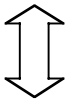
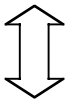
UNICEF, New York
Go to- http://www.unicef.org/programme/lifeskills/
Background 1.

What is the link?

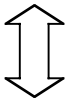
Child-friendly Schools



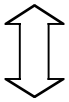
FRESH



Health Promoting Schools



Skills-based health education



Life skills

Background 2.

Child-friendly Schools

Quality learners: healthy, well-nourished, ready to learn, and supported by their family and community

Quality content: curricula and materials for literacy, numeracy, knowledge, attitudes, and skills for life

Quality teaching-learning processes: child-centred; (life)skills-based approaches, technology

Quality learning environments: policies and practices,facilities (classrooms, water, sanitation); services (safety, physical and psycho-social health)

Quality outcomes: knowledge, attitudes and skills; suitable assessment, at classroom and national levels

*And **gender-sensitive** throughout*

Child-centred and Child-seeking

- **Healthy & protective**
- **Effective for learning**
- **Inclusive**
- **Involved** with families and communities and children
- **Gender sensitive**

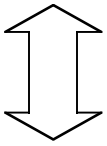
Background 3.

F.R.E.S.H.

Focusing Resources on Effective School Health

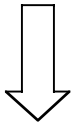
***Water and Sanitation facilities**

Policies **Skills-based health education** **Related services**



Participation and school-community links

What is skills-based health education?



part of

Good quality education

Some criteria
for skills-based health education for HIV/AIDS prevention

- Is **behaviour change** part of the program goal?
- Is there a balance of **knowledge, attitudes & skills**?
- Are **participatory methods** for teaching & learning used?
- Is it planned around **student needs**?
- Is it **gender sensitive throughout**?

Purpose

Reinforce existing……..Prevent or reduce

Accurate and relevant knowledge **Positive attitudes** **Pro-social and health related skills**	**Myths & misinformation** **Anti-social attitudes** **Risks related to harmful behaviours**

Two main elements of skills-based health education

CONTENT	METHODS
The content area/s	The methods for teaching & learning

Handout 5

Content
Skills-based health education for HIV/AIDS prevention

1. Knowledge	2. Attitudes	3. Skills
about what?	towards what?	for what?
Transmission & Non-transmission Protection & Prevention Personal risk Prevalence and impact of HIV/AIDS, personal risk, impact of HIV, what works?… STDs, (intravenous) drug use, reproductive health, general health Care & support	Social justice/rights, gender, culture, norms, discrimination.. Attitudes & values about self, relationships & sex, HIV+ people, personal risk …. Children affected by HIV, orphans Employment & conditions of PLWA…	(Life Skills) Communication skills - Refusing undesired sex - Resisting pressure to use drugs - Refusing unprotected sex - Insisting on/negotiating protected sex Values analysis and clarification - acting on human rights, such as acting against discrimination Decision making - identifying consequences of decisions and actions - demonstrating critical thinking Stress management & coping - Seeking trusted person for help - Identifying health services

These are also the expected
Learning Outcomes

Handout 6

Examples of Life skills

Communication Skills	Values Analysis & Clarification Skills	Decision-Making Skills	Coping & Stress Managemt Skills
Empathy building Active listening Giving & receiving feedback Non/Verbal Communication Assertion, resistance & refusal skills Negotiation & conflict managemt Cooperation & Teamwork Advocacy skills Relationship & community building skills	Skills for understanding different - social norms, beliefs, myths, ethics, culture, gender, diversity & tolerance, stereotypes, discrimination.. Self assessment skills for identifying what is important, influences on values & attitudes, and aligning values, attitudes & behaviour Skills for acting on discrimination and stereotypes Identifying & acting on rights, responsibilities & social justice	Critical & creative thinking skills Problem solving skills Analytical skills for assessing (personal & other) risks Skills for generating Alternatives Info gathering skills Skills for evaluating information eg. the media Skills for assessing Con-sequences	Self awareness and self control skills Identifying personal strengths &weaknesses Coping with (peer) pressure Time managemt skills Dealing with emotions: grief, anxiety Positive thinking skills Dealing with difficult situations (conflict-also loss, abuse trauma,) Goal setting skills Help seeking skills

METHODS

For effective teaching and learning

child centred, interactive & participatory

- group work & discussions
- brainstorming
- role play
- educational games
- story telling
- debates
- practising (life) skills and skills specific to a particular content area or context with others
- audio & visual activities eg. the arts, music

etc…etc…etc…

Who can facilitate Skills-based health education?

