concern. These seven stages explain the different concern levels of individuals who are experiencing the change:

Focus	Stages	Expressions of typical concerns
Unrelated	1. Awareness	I am not concerned about it
Self-concern	2. Informational	I would like to know more about it
	3. Personal	How will using it affect me?
Task-concern	4. Management	I am spending all my time to get materials ready
Impact-concern	5. Consequence	How is my use influencing the learners? How can I refine the programme to have more impact?
	6. Collaboration	How can I relate what I am doing to what others are doing?
	7. Refocusing	I have some ideas about something that would work even better

These stages have three major implications for pre-service and in-service providers. One implication is the importance of addressing concerns of teachers and students and monitoring progress to determine areas of improvement. Another implication suggests the importance of monitoring the change process over several years. It may take time for concerns to be addressed and new concerns to emerge during the change process. It is imperative to provide assistance during the change process to work out problems and allow for good teaching strategies to arise. A final implication is that time for the change to become routine should be allowed.

8.4.2 Design interventions for school administrations

In addition to the interventions for teachers, planners can also design interventions for school managers. This of course depends on whether planners have identified obstacles in the adoption of the programme by a school administration. If there are no obstacles, planners do not need to design interventions. Planners use the overview of objectives (see annex 8.2) as a guidance for the design of interventions targeting school administrations.

Examples of interventions include organising an awareness meeting with the managers of schools to convince them to adopt the programme and provide them with information. It is also possible to provide a letter or brochure with information about the project. And it may be necessary to get the authorisation of the Ministry of Education, or a letter from the ministry in favour of the programme.

8.4.3 Design interventions for the community/ parents

When planners have identified obstacles among the community or parents, they also need to address these in an intervention. For example, parents may not allow their children to participate in a sexuality education programme. If this is the case, planners can involve parents or organise an awareness meeting to convince them of the need for their children to participate. See the Internet for documents with examples of how other organisations have involved parents in their sexuality education programmes targeting young people.^{37,38}

Also here it depends on the objectives that need to be achieved among the community and parents. If the objectives state that parents should be able to communicate with their children, a more intensive method may be needed than when planners want to inform parents and the community about the programme.

One of the ways to involve the community and parents is by organising an awareness meeting with the parents and maybe some community members who can be key informants of change. Another option is to develop a brochure that is available for the community.

8.4.4 Design other adoption and implementation interventions

It may be possible that the analysis shows that there are other obstacles in adoption and implementation. For instance, one of the barriers can be that health service providers are not able to provide support to young people who are referred to them with SRHR related problems.

One way to intervene among them is by informing them that schools implement an SRHR programme and that this may lead to an increased number of young people who come for information or testing. Depending on the scope of the programme, it is also possible to train health service providers to provide youth friendly services.

8.5 Task 5.5 Design an implementation plan

When the intervention materials for the adoption and implementation are finalised, planners develop an implementation plan. This plan describes how to get the intervention programme adopted and implemented. This is as important as the intervention plans discussed in IM Step 4 (Evidence-Based Intervention Design). It includes a scope and sequence of activities, staffing and budget. This may include a description about how to work with the pilot schools and teachers, when to conduct a teacher training, and when to start and finish with the implementation.

8.5.1 Select schools and teachers for the pilot implementation

This manual emphasises a way of working that starts with a small scale implementation of the intervention programme (pilot), and only at the long term diffuse the programme to a larger scale. In the pilot implementation, a relatively small number of schools are involved, and teachers are selected and trained. Planners need to identify the students, schools, and teachers that will be involved in the pilot implementation.

It may be possible that these students, schools and teachers have already been selected in step 0, and have been involved in the working group.

8.5.2 Conduct the teacher training

The next task is to plan the teacher training and other activities to support implementation of the curriculum. Some practical aspects of the teacher training are the number of days, time, participants, and facilitators of the teacher training.

The *teacher training* may be provided by organisations or institutions that are specialised in training (of teachers) concerning sexuality and SRHR, for example training colleges or Family Planning Associations. Planning of the days to conduct the training depends on the teaching schedules of the teachers. One option is to conduct the training in 2 or more weekends, or to organise this during holiday breaks.

8.5.3 Instruct schools and teachers concerning implementation

Before the implementation starts, planners have to provide all people who are involved in implementation with sufficient information about what is going to happen. In SATZ, the planning team in Cape Town provided the teachers with an '*Implementation Roster Guide*' to assist them in planning the implementation carefully and take into account holidays when planning their own implementation-scheme.

Box 8.11 Adoption of sexuality education curriculum by Dutch teachers

A study among Dutch secondary school teachers revealed that teachers' decisions to adopt and implement an HIV-prevention programme were strongly related to their self-efficacy regarding programme implementation and their anticipation of the effort involved, their colleagues' approval and their students' response³⁹. Teachers' beliefs about programme effectiveness were not associated with their intentions to provide HIV education or adopt a particular HIV-prevention programme. Attempts to promote adoption among Dutch teachers by emphasising programme effectiveness are therefore unlikely to be successful. Teachers are more likely to adopt a programme that is presented as easy to use, having ready-made lesson plans and materials, approved of by other teachers and having had positive evaluations by previous recipients.

8.5.4 Include monitoring & evaluation procedures in the implementation plan

Monitoring and evaluation procedures of the pilot implementation have to be part of the implementation plan. The theory behind it and suggestions for doing this are provided in chapter 9.

8.6 Task 5.6 Plan for sustainable adoption and implementation

When planners only start with thinking about sustainability of the programme implementation, they are far too late and very unlikely to succeed. Planning for sustainable implementation does not start after the pilot implementation, but has already started at the very beginning of intervention planning: by involving influential stakeholders; by embedding the intervention in the national and regional policies related to young people and SRHR related education for young people in schools; by involving educators from the start in intervention planning.

Sustainability can be defined as the maintenance and institutionalisation of a programme or its outcomes. Looking at sustainability of sexuality education programmes, we can distinguish different levels: on a national or regional level and on the school level. The World Health Organization provides an interesting document to assist planners in planning for sustainable implementation.⁴⁰

8.6.1 Sustainable implementation on national/ regional level

On national or regional level, sustainability can imply that the implementation is taken over by the Ministry of Education or another governmental institution. In South Africa, the University of

Stellenbosch in collaboration with WPF has been able to make the programme sustainable through this mode. The Ministry of Education has acknowledged the programme as one of the programmes that can be used for sexuality education.

