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Education Matters: Empowering Young People to Make Healthier Choices

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Input Paper

Siegrid Tautz

Director of evaplan at the University of Heidelberg
& Consultant in International Health

Germany

The impact of sexuality education would consist in improved health outcomes such as a decrease in the new infection rate (incidence) of sexually transmitted infections including HIV, a reduction of unplanned (teenage) pregnancies, a lower rate of complications of unsafe abortion, among others. This would have to be preceded by behaviour change (possibly as an outcome) of a sexuality education intervention.

A key prerequisite for monitoring changes and evaluating results is a situation analysis as a baseline before the intervention begins. In reality, many sexuality education interventions do not conduct an initial systematic situation analysis such as a KAP survey; hence face the challenge of having to prove their success at a later stage.

However, even if a baseline exists, it is difficult to attribute changes in knowledge, attitudes and particularly, behaviour, let alone impact (health outcomes) to one specific intervention given the fact that it is not implemented in a vacuum; young people may be exposed to other sources of information or interventions and societal change as a whole. There may also be unexpected effects by unfavourable social and political developments (e.g. emergency situations and resulting vulnerabilities particularly of young people).

Still, for accountability sake and for being able to learn from M&E, and adjust interventions respectively, RBM and evaluation are essential. How can results at various levels be assessed in a down-to-earth way? Here, an important prerequisite is a set of indicators with SMART properties (Specific, Measurable, Achievable, Relevant, Time-Bound). The results hierarchy used in German development cooperation presents a useful logic: an intervention's activities (e.g. training, curricula/manual development,) result in products/services (appropriate curricula, YFS); the utilization of such products (e.g. SRH peer education/learning groups) ideally leads to results at the level of the project objective (e.g. increased knowledge, changed attitudes and behavior). These should be able to be related plausibly to the project's products and services. The desired impact (improved health) is at a higher and long term level; many actors and circumstances contribute to its achievement.

A recent evaluation of DSW's Youth-to-Youth Initiative applied the approach below. Since more than ten years DSW supports ASRH projects in Africa and Asia in order to help young people to protect themselves from unwanted pregnancies, sexually transmitted infections (STI) and HIV. To date, the Youth-to-Youth Initiative (Y2Y) has led to the establishment of over 600 youth clubs and their networks in four East African countries: Ethiopia, Kenya, Uganda and Tanzania, with over 30,000 members, and reaching many other young people and their communities with SRH information and services. Over the years the Y2Y initiative evolved from an intervention predominantly focused on SRH issues to a more holistic approach incorporating ASRH issues, economic empowerment, capacity building in leadership and management skills, among others.

This study took place from 27th April to 11th May 2011 in Ethiopia and Kenya. The aim was to assess the results of the Y2Y-Initiative for young people with an emphasis on gender equality in the project regions both at individual level for participating young women and men as well as at the level of potentially changed perceptions of, and attitudes towards young people, in particular women, in their social environment. This study was not an impact study in a rigorous sense as there is no baseline nor control group which could have allowed

separating Y2Y influences from other influences through media, schools etc. The approach was largely qualitative and included semi-structured individual and group interviews. Respondents included young people of both sexes from various levels: peer educators and leaders, peer club members, key informants from local government and the ministries of health and youth. Some adjustments and trade-offs had to be made in the field.

The contributions DSW's Y2Y Initiative has made towards informing and educating young people about SRH and rights, and to developing their own capacity in many ways are considered important at all levels: by themselves, representatives of local government and health professionals as well as at policy level. The development and empowerment many of the young people who are/were part of Y2Y initiative experienced spans from the acquisition of potentially life-saving knowledge or at least have essential implications for their health and future lives to multiple skills such as communication (interpersonal and a strategic approach to community interaction), leadership, (self)-management, artistic skills, practical skills for income generation, and conflict management.

Looked at Y2Y through a "gender lense", results are positive at various levels: DSW promotes equal participation of girls in training, club membership and club leadership. Particularly girls related the life skills and the self-esteem they now enjoy to the club experience and to the comprehensive training opportunities of the Y2Y programme that helped them to develop their whole personality, and in a number of cases, to provide for themselves and their families through self-generated income. Equally impressive is the courage and commitment young women - supported by some of their male peers - show in their fight for women's rights and against HTP and GBV, both in Ethiopia and in Kenya. Here, human rights training opportunities through other organisations (in Kenya) create synergies with the Y2Y capacity building components.

In terms of health benefits, it is important to note that the information presented covers perceived and reported changes related to health. No health information data at the level of relevant catchment areas could be accessed for the purpose of this evaluation and it is not shared routinely with the peer learning clubs. Apart from a general increase of knowledge and improved attitudes regarding SRHR including HIV among young people and in their communities, effects were reported by both young people and key informants from the health sector regarding increased demand for condoms, increased uptake of HIV testing, as well as of modern contraception. Overall, young people were reported to access health services more.

At policy level DSW's role as a catalyst of young people's influence on formulation of strategies and policies by facilitating youth participation was emphasized as well as DSW's contribution by representation in different fora and technical working groups in both countries. As a result, the overall impact of the Y2Y Initiative appears important.

In conclusion, there is a need to expand the so far largely output-based monitoring system towards more results-based monitoring and evaluation at different levels. This may include knowledge-attitude-practice (KAP) surveys at peer level (in new intervention areas as baseline, and as follow-ups); complementing output-based monitoring with more process-oriented data qualitative/quantitative); and establishing feedback mechanisms for relevant health information data to club leadership in districts. And, above all, there is a need to formulate objectives and result indicators for future results-based monitoring and evaluation. The RBM system should be as much as possible harmonized with that of other stakeholders

from ministries and development partners including NGOs. In almost all countries there are technical working groups and policy fora, in which all pertinent stakeholders participate. These are commonly under the guidance of the ministries of health/divisions of adolescent sexual and reproductive health. These fora constitute the opportunity of harmonizing monitoring and evaluation systems.