Almost anybody!

- teachers
- young people (peer educators)
- community agencies
- non-government agencies
- religious groups
- parents
- others...

What settings can be used?

Almost anywhere!

- school
- community
- street
- vocational & training
- religious
- existing groups or clubs
- others...

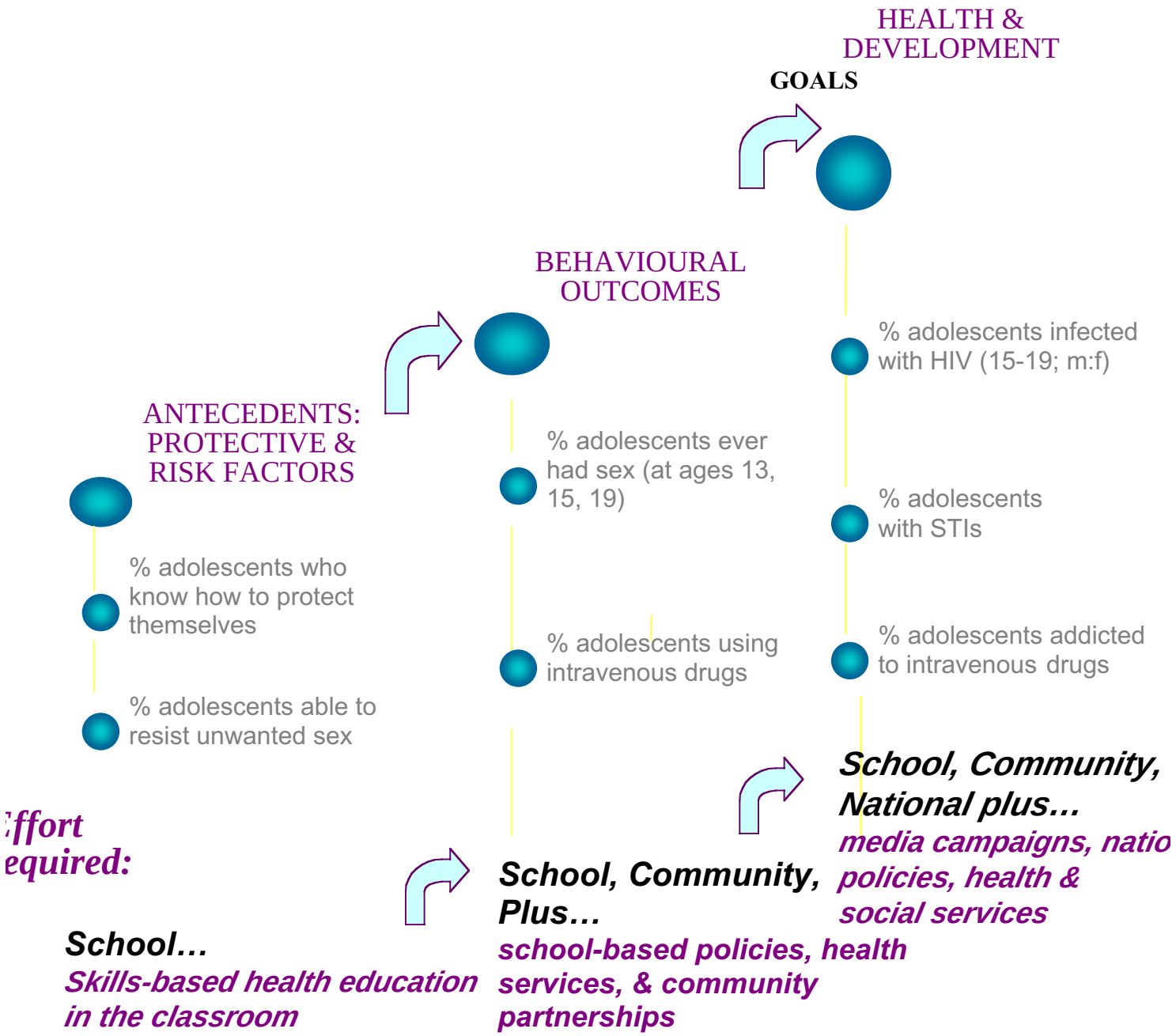
What are the limits of skills-based health education?