Another option is that the teacher training attached to the programme is included in the education of teachers (high schools, teacher colleges), meaning that teachers are already aware of the programme and able to teach it when they get a job in a school. In Uganda, the teacher training for WSWM was accredited. In Vietnam, WPF is working on the inclusion of the teacher training on sexuality education in universities where teachers are educated.

In various countries, however, it is not possible that the Ministry of Education takes over implementation. For example, in Uganda, the political climate is not in favour of comprehensive sexuality education, and it is very unlikely that the government can agree with the content of WSWM. However, also on other levels, planners can try to work on sustainability. In Uganda, other organisations provide resources for the implementation of the programme.

8.6.2 Sustainable implementation in schools

On the school-level, planners can also try to make the programme sustainable. One way to do that is by developing a school policy in which SRHR education and care and a supportive environment are embedded. In addition to training and support of teachers, the school setting requires particular conditions to enhance effectiveness of the educational programme and to create a safe environment for both students and teachers.

One important condition is the commitment of school administrators to the program, not only for legitimating and facilitating the implementation into the school work plan, but also to support and back-up teachers in case of constraints with students, colleagues or parents regarding the program. Another condition for effective implementation is related to personal concerns and questions of students. Participatory sexuality education can provoke personal questions, meaning that teachers need to be sensitive to individual problems of students and have options available to refer students to support and care. School administrators therefore need to arrange supportive facilities in the school, including mentoring and counselling. Moreover, they need to set up a referral system to specialised counselling and health services.

School administrators can also play a major role in creating supportive conditions. They may involve parents in the curriculum, aiming to get their commitment and to promote parents' own education in line with the school program. Ideally, the school integrates sexuality education into the existing (health) policy of the school. This is referred to as a 'SRH school policy'. This section discusses the need and structure for such a policy.

Identify barriers and opportunities in sustainable implementation

Despite the fact that it is widely acknowledged that schools are an important arena to promote the sexual health of young people, and several signed UN conventions from the last decade emphasise the right of young people to education and information, most school-based AIDS-prevention programmes that have shown to be effective in scientific trials, have never been implemented effectively on a wide scale for a variety of reasons.⁴¹ In each particular project, planners can conduct additional research to identify the barriers and the opportunities for the sustainable adoption and implementation of the programme. They can assess the needs and opinions of the people who are responsible for the adoption of sexuality education programmes in the schools.

The need for a SRH school policy

There is a need for schools to adopt a policy for sexual health.⁴² This policy should be realistic about the natural limitation of schools' impact in these complex areas of young people's personal lives and behavioural decision-making. It should be a motivating policy for schools, encouraging a confident, coherent and consistent approach of sexuality education without undue rigidity of content or delivery.⁴³ A school policy exceeds mere teaching and integrates education with the care for students and school personnel and a school environment that is beneficial to their health, promoting healthy behaviour of whole the school population in an indirect way.

Box 8.12 Vulnerable groups and a school policy

The HIV status is never a reason to exclude a student, teacher or other school personnel from school. Both students and teachers can perform their normal duties while they are physically able to. Only secondary diseases like an infection or diarrhoea can keep an HIV positive person at home - in the first place for their own health. In addition, schools have to be aware of the sometimes difficult position of orphans, of whom parents died due to AIDS: schools have to make sure everyone knows that they are not to blame for their parents' death; they may or may not carry the HIV virus, but even if they do, schools should guarantee that all children know they can still safely play with them and sit next to them in class.

In their school policy, schools need to include strategies how to cope with HIV-positive teachers, school personnel and students and how to avoid stigmatisation of HIV-positive people and orphans in school. In addition, education about HIV/AIDS should be part of comprehensive, rights-based sexuality education in school curricula, and schools should address the 'culture of silence' surrounding HIV/AIDS and protect children living with HIV/AIDS, orphans and school staff of being discriminated. Schools should have a counsellor or specially appointed teacher to help students cope with HIV themselves or with an HIV infected family member or friend. Schools should also have a gender-sensitive education and school climate, in which attention is paid to the vulnerability of girls and women.

The three pillars of a school policy on SRH

In line with the concept of Health Promoting Schools of the World Health Organization,⁴⁴ a school policy on sexual and reproductive health builds on three pillars: education, care and environment.

In the long run, sexuality education should be part of a health promoting strategy which promotes a healthy life style and which gives young people the tools to make their own choices in their own life environment. A structural approach to the instruction on AIDS and other STIs and to sexuality education demands a policy in schools; a policy that exceeds mere teaching and integrates education with the care for students and school personnel and a school environment that is beneficial to their health and can promote healthy behaviour in an indirect way.⁴⁵ Education, care and school environment are the three cornerstones of a school health policy on sexuality education. See the Internet for more background information and examples of what could be included in a school policy.⁴⁶

A health promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working:

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

Health promoting schools focus on:

- Caring for oneself and others
- Making healthy decisions and taking control over life's circumstances
- Creating conditions that are conducive to health (through policies, services, physical / social conditions)
- Building capacities for peace, shelter, education, food, income, a stable ecosystem, equity, social justice, sustainable development
- Preventing leading causes of death, disease and disability: tobacco use, HIV/AIDS/STDs, sedentary lifestyle, drugs and alcohol, violence and injuries, unhealthy nutrition
- Influencing health-related behaviours: knowledge, beliefs, skills, attitudes, values, support

Education

Sexuality education focuses on how to make informed, healthy decisions in the own personal environment. This approach requires openness in the classroom and frank communication about personal values, life style and life environment. It is preferable to include this particular education in the school policy, make it examinable and make it part of the work teachers have to do regularly (and not an extra activity). A sexuality education curriculum contains lessons about sexuality and relationships in which AIDS/STI is embedded. In addition to the transfer of knowledge, value communication and negotiation skills are needed in order to teach students to make healthy choices in their own personal environment.

Out-class education can be offered in the school by means of posters and leaflets and in the library by means of brochures, papers and books. Outside-class educational activities such as relevant theatre, movies or hosts presenting their NGO services, can be organised to involve whole the school population in sexuality education.

Care

A school policy includes the guidance of students in their development. Mentoring, counselling, consulting-hours with the school-nurse and confidential teachers are in many countries part of this students' guidance.