Outcome expectations for different levels of programming for HIV/AIDS prevention: single strategies will have more modest results that coordinated multi-strategy programs.

Level	Target	Outcome Examples
Goal many more strategies required to achieve outcomes at this level *eg. all of the strategies below plus public health policy and laws, media campaigns, national leadership and advocacy*	Change in Health Outcome or Health Status ↑	HIV infection rates, STI rates, pregnancy rates
Objective more strategies needed to achieve these more complex and broad outcomes *e.g. classroom education program, related school policies, access to related health services, school-family-school partnerships*	Reduce risk behaviours ↑	delay sex, increase condom use, reduce partners, reduced sharing of needles (IV drug use)
Sub Objective fewer strategies required to achieve relatively specific, immediate outcomes *eg. classroom education program*	Increase knowledge, attitudes and skills ↑	Knowledge: of transmission and prevention Attitudes: that reduce stigmatisation Skills: assertion, decision making, values clarification

What are the limits of skills-based health education?

SBHE cannot do it all, and will work best in the presence of other supportive and consistent strategies.



Evaluation & Indicators

Process Indicators

Outcome Indicators

Immediate

For program

Was the program implemented as intended? (see below)

Did intended knowledge, Attitudes & skills change? (see below)

For facilitators/teachers

Enhanced teaching methodology

Teacher confidence/satisfaction

Teacher Knowledge, Attitudes, Skills (KAS)

For participants

Participation

Satisfaction levels

Learning Outcomes – KAS (Knowledge, Attitudes, Skills)

Medium – Long Term

For program

Was the program implemented as intended? (see below)

Did intended intended behaviour change? (see below)

For facilitators/teachers

Enhanced teaching methodology

Teacher confidence/satisfaction

Teacher Knowledge, Attitudes, Skills (KAS)

Teacher effectiveness: assessed via student outcomes – (KAS/behaviours)

For Participants

- Participation
- Satisfaction levels

Risk Behaviour Changes

Attitudes & Values Changes

Health Outcome Changes

Process Indicators for Program Level

Coverage - Is the intended audience being reached? Who is not reached?

a) Is the program being offered in all intended settings? Eg.schools?
   - % of schools offering programs, formal and non-formal
b) Is the program reaching the intended audience of facilitators/teachers?
   - % of all teachers/facilitators trained
c) Is the program reaching the intended audience of children and young people?
   - %girls/boys (rural/urban; ethnic groups, other…)

Quality - Are facilitators/teachers implementing the program according to quality standards?

Possible Program Quality Standards

- Is it planned around student needs?
- Is it gender sensitive throughout?
- Is behaviour change part of the program goal?
- Is there a balance of knowledge, attitudes & skills?
- Are participatory methods for teaching & learning used?

- Are policies in place to support the program? Eg. teacher preparation, in-service and ongoing support?
- Are related support services accessible to the audience/participants?
- Are stakeholders consulted? Involved?

- Are facilitators/teachers trained for this purpose?
- Are facilitators/teachers supported in implementation phase?

- Is the program of sufficient duration to achieve the desired objectives?
- Are relevant educational materials utilised? (accurate, gender sensitive, age appropriate, accessible, appropriate language, durable…)
- Is the program based on relevant, current, accurate information and methods?
- Is program impact and process evaluation in place?

Outcome Indicators
Examples of indicators at three levels of outcome evaluation

Level of Evaluation	Outcomes
Level 1. Session or classroom level Immediate outcomes Knowledge, attitudes, and skills - Assessed by the facilitator/teacher at the time of, or very soon after the educational activities are completed *The term ''Attitudes'' is used here to encompass a wide range of concepts including: intentions, beliefs, feelings about self (confidence) and others (discrimination), values, thoughts, social, religious and cultural tenets, morals and ethics. *The term ''skills'' is used here to refer to Llife skills, psychosocial and interpersonal skills that can be applied to AIDS prevention, and related issues. These skills are important because they can facilitate and may lead to behaviour change, when supported in comprehensive ways.	Knowledge a.Transmission & Non-transmission • Do participants feel confident they know how to reduce their risk of HIV/AIDS and STIs? • What (behaviour/attitudes/ knowledge or lack) transmits HIV/AIDS/STDs? • What does NOT transmit HIV/AIDS/STDs? • Do participants know how to use a condom? • What & how social justice/rights, gender, culture, norms, discrimination.. affect HIV/AIDS/STDs risk and those affected/infected by HIV/AIDS? Eg. Orphans, employment. b. Prevalence and impact of HIV • How widespread are HIV/AIDS/STD/s? where? Who? my risk? • What are symptoms of HIV/AIDS/STDs? c. Care & support. • What care & support is available? d. Reproductive health, general health • What (behaviour, attitudes, knowledge) keeps people healthy? • What are the consequences of various risk behaviours/early pregnancy/ other...? Attitudes* • Do participants 'intend' to use a condom if they have sex? • Do participants intend to "wait" until ….older/ marriage? before having sex? • Do participants feel 'connected' to peers, family, school? • How do participants feel towards those affected/infected by HIV/AIDS? • Do participants feel confident they know how to reduce their risk of HIV/AIDS and STIs? Skills*: • Can participants apply the life skills to 'hypothetical or practice' situations related to HIV/AIDS/STD risk and discrimination…(eg. Through unfinished sentences, scenarios, short answers, story telling, ranking, role play…) • Do participants feel confident they can apply the skills in real life situations? Eg. Communicate well with peers, teachers, parents, others; Refuse undesired sex, Resist pressure to use drugs, Refuse unprotected sex, Insist on/negotiating protected sex; Identify personal risk level; Act on human rights issues, such as acting against discrimination; Identify consequences of decisions and actions; Weigh up pros and cons of decisions about…eg. early pregnancy or other risk situation; Demonstrate correct condom use in hypothetical situation; Seek trusted person for help; Identify and utilise health services

Continued…Examples of indicators at three levels of outcome evaluation …

Level of Evaluation	Outcomes
Level 2. **Behavioural level** Short term behavioural outcomes - Assessed a short time after intervention - It is assumed that achievement of the outcomes of Level 1 will lead to achievements at this level.	Behaviour • Was a condom used at last sex? • Has the number of sex partners reduced? • Is age at first sex increasing? (Is the partner low risk? What age/Older men?) • Is intra-venous drug use decreasing? • Are more intra-venous drug users cleaning needles? • Are less intra-venouse drug users sharing needles? • Are participants (and others) affected by HIV/AIDS treated as well as others? • Are participants seeking help for health issues? (trusted adult, professional)
3. Social Health Epidemiology level Long term health and social outcomes	Health and Social Outcomes • Are STIs decreasing? (Is the average duration of STI decreasing? Are health services accessed (more/earlier)? • Is age of first pregnancy increasing? • Is age of first marriage increasing? • Is HIV decreasing? • Are those affected by HIV/AIDS healthier? Living longer (than before)? • Is drug addiction decreasing? • Is mental health improved? Eg. self esteem, self confidence, outlook, connectedness/sense of community? • Are more children affected by HIV/AIDS staying at school?