If a school offers sexuality education in which students are open about their personal life style, teachers can signal personal problems of students, i.e., problems with making social contact, sexual harassment, violence and abuse, and discrimination based on race, religion and gender, living with

HIV/AIDS, homosexuality and sexual abuse. In this case, counsellors and health services have to be available to support those students.

Environment

A health promoting physical and social environment in the school is essential for students and school staff^{47;48} and should therefore be an essential part of a school health policy.

At first, it concerns the pedagogical climate in the school. For example, are responsibilities given to students or are they strictly prescribed how to behave according regulations and control? This also includes facilities, including adequate information out of the class, school regulations related to SRHR and possibly condom vending machines. For example, regulations may concern female and male students who get pregnant/ have impregnated; how to deal with teachers and students who have HIV/AIDS;^{49;50} regulations with regard to the interaction between teachers and students (i.e., to prevent harassment or abuse by teachers); and explicit school rules about rejection of discrimination because of religion, gender, race or sexual orientation.

A supportive school environment also involves parents and communities. A school policy may facilitate the degree of involvement of parents and community, the ways of involvement and roles and responsibilities regarding sexuality education.

A school policy allocates the different tasks that are required for effective implementation of sexuality education, to the responsible school officials in a coherent way, guaranteeing necessary staff training, providing procedures in references to health services in- and outside school, establishing and adhering to school rules and involving parents and community.

School policy and sustainable implementation

Working towards a school policy is part of the comprehensive view on school-based sexuality education that is advocated in this manual. This has also consequences for intervention design and planning from the start of Intervention Mapping. It has consequences for which stakeholders to involve from the start and which aspects to assess in the situational analysis.

A school policy can be developed and implemented combined with the development and implementation of an SRHR curriculum, simultaneously intervening at more levels in the school: students, teachers, counsellors, health providers, school staff and school administration. A school policy can also be developed after having developed and implemented a SRHR curriculum. Whatever the choice, a school policy is a prerequisite for ensuring the sustainability of newly implemented SRHR curricula, as it means that SRHR education and care and a supportive environment are all embedded in the school and integrated with other (health-related) activities in the school.

8.6.3 Training of trainers

In addition to the interventions on the level of the schools and if possible on national or regional level, planners also have to plan for sustainable training of the teachers.

One of the experiences of WPF in the implementation of The World Starts With Me is, that it is an effective and efficient approach to select teachers during the pilot implementation of the programme, who can be the trainers of future teachers.

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- ²⁴ Kirby, D., et al., Evaluation of Education Now and Babies Later (ENABL): Final Report. 1995.
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www.unaids.org/html/pub/publications/irc-pub04/schooltu_en_pdf.pdf

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³² D. Kirby, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy (The National Campaign to Prevent Teen Pregnancy, May 2001).

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³⁵ Hall, G., & Hord, S. (1987). "Change in schools: Facilitating the process." Albany, NY: State University of New York Press.

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³⁸ www.fhi.org/en/Youth/YouthNet/ProgramsAreas/SexEducation/parents.htm ; www.advocatesforyouth.org/parents/

³⁹ Paulussen, Kok & Schaalma, 1994; Paulussen et al., 1995

⁴⁰ World Health Organization (2004). Key Issues in the Implementation of Programmes for Adolescent Sexual and Reproductive Health. Geneva: World Health Organization. See: www.who.int/child-adolescent-health/New_Publications/ADH/WHO_FCH_CAH_04.3.pdf

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⁴² See, for example: www.freshschools.org/schoolpolicies.

⁴³ www.ers.north-ayrshire.gov.uk/Health/Sexhealthpolicy.htm

⁴⁴ See: www.who.int.

⁴⁵ (European Information Centre 'AIDS and Youth', 1996)

⁴⁶ Focusing Resources on Effective School Health (FRESH). See: www.freshschools.org/schoolpolicies.htm

⁴⁷ WHO (1999). Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health Promoting Schools. Information series on School Health, document 6. See: www.who.int.

⁴⁸ WHO (2000). Local Action. Creating Health Promoting Schools. Information series on School Health. See: www.who.int.

⁴⁹ WorldBank & UNAIDS (2002). Education and HIV/AIDS; modelling the impact of HIV/AIDS on Education systems; a training manual. See: www-wds.worldbank.org.

⁵⁰ Kelly, M.J. (2000). Planning for education in the context of HIV/AIDS. Paris, France: UNESCO. See: unesdoc.unesco.org.

Annexes

Annex 8.1 Worksheets IM Step 5. Adoption and Implementation

WORKSHEET 5.1 Involve relevant stakeholders in planning adoption and implementation

Annex 8.2 Outline Documentation Step 5. Adoption and Implementation

Annex 8.3 Examples of change objectives for adoption and implementation

Annex 8.2 Outline Documentation Step 5. Adoption and Implementation

Tasks in pilot implementation and monitoring & evaluation

- When will what be done?
- Who will do what?

Tasks	When	Who
Pre-test of the draft intervention (materials)		
Production of the final intervention materials		
Development of training materials to train implementers		
Training of the implementers Selection Logistics (venue, ...) M&E		
Selection of the intervention groups (i.e, schools, youth groups, community groups, ...)		
Create commitment		
Organise linkage with health services		
Organise linkage with counselling (in or outside school)		
Organise linkage with relevant community programmes		
Make implementation plan for the implementers (who implements when)		

Annex 8.3 Examples of change objectives for adoption and implementation

Behavioural outcomes:

1. **Teachers** involve young people in the learning process so that they are able to make and act out healthy decisions about sexuality
2. **Teachers** teach the new programme according to guidelines provided by the development team
3. **Peer educators** teach the programme according to guidelines provided by the development team
4. **Parents** and the **wider community** support young people to participate in the programme
5. **School administration** supports implementation of the programme

Behavioural Outcome 1. Teachers involve young people in the learning process so that they are able to make and act out healthy decisions about sexuality

At the end of the programme, teachers can ...

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
PO 1 Teachers express support of the programme	<ul style="list-style-type: none"> · Describe the content, assumptions, values and teaching methods of the programme 	<ul style="list-style-type: none"> · Explain that they have an attitude of acceptance towards the programme · Justify the usefulness of the programme 	<ul style="list-style-type: none"> · N.A. 	<ul style="list-style-type: none"> · Describe the norms of other colleagues towards the programme and how this fits with or departs from own norms towards the programme 	<ul style="list-style-type: none"> · Describe how they respond to critical feedback about the programme in a useful manner
PO 2 Teachers discuss sexuality in an open and explicit way	<ul style="list-style-type: none"> · Describe the personal, emotional and socio-cultural issues that makes it difficult to deal with sex openly 	<ul style="list-style-type: none"> · Show self-awareness of own sexuality that would hinder open discussions · Show an attitude of openness towards discussing sexual matters 	<ul style="list-style-type: none"> · N.A. 	<ul style="list-style-type: none"> · Describe the potential negative norms of others (teachers, principal, parents) towards the open discussion of sexuality 	<ul style="list-style-type: none"> · Describe how they would verbally respond to the potentially negative norms towards open discussion of sexuality · Describe step by step how they deal with the behavioural and

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
					emotional manifestations of learners arising from discussions about sex · Describe how they can overcome resistance by learners to speak comfortably about sex
PO 3 Teachers create and maintain a safe environment	<ul style="list-style-type: none"> · Explain what a safe environment means (respect, confidentiality, boundaries) · Describe strategies of how to create and maintain a safe environment for learners 	<ul style="list-style-type: none"> · Show they value engagement with learners · Describe they have an attitude of respect towards learners · Describe they have an attitude of acceptance of learners' individuality · Verbally justify the importance of creating a safe environment for learners 	<ul style="list-style-type: none"> · Explain that boundaries are necessary to ensure safe environment in which to engage in sexual matters for both learner and teacher 	<ul style="list-style-type: none"> · Describe the norms of others (teachers, principal, parents) towards a safe environment for learners 	<ul style="list-style-type: none"> · Describe how they use listening skills so that all learners feel included · Explain how they manage learners' emotional fallout · Explain how they set and enforce boundaries in a respectful manner · Recognise threats to a safe environment and have skills to mobilise resources to correct the situation

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
<p>PO 4</p> <p>Teachers teach in a non-judgemental manner</p>	<ul style="list-style-type: none"> · Explain how easily personal values, feelings and beliefs about sexuality can be transferred during teaching · Describe the diverse value positions that learners may represent 	<ul style="list-style-type: none"> · Display a willingness to explore own values · Display willingness to explore discomforts around sexuality issues that may impact on teaching. · Express an accepting and open attitude towards teenage sexuality 	<ul style="list-style-type: none"> · Displays willingness to explore own vulnerability towards sexual health problems 	<ul style="list-style-type: none"> · Describe values of others related to sexuality in general and teenage sexuality in particular 	<ul style="list-style-type: none"> · Demonstrate ability to explore own values and can discuss these objectively · Engage and discuss the tensions between own and others' value positions regarding sexuality and teenage sexuality · Acknowledge own values that may impact on teaching situation and explain how he/she will deal with this
<p>PO 5</p> <p>Teachers apply participatory learning principles in classroom</p>	<ul style="list-style-type: none"> · Explain that teaching sexuality requires a participatory (democratic) style of teaching · Describe that teaching in a participatory style presupposes a sense of comfort with own sexuality · Explain what participatory learning is and can list different kinds of participatory learning approaches · Explain how roles shift in 	<ul style="list-style-type: none"> · Express open attitude towards learners and towards sexuality. · Express flexible attitude (can accommodate differences) · Explain that they take the contributions of YP seriously · Express awareness of own sexuality. · Express awareness of risks for gender bias · Explain how own values might impact on programme delivery 	<ul style="list-style-type: none"> · Acknowledge own vulnerability to sexual health problems and the impact of this on learners 	<ul style="list-style-type: none"> · Describe values of others related to sexuality in general and teenage sexuality in particular 	<ul style="list-style-type: none"> · Demonstrate conflict management, facilitation, and group dynamics skills · Explain how they manage the emotional fall out of learners · Describe how they can empower YP and encourage them to participate · Demonstrate how to use and apply participatory learning strategies · Explain how to practice flexibility in teaching,

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
	participatory learning Describe that participatory learning approach can only be effectively applied within certain parameters of safety, openness and physical setting				i.e. can switch strategies, roles where necessary

Behavioural outcome 2. Teachers teach the new programme according to guidelines provided by the development team

At the end of the programme, teachers can ...

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
PO 1 Teachers read the instructions for each session of the programme in the teacher manual	· Explain that for each session, the development team has provided an instruction	· Express that they find it important to take time for reading the instructions for each session	·	· Explain from whom they would ask advice for the implementation in case of any questions	·
PO 2 Teachers also teach the more difficult activities in the programme	· Describe the activities they find more difficult to teach in the programme	· Convince others that exact implementation according the teacher manual is critical for creating change among their students	· Express awareness of their own barriers in implementing particular activities in the programme	· Explain who can help them in case of difficulties	· Explain how they will deal with difficult activities in the programme and think of creative alternatives
PO 3 Teachers seek help when they find particular activities difficult to teach	·	· Explain that it is important to seek help if they find particular activities difficult to teach · Explain that asking for help is not a sign of failure but of strength	· Express awareness of their own barriers in implementing particular activities in the programme	· List 3 persons who can assist them when they have questions about the programme activities · Express that they feel supported by other teachers who also implement the same programme	·

Behavioural outcome 3. Peer educators teach the programme according to guidelines provided by the development team

At the end of the programme, peer educators can ...

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
PO 1 Peer educators discuss sexuality in an open and explicit way	<ul style="list-style-type: none"> · State that every person has the right to think and believe what he or she wants · Describe the right time and setting to talk with peers about sensitive issues · Explain that what they tell other people is only effective if they behave according to what they say 	<ul style="list-style-type: none"> · Express that each person is unique and has a right to take his/her own decisions · Express an open, honest, non-judgemental attitude towards other people when talking about sexuality · Emphasize the importance of keeping private and confidential things they have been told in confidence 		<ul style="list-style-type: none"> · Show awareness of the positive and negative influences of peers · Demonstrate how to cope with peer pressure, while sticking to their own opinions 	<ul style="list-style-type: none"> · Provide a scenario for when, how and what they will share with peers · Demonstrate they respect the rights of other people and support peers in decision-making
PO 2 Peer educators seek help when they find particular activities difficult to teach	<ul style="list-style-type: none"> · Explain that, in educating other people, they should only pass on information they are sure of and do so in an honest, open and non-judgemental way 	<ul style="list-style-type: none"> · Emphasize the importance of the guidelines presented in this lesson when they discuss issues with peers 			

Behavioural outcome 4. Parents and the wider community support young people to participate in the programme

At the end of the programme, the community can...