Barriers to effectiveness

- **poorly understood**
- **competing priorities**
- **poor policy support**
- **poor and uneven implementation**

How to implement skills-based health education, including life skills, in schools

3 main ways

1. "Carrier" Subject alone	2. Separate Subject	3. Integration/Infusion alone

1. "Carrier" Subject – eg. Skills-based health education to prevent HIV/AIDS is placed in an existing subject which is relevant to the issues, such as civic/ social studies or health education

(Good short term option)

Pros	Cons
- Teacher support tends to be better than for infusion across all subjects - Teachers of the carrier subject are likely to see the relevance of the topic to other aspects of the subject - Teachers of the carrier subjects are likely to be more open to the teaching methods and issues being discussed due to their subject experience - Training of teachers is faster and cheaper than via infusion - Cheaper and faster to integrate the components into materials of one principle subject than to infuse across all - The carrier subject can be reinforced by infusion through other subjects	- Risk of an inappropriate 'carrier' subject being selected, eg. biology is not as good as health education or civic education because the social and personal issues and skills are unlikely to be adequately addressed

2. **Separate Subject: Skills-based health education (**eg. Health and Family Life Education) **is taught as a specific subject to address HIV and other important issues** (good long term option)

Pros	Cons
- likely to have teachers who are focused on the issues, and *more likely* to be specifically trained (but not guaranteed) - Most likely to have congruence between the content and teaching methods in the subject, rather than shortcutting which may occur through 'infusion' or 'carrier subject' approaches.	- the subject may be attributed very low status and not seen as important, especially if not examinable - requires additional time to be found in already overloaded curriculum

3. **Infusion or integration across subjects – eg. Aspects of skills-based health education to prevent HIV/AIDS is across many existing subjects through regular classroom teachers**

Pros	Cons
- a whole of schools approach can be taken - many teachers involved – even those not normally involved in the issue - high potential for reinforcement	- the issues can be lost among the higher status elements of the subjects - teachers may maintain a heavy information bias in content and methods applied, as is the case with most subjects - teachers are usually not trained (adequately) - very costly and time consuming to access all teachers, and influence all texts - some teachers do not see the relevance of the issue to their subject - potential for reinforcement seldom realised due to other barriers

4. **Other Combinations of the above, and non-formal approaches**

Talking Points

Background
Background 1. **What is the link?**

- Child-friendly schools is the umbrella concept which sets a vision for what schools could be
- FRESH is a concept which sets a visions for addressing key elements of the health aspects of a child friendly school
- Skills-based health education refers to the curriculum aspects designed to address health issues at or through schools. Skills-based health education addresses a balance of knowledge, attitudes and skills using interactive and participatory teaching and learning methods. Skills-based health education is also one element of the FRESH concept, although it applies to many other approaches.
- Life skills is a term often used to describe the particular type of 'psychosocal and interpersonal skills addressed in skills-based health education, along with knowledge and attitudes.

Background 2. **Child-friendly schools**
– are concerned about achieving quality education and in so doing, becoming more Inclusive of children, Effective with children. Healthy and protective for children, Gender-sensitive, and Involved with children, families, and communities

Background 3. **FRESH** – the elements of the FRESH concept are provided in the slide

Handout 1

1. What is the link?

- **Child friendly schools** is the umbrella concept which sets a vision for what quality education could be.
- **FRESH** (Focused Resources for Effective School Health) is a call to action which sets a vision for addressing key elements of the health aspects of a child friendly school.
- **Health Promoting Schools** is one particular mechanism for addressing FRESH, and identifying the health issues relevant to the school environment.
- **Skills-based health education** is one part of FRESH. It refers to the curriculum aspects designed to address health issues at or through schools. Skills-based health education addresses a balance of knowledge, attitudes and (life) skills using interactive and participatory teaching and learning methods.
- **Life skills** is a term often used to describe the particular type of psychosocial and interpersonal skills addressed in skills-based health education, along with knowledge and attitudes.

- This briefing is intended to clarify a range of terms used to describe educational processes involving life skills – the preferred term used here is ‘’skills-based health education”
- Well trained and well supported teachers are able to contribute to ‘good education’ by applying effective teaching methods.
- The ‘skills’ referred to in this context are ‘psycho-social and interpersonal skills’ often referred to as ‘life skills’, such as communication skills and negotiation skills, decision making skills, critical and creative thinking skills, skills for coping with emotions and stress and conflict, and self awareness building skills.
- Skills-based health education can be applied to a wide range of content areas or issues, of which health education is one example, and within that, HIV/AIDS education might be considered a subset.
- Skills-based health education can be utilised as well in school-based programs as non-school programs, however a particular focus here is on school settings.