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
PO 1 Parents allow young people to attend the sexuality education sessions	<ul style="list-style-type: none"> Describe how this will improve the well being of children. List how otherwise adolescent might get wrong information 		<ul style="list-style-type: none"> Explain how lack of education will make children less aware of SRH. 	<ul style="list-style-type: none"> Convinced that it is better for the children. Argue that it is timely for children to know of reproduction and body changes. 	
PO 2 Parents discuss sexuality related issues with their children	<ul style="list-style-type: none"> Children need to share their emotional and physical concern with responsible persons. 	<ul style="list-style-type: none"> Recognise that it is okay to encourage children to talk on such topic. 	<ul style="list-style-type: none"> Delay in sharing of problem will affect health and study. 	<ul style="list-style-type: none"> Describe the social norms around it. 	<ul style="list-style-type: none"> Describe the scenario when it will be possible to talk to children.

Behavioural outcome 5. School administration supports implementation of the programme

At the end of the programme, school administrations can...

PERFORMANCE OBJECTIVES	DETERMINANTS				
	KNOWLEDGE	ATTITUDE	RISK PERCEPTION	SOCIAL INFLUENCE	SKILLS & SELF-EFFICACY
PO 1 School administration encourages teachers to implement the programme	<ul style="list-style-type: none"> · Explain the major topics and approaches of the programme 	<ul style="list-style-type: none"> · Describe the need for the sexuality education programme · Explain that both male and female teachers need to be implementing teachers 	<ul style="list-style-type: none"> · 	<ul style="list-style-type: none"> · Express that they experience support of other schools and the Ministry of Education to implement the programme 	<ul style="list-style-type: none"> · Explain step by step how they convince teachers to implement the programme in the school
PO 2 School administration provides resources (time, venue, funds, ...) for implementation of the programme	<ul style="list-style-type: none"> · 	<ul style="list-style-type: none"> · Express that they are convinced of the importance of the programme 	<ul style="list-style-type: none"> · 	<ul style="list-style-type: none"> · 	<ul style="list-style-type: none"> ·
PO 3 School administration encourages/ organises teacher support meetings	<ul style="list-style-type: none"> · Describe what is needed to organise support for teachers to function in the most optimal way 	<ul style="list-style-type: none"> · Express that they are convinced of the importance of the programme 	<ul style="list-style-type: none"> · 	<ul style="list-style-type: none"> · 	<ul style="list-style-type: none"> ·

9. Step 6. Monitoring and Evaluation

Steps in Intervention Mapping

1. Involvement
2. Needs Assessment/ Situation Analysis
3. Objectives
4. Evidence-Based Intervention Design
5. Adoption & Implementation
- 6. Monitoring & Evaluation**

Where are we in Intervention Mapping?

When the programme is implemented, planners like to assess whether this is done the way they had intended, and they like to know whether the programme makes any difference (is effective).

In Step 6, planners make a plan for monitoring and evaluation of the programme and its implementation. We distinguish between the pilot implementation and sustainable implementation, as these are two different phases in intervention planning. Usually, the number of students and implementers is large enough during the sustainable implementation, to measure the effect of the intervention in a quantitative way. In the pilot phase the emphasis is on the monitoring of implementation and analyse what can be improved about the programme.

The last step in Intervention Mapping is the development of a plan for monitoring and evaluation (M&E). M&E should be an integral component of any school-based sexual health programme, in order to assess whether the programme is appropriate and acceptable, whether it is achieving the objectives, and thus whether it contributes to a reduction of the magnitude of the various SRH problems of young people.

The product of this step is an evaluation plan, which includes the evaluation questions (purpose of the evaluation), design, indicators and measures, and timing of the measures. The plan also includes how the resulting data will be analysed and presented to the stakeholders. Finally, the plan outlines the resources required to conduct the evaluation.

The Internet provides many resources that can help planners in creating a monitoring and evaluation plan.^{1;2} One of the evaluation methods that are used by international NGOs is the 'Most Significant Change' method, a qualitative method to measure change in the community.³

Some organisations decide to collaborate with a (local) consultant. In this case, clear instructions and expected outcomes are important to communicate with the consultant.

Planners complete a number of tasks to plan monitoring and evaluation:

- | | |
|----------|--|
| Task 6.1 | Involve relevant stakeholders |
| Task 6.2 | Decide about the scope of the evaluation |
| Task 6.3 | Write questions |
| Task 6.4 | Monitoring |
| Task 6.5 | Outcome evaluation |
| Task 6.6 | Write report and use findings |

Related to the description of the purpose of an evaluation, we can distinguish between formative and summative evaluation:

- *Formative evaluation* is done to obtain information to guide program development or improvement
- Primary purpose of a *summative evaluation* is to make a judgement on whether a program met its goals and objectives⁴

In the *process* and *outcome evaluation*, intervention planners determine whether the intervention was or was not successful in meeting programme goals and objectives (outcome) and why the intervention was or was not successful (process).

- *Outcome evaluation*, sometimes referred to as *impact* or *effect evaluation*, describes the differences in outcomes with and without the program. Possible outcomes of interest include health indicators, behaviours and determinants of behaviour. Outcome evaluation involves determining if these factors change as a result of the intervention, which usually means comparing the group that received the program (intervention group) to one that did not (control group).⁵
- *Process evaluation* involves several aspects of program design and implementation to determine why an intervention was or was not successful. Process evaluation aims to provide information about two aspects: program implementation and explanations why the intervention is implemented the way it is implemented. *Fidelity* is the extent to which the intervention was delivered as intended and *reach* is the proportion of the intended audience to whom the program is actually delivered.⁶

9.1 Task 6.1 Involve relevant stakeholders

An important goal of every evaluation should be that the results are used by someone. To ensure this, the evaluator must engage the attention of the evaluation stakeholders, including program consumers, donors, planners, and implementers.

Our experience is also, especially in case of an external evaluation (conducted by an external organisation), that it is very crucial to have the commitment of the implementing organisation from the start. This increases the commitment to collaborate in data collection but also the commitment to do something with the conclusions of the evaluation study.