Handout 2

Some criteria

- Skills-based health education is distinct from other education strategies in that changes in behaviour form at least part of the program objectives. This implies some form of change in *not only* knowledge, but also attitudes, and skills which contribute to and facilitate the desired behaviour change.
- Planning around student needs, means that the program is participant-centred, and that the needs of participants are taken into account when designing the program content and learning processes. Individual differences should be considered, including gender, ethnic background, native language, socioeconomic factors, and geographical factors
- Participatory teaching and learning methods involve more than merely sitting in groups and talking. Examples include debates, brainstorming, educaitonal games, role plays, exploratory learning, school-community projects and many other techniques. Traditional ‘information-based’ approaches which tend to still dominate, although helpful, are generally not sufficient to yield change in attitudes and behaviours. More effective teaching and learning outcomes are likely to result from content and accompanying teaching processes which address a balance of skills, as well as information and attitudes that is relevant to the participants and issues

- Sensitive issues, such as sexual health, HIV/AIDS risk, drug use, or other personal issues, are best addressed within the context of other relevant lifestyle issues, and NOT as isolated issues.
- Skills-based health education is but one of the many strategies required for behaviour change or behaviour development to be effective. Skills-based health education will work best in the context of other strategies such as policy development, access to appropriate health services, community development, media, and so on.

- The emphasis in this document is on life skills within the context of 'skills-based health education' for young people. Although the approach is clearly applicable to many other content areas, populations, and settings, the term 'health education' will be used here, and the example of HIV/AIDS will be used to illustrate key points.

Handout 3

Purpose of skills-based health education

- The purpose is two-fold, in that there is both an augmenting (positive) and a reducing (negative) side to the purpose, such that the whole person and their overall development is considered, rather than only addressing what is perceived as negative.
- Skills-based health education is basically a 'behaviour change' or behaviour development' approach designed to address a balance of 3 areas: knowledge, attitudes, and skills – and outcomes related to all three areas can be pursued. Indeed, shifts in risk behaviour, are unlikely if knowledge, attitudinal and skills based competency are not addressed.
- In this context, the term - 'health' – is used in its broadest sense to reflect a social view of health, which includes more than physical aspects, but also mental, social and spiritual aspects.

Handout 4

Two main elelements of skills-based health education

(i) Content – This does not mean information only, but rather, "what are the messages, themes, philosophies - knowledge, attitudes, and (life) skills that are to be explored?"
(ii) Methods – A wide range of teaching and learning methods can and should be employed. Information-based approaches may be legitimate for meeting certain program objectives, however they should not dominate.

Handout 5

(i) Content

- To effectively influence behaviour, knowledge, attitudes and (life) skills must be applied in a particular content area, topic or subject. 'What are we making decisions about?' Learning about decision making will be more meaningful if the content or topic is relevant and remains constant or linked, such as looking at different aspects or types of decisions related to relationships, rather than considering decisions about a number of unrelated or irrelevant issues. Genuine participation of the group is essential for identifying the relevance of content.
- Whatever the content area, a balance of three elements needs to be considered in implementing skills based health education:
- 1. Knowledge[1] 2. attitudes [2], and 3. Skills[3]
- The question for program designers is 'what' knowledge, attitudes and skills will be addressed?
- The balance of these three elements will be decided by gathering information from many sources, such as related literature and research, professional expertise, and the actual group, or similar group, of participants.
- The 'skills' referred to above are sometimes called ''life skills" – or psychosocial and interpersonal skills.
- Life skills and their related teaching and learning activities can be utilised across many content areas, meaning issues, topics or subjects. For example, health issues such as drug use, HIV/AIDS/STD prevention, suicide prevention and mental health, self esteem; Other issues, such as consumer education, environmental education, peace education, or education for development; livelihood skills such as various income generating activities, vocational programs, and career guidance.
- Note that life skills do not include specific skills such as interviewing skills, physical or manual skills involved in agriculture or animal husbandry, which might be called **'livelihood'** skills.
- A very general example of a possible content overview for HIV/AIDS/STD prevention is provided in the table, which can be used to frame the learning objectives and outcomes expected from the program.

[1]'Although there are perhaps important differences in meaning between the terms 'knowledge' and 'information', the two will be used almost interchangeably here. In general information might be described as passive and merely what might be provided without necessarily being used, whereas 'knowledge' might be considered internalised information able to be used or applied in some way.
[2] The literature suggests that 'attitudes' are more amenable to change than 'values' however both are socially derived and are not generally objective 'facts' agreed by all. Attitudes and values tend to differ between individuals, communities, regions or countries. The terms are also intended here to encompass a category of such concepts as ethics, beliefs, culture, social norms, opinions, spirituality and even religion and human rights.
[3]'Skills' will be used here to refer to psychosocial and interpersonal skills that can be taught or learned, often in hypothetical or practice situations, and these skills form the building blocks to more complex 'behaviour' in the medium term. For example, role playing assertive behaviour in an education session shows *skills* development, which may contribute to *behaviour* in real life situations such as assertively refusing an offer to smoke or use drugs.

Handout 6

More on Life Skills

- Skills-based health education involves a group of psycho-social and inter-personal skills, often called "'life skills".
- There is no definitive list - Life skills can be broken down many different ways – social, cognitive, and emotional skills - is one way; or a more detailed listing of skills under communication skills, values (analaysis and) clarification skills, decision-making skills, and coping and stress management skills.
- A huge number of component skills might be listed under each of the general categories of Life Skills provided.
- In practice the particular life skills are not separate, but are all inextricably linked - and many of these skills would be used simultaneously; eg. decision making is likely to involve creative and critical thinking components (what are my options?), values analysis (what is important to me?)
- The more detailed table of skills gives further insight into the types of (life) skills generally agreed as important in risk reduction programs - inter-personal communication skills, decision making skills, critical and creative thinking skills, skills for coping with emotions and stress, and self awareness building skills. Equally, other programs, publications or issues may utilise different categories of skills, however the basics tend to remain conceptually similar.

Handout 7

Methods for effective teaching and learning

- Well trained and well supported teachers use a range of methods and resources to achieve quality learning outcomes. There is a place for information focused sessions and teacher- focused or teacher-led sessions, within a varied methodology, however these methods are generally quite widespread. The greater need appears to be for the implementation of more interactive and child-centred methods. A list of some of these is provided.
- Skills-based health education is not synonymous with interactive teaching and learning methods, although it relies on the use of these methods. Skills-based health education cannot occur where there is no interaction among the participants – student to student and student to teacher.
- The interaction of groups of people guided through the educational processes of skills-based health education facilitates and generates the learning at individual and group level. For example, it is difficult to imagine analysing values and attitudes if only one individual's ideas are present; Equally, a broader field of information and a longer list of options is likely to be generated by a group of people rather than an individual in the process of decision making. Interpersonal and psycho-social skills cannot be learned from sitting alone and reading a book.

- Skills-based health education requires that all three components in place, (i) the actual (Life) Skills identified, (ii) the content area or focus for the program, and (iii) the interactive teaching and learning methods.
- A simple model for thinking about indicators for the skills-based health education is provided

Handout 8

Who can facilitate skills based health education for HIV/AIDS prevention?

- while teachers are an obvious entry point, for many reason, a number of other possible facilitators need to be considered;

Handout 9

What settings can be used for skills based health education for HIV/AIDS prevention

- while schools are one useful entry point, for many reasons, including maximising the reach of programs to those who need them most, other settings also need to be considered.

Handout 10

What are the limits of skills-based health education?

- This table illustrates that skills-based health education will be most effective in achieving relatively specific knowledge, attitudes and skills outcomes. However to achieve higher level goals, and sustainable behaviour change related to those goals, a relatively narrow strategy such as skills-based health education needs to be augmented with multiple strategies.
- Behaviour change is a medium to long term goal, and skills-based health education will work best to achieve and maintain behaviour change where reinforcing strategies are in place. Given the high number of influences on young people it is unreasonable to believe that