PLANNING PHASE	STAKEHOLDERS	TASKS
6 Monitoring & Evaluation	a. Planning group	<ul style="list-style-type: none"> · Conduct the evaluation study · Involve evaluation experts if needed · Organise involvement other stakeholders
	b. Working group young people	<ul style="list-style-type: none"> · Involved in the planning of evaluation and if needed in the collection of information
	c. Working group teachers	<ul style="list-style-type: none"> · Involved in planning of the evaluation
	d. Advisory board	<ul style="list-style-type: none"> · Involved in planning of the evaluation
	e. Others · Researchers and research assistants	<ul style="list-style-type: none"> · If needed provide additional expertise in conducting evaluation of behaviour change interventions

In order to create ownership among the working groups and advisory board, it is important to involve them in monitoring and evaluation. It depends on the scope of the M&E plan what their role

will be. This may vary from just informing them that M&E takes place, or actively involving them in this exercise, for instance, involving the working group of young people as research assistants or asking their advice for how to collect the information from young people in the most optimal way.

If M&E is conducted by an external evaluator, he/she should be thoroughly briefed about the project and the intervention, and the planning process. The researcher has to know the programme very well, particularly the objectives as they were stated for the 'core' intervention for young people, as well as the objectives for adoption and implementation interventions.

9.2 Task 6.2 Decide about the scope of monitoring and evaluation

The scope of the monitoring and evaluation often depends on a lot of factors, including the purpose of M&E, the project stage (pilot, up scaling, sustainability), and available resources and the timeframe for expected effects.

9.2.1 Purpose of Monitoring and Evaluation

To clarify the purpose of M&E, planners can first consult relevant stakeholders. Most likely, the main purpose of M&E will be to see whether the objectives of the programme are achieved, either on the level of implementation, but also on the level of the promotion of young people's decision-making and healthy behaviour. The M&E may lead to an adaptation of the intervention materials and activities.

One of the stakeholders could be the donor agency. Most donor agencies require that organisations monitor and evaluate their programmes. It is useful to have an idea what the donor agency would like to see in the M&E plan. If the purpose is to inform donors about the progress and effect of a certain program, the evaluation might be done differently than when its main purpose is to improve the program in terms of activities.

Another purpose of M&E may be to have evidence to use of lobby and advocacy for the programme. For example, to be able to mainstream the sexuality education curriculum into the regular curriculum in schools. Or to convince schools to adopt the programme and implement it in their schools.

9.2.2 Project stage (pilot, up scaling, sustainable implementation)

In this chapter, we distinguish between the M&E of the pilot implementation and the M&E of up scaling or sustainable implementation. During pilot implementation, planners particularly focus on intensive monitoring of the implementation process and may also measure whether there is change in knowledge, attitude, skills (determinants). Our experience, however, is that in practice the number of schools and students is relatively small in pilot implementation, which makes it difficult to draw reliable conclusions about the impact of the programme on determinants (and behaviour) of young people.

During the years, during or before sustainable implementation, this is much easier. Larger numbers of people participate in the programme. The focus goes to impact evaluation and less on intensive monitoring, although planners should also keep records of the implementation.

Phase	Monitoring & Evaluation
1. Pilot implementation	Intensive monitoring of pilot implementation
	Basic outcome evaluation
2. Sustainable implementation	Regular monitoring
	Intensive outcome evaluation (behaviour change among young people)
	Teacher support evaluation (teaching performance of teachers)

9.2.3 Time frame for expected effects

The scope of the evaluation (both outcome and process evaluation) depends to a large extent on the available resources.⁷ Especially outcome evaluation studies can involve a lot of time, budget, and technical expertise to be able to conduct the studies. Planners therefore have to decide whether an effect study does meet the objectives of their evaluation or not and fits within available resources.

Outcome evaluation among students

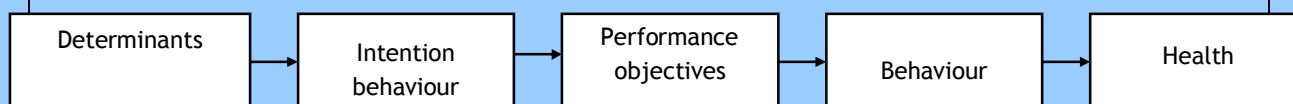
Having a clear understanding of the time frame for being able to create certain programme outcomes is important to making sure that the expectations for measuring programme effects in an evaluation are realistic. Some programme donors, planners and other stakeholders are satisfied with positive outcomes in the process evaluation, such as participation of the at-risk group; others will not be satisfied until they see evidence of a relevant reduction in the health problem and improvement in quality of life.

Literature on learning about language and mathematics in the Netherlands however shows that only approximately 15% of what students learn, can be explained by school factors. The other 85% young people learn at home, from friends, media and other sources in the community young people live. As a result, programme planners have to be realistic in what they expect from implementation of a programme and the results they will find in an evaluation of their sexuality education programme with regard to behaviour change and determinants.

Determining the evaluation questions requires thinking about the time frame for expected effects. For instance, health and quality-of-life outcomes for a school based sexuality education programme to prevent HIV, STIs and pregnancy, can hardly be evaluated because of the timing of expected effects from the programme.

If a programme is designed to reach students before they begin having sexual intercourse, changes in behaviour are outside the timeframe for an initial programme evaluation. The behaviour of interest is expected to occur a year or more from the time of the programme. Therefore, behaviour change is not an appropriate short-term evaluation goal, even though it is part of the programme logic model. The short-term impacts that programme developers can expect are changes in determinants, such as increased knowledge, skills development and increased self-efficacy.

Looking again at the logic model underlying behaviour change communication, evaluation also follows this sequence. The higher the level of objectives (e.g. health), the more precise impact can be measured. This however depends highly on available resources (time, funding, expertise).



Health. Ideally, the evaluation measures impact on the level of health change: reduction of new HIV infections, reduction of new STI infections, reduction of unwanted teenage pregnancies, etc. It is however rather difficult to measure on this level, especially attributing the changes to a particular sexuality education intervention.

Behaviour. Measuring on the level of behaviour is also not very easy. One may try to measure whether condom use among sexually active young people has increased, and whether age of onset sexual intercourse is increased.

Performance objectives. A more easy to attain design would be the measurement of performance objectives, predictors of actual behaviour. Performance objectives are sub-behaviours of the defined behaviours and a relatively good predictor of actual behaviour change (for condom use, but also for delay/abstinence?).

Intention. The intention towards behaviour can also be measured. This can be done in a pre-test - post-test design. Intention is a relatively good predictor of change in performance objectives and behaviour change.

Determinants. Determinants of behaviours (and/or performance objectives) can be measured, and include: knowledge, risk perception, attitudes, perceived social influence, skills and self-efficacy, although the two latter are relatively difficult to measure. This can be done in a pre-test - post-test design.

The evaluation should be realistic and take into account the complexity in influencing a health problem. First, intervention outcomes require time to develop. For example, skills training and self efficacy building with regard to condom use, may require some years and experience.

Secondly, health education is often directed at people's future behaviour at a time when a risk behaviour has not yet emerged. For example, sexuality education programs often aim to reach young people who are not yet sexually active. In this case the desired changes may become observable only years after the intervention. Third, the intervention itself needs time, especially when the intervention is targeted for long-term change, such as empowerment and community development.⁸

9.2.4 Ethical considerations

If needed, planners need to obtain ethical clearance to be able to collect information from young people or others. Parents may need to be informed about the evaluation study. This is different for each country or research setting (e.g., conducted by research institute or university), but needs to be secured.

9.3 Task 6.3 Write questions

The third task is to state questions both for monitoring (process evaluation) and the effect evaluation. Planners first look at the objectives that they have stated in IM Step 3 Objectives and in IM Step 5 Pilot Adoption and Implementation. And they state the indicators: when do planners think that the programme has been successful with regard to improved determinants?

9.3.1 Outcome evaluation

Questions related to outcome evaluation are concerned with the programme objectives and determinants and behavioural and environmental outcomes. ‘What changes in behaviour and environmental conditions were achieved? What changes did the program create in the hypothesized determinants of the behaviour or the environmental condition? And were there differences between certain sub-groups (i.e., different age groups, between girls and boys, rural or urban, etc.)?’

If the programme was well implemented and the design assumptions were met, the health educators can expect changes in programme objectives. In other words, they can expect to observe changing in knowledge, skills, risk awareness and self-efficacy of students. Evidence shows that when these determinants have changed and the ‘logic model’ is strong and evidence-based, a change in determinants is a prediction of behaviour change (e.g., condom use). This in turn predicts an improvement of people’s sexual and reproductive health and rights.

On the internet you can find quite a number of documents with suggestions for indicators.^{9;10} One of the limitations however is that most documents focus on indicators for measuring success on national level or of programmes that have been implemented on a large scale. Another limitation is that many documents focus on HIV/AIDS and less on the comprehensive scope of SRHR.

9.3.2 Process evaluation

In contrast to outcome evaluation, which makes comparisons between groups, process evaluation is concerned with the group that received the intervention. Part of process evaluation can be to measure efficiency of the intervention, meaning whether costs and benefits of the program are balancing. For example, when a very costly program reaches a relatively small number of students, the program is not efficient.

Programme implementation questions include, ‘is the program being delivered to the persons for whom it was intended (in our case to students)? Is the program being delivered in a form that maintains fidelity to its original design (have teachers done the activities according to the initial purposes of intervention planners?)?’

This aspect of evaluation also includes whether theoretical methods have been appropriately operationalised in the program activities. Process evaluation also attempts to describe the program, organisational, and implementation factors related to why an intervention is implemented in a certain way. For example, a sexuality education program can be well designed but not well implemented because the teachers have not been trained well enough to do certain activities, or because intervention planners have misjudged the actual needs of young people.

In sexuality education programs for schools, the first evaluation issue would be to determine if the program is implemented completely and correctly. After that, evaluators can explore whether

execution of the program met assumptions made in program design, including selection of theoretical methods and activities.

Some examples of questions to be answered by monitoring/ process evaluation:

- To which extent was the intervention designed in such a way that it meets the characteristics of effective interventions?¹¹ Both looking the way the intervention was designed (process) and the content of the programme
- How many young people have completed the whole intervention? And what were reasons for drop-out?
- Actual implementation of the intervention activities by facilitators. Did they implement all activities as designed? Why (not)?

9.4 Task 6.4 Monitoring/ process evaluation

The process evaluation carefully checks all the decisions and assumptions that the program developers have made within the Intervention Mapping process. That information is essential for the interpretation of the outcomes of the effect evaluation. If the program fails to show an intervention effect, the process evaluation data can help determine why the program failed. It is very important to the field of health education and health promotion that planners critically analyse programs that are not effective, to learn from these programs and share the learning with other intervention planners.

Process evaluation generally focuses on three categories of questions: fidelity and reach of the program, reasons for fidelity and reach, and an exploration of theoretical methods and activities. The first task in asking process questions is to fully describe the program that should be delivered. What is each program component? What are the program support materials? What is entailed in complete and acceptable delivery of the program? How should the program methods be translated in order to ensure that they produce change?

Process evaluation questions related to the program *reach* would include: what proportion of the intended groups are participating in the program? Are any students who are not members of the intended groups participating in the program? How much of the program are the intended participants receiving? Are the people receiving the program representative of the intended populations? Questions related to *fidelity* (to what extent is the intervention done as was intended in the program plan?) could include questions such as: are the type of teachers delivering the program those specified in the plan? Do the staff have available program materials? Is time scheduled for the program? Is the protocol followed in program delivery? How often is the protocol, or parts of the protocol omitted? Which parts are omitted? In programs for sexuality education teachers can be asked about program adoption and use¹². To what extent they are familiar with the program and whether teachers used the program. Fidelity can be assessed with the question how they did use the program. They were also asked whether they had used other materials along with the program materials.

The evaluator will want explanatory data for the extent and fidelity of implementation. What barriers were there for implementation? For example in the evaluation of a Dutch AIDS program,^{13,14} teachers were asked questions that could explain implementation failure, such as 'Is AIDS prevention a structural part of your curriculum?' 'The program is sufficiently flexible to be used in classes with substantially different subgroups'.

Evaluators do not assess the effects here, but the judgements, such as satisfaction, positive emotional reaction to the materials, an understanding of the message, whether the program was of help, or conversations with peers about the program.

9.4.1 Process evaluation design

Qualitative methods that can be used for process evaluation include case studies, focus groups, interviews, observations, document review, and open-ended surveys. Also the data obtained using qualitative methods must bear scrutiny in terms of reliability and validity. Credibility of findings is increased through prolonged engagement, through the investment of sufficient time to understand the phenomenon being studied, through persistent observation to understand what aspects of the situation are most relevant, and through triangulation of sources, methods, investigators, and theories.

Box 9.3 Data collection tools

Why (objective)	Completed by	When	How (tools)
· Impact of intervention on determinants of young people's SRHR related behaviour	Students	Before and after implementation	Short questionnaire knowledge, attitude, confidence, skills
· How do young people think about the programme (content, layout, etc.)	Students	During implementation	Lesson evaluation form Focus group discussions In depth interviews
· Impact of teacher training and implementation on determinants of teaching behaviour	Teachers	Before and after teacher training, after implementation	Short questionnaire knowledge, attitude, confidence, skills
	Staff implementing organisation	During implementation	Observation form
	Students	During/ after implementation	Focus group discussion In depth interviews
· How do teachers think about the programme (implementability, content, layout, etc.)	Teachers	During implementation	Lesson evaluation form

9.4.2 Develop data collection tools

To be able to collect the information, planners develop data collection tools. For example, they can develop a tool to conduct observation of teachers and students during implementation. Or develop an outline for conducting focus group discussions and/or in depth interviews with students, teachers, school administration, parents/community.

9.4.3 Select the sample

After developing the tools and if necessary training of the data collectors, planners can select the people among whom the information about implementation is collected.

9.5 Task 6.5 Outcome evaluation

The magnitude of the evaluation depends to a large extent on what an organisation will do with the results of the evaluation study. More and more, donor organisation want implementing organisations to measure the impact of the intervention on behaviour change of young people.

In this manual we do not provide information about how to measure the impact on health level. It is very difficult to measure whether a programme has had effect on decrease in HIV-infections, STI-infections, pregnancy rates or sexual abuse or stigma. This usually requires a design which needs a lot of resources, including time, people, funding.

In an effect evaluation the purpose of a design is to enable the evaluator to answer two questions: 'How do indicators of desired program effects compare before and after the program?' and 'Can changes noted be attributed to the intervention being evaluated?' The first question requires a design in which the evaluators measure program outcomes before the program is implemented (usually referred to as baseline or pre-test measures) as well as after the program has been conducted (follow-up or post-test measures). Sometimes multiple follow-up measures are made to monitor how long it takes for change to take place or how long change is sustained once it does occur.

However, change in the outcome measures over time may result from influences other than the health promotion program being evaluated. Thus the second question and the need for designs that include a comparison group. The evaluator needs to know if there is a difference between people participating in the program and those not participating. This added feature leads to a design containing pre- and post-program measures in exposed and non-exposed groups. An important methodological principle in program effect evaluation is ensuring comparability between treatment and control groups on all factors that may influence the outcomes of interest. This principle is most easily adhered to by using an experimental design with random assignment of participants to the intervention and control group.

9.5.1 Outcome evaluation design

Ideally, an impact evaluation is done with intervention and control groups and among a sufficient number of students as recipients, to be able to come up with significant data. The data are reported data, and are not necessarily the actual behaviour. Everything should be done to make the recipients most comfortable to be open about their real behaviour and experiences. For example, by making the questionnaire anonymous, asking the questions in a correct way, by pre-testing the questionnaire to find out whether it reveals the information that is needed.¹⁵

The intervention objectives are the most specific objectives for program development *and* for the effect evaluation. The matrices that are created for program development can also be used for program evaluation, specifying objectives for each determinant. For example, if program objectives for adolescents include skills on all sub-behaviours of condom use (i.e., buying condoms, negotiating use with partner, maintaining condom use), then the *measurement blueprint* (initial list of questions to be used for final development of the evaluation instrument) includes skills program objectives for all these sub-behaviours. However, the evaluator must go to the literature on skills to determine how the construct is typically measured and use this literature as a guide for the actual instrument development.

Submission of a questionnaire to students before and after implementation of the curriculum can be used to measure whether the intervention is effective in changing behaviour and determinants

(including knowledge, risk perception, attitude, social influence and skills). See Annex 24 for a questionnaire measuring behaviour & determinants with 100 multiple-choice questions.

This can be assessed among students who have been exposed to the intervention (intervention group) and students who have not (comparison group). A questionnaire is distributed before exposure to the intervention (baseline study), and after exposure (post-test). Optionally a second post-test can be done after half a year.

9.5.2 Select the sample

The next task is to select the sample for the evaluation study. Planners need to take decisions about the number of students to participate, whether it is possible to select intervention and control groups. The control groups do not receive the intervention at the moment of evaluation, but should be offered to also participate in the programme after the evaluation is finished.

Sometimes evaluators want to find out whether their intervention is more successful than the standard program or practice. In this situation, the control condition is not a condition without a program, but a condition with the usual program. The evaluators are estimating program effects for the new program compared to usual care or practice. This group is usually called a comparison group rather than a control group.

Box 9.4 Randomisation

Ideally, planners include intervention and control schools in their design, and randomise these. This means that beforehand, the schools and the planners do not know which schools are getting the intervention and which schools do not. The aim of randomisation is that this excludes bias. Without randomisation, differences between intervention and control schools could be explained by the fact that the intervention schools are already more willing to implement the programme, which may influence the performance of students. Ideally, whether a school is an intervention or control school, should therefore be a coincidence.

In academic experiments it is possible to include this condition in the evaluation design. In the implementation practice, however, this is hardly possible, because it means that schools do not know beforehand whether they are part of the intervention or control group. In practice, however, organisations have to plan with schools for the implementation of the intervention.

9.5.3 Develop evaluation instruments

A large number of evaluation instruments is already available for the evaluation of sexuality education programmes for young people. It is therefore advisable to collect existing instruments and adapt these, depending on the questions of Task 7.3.¹⁶

For the design of instruments to measure sexual behaviour and determinants of behaviour, planners use the following ‘rule’: with 2 questions for each determinants (knowledge, attitude, self-efficacy, social influence) of one behaviour can be questioned. This means that in addition to some questions related to previous behaviour and intention towards behaviour, 15 questions are needed to assess the determinants of one behaviour.

9.6 Task 6.6 Write report and use findings

The outcomes of the evaluation are used for different purposes, depending on the objectives of the evaluation. The outcomes can be used to promote the further adoption and dissemination of the programme on a wider scale, for example by presenting the outcomes during the official launch of the final curriculum. The outcomes can also be disseminated to the participants in the research (teachers and students), to stakeholders of the project, and the donor organisation.

In case the evaluation requires improvement of the curriculum, the outcomes of the evaluation can be used to adapt the final curriculum.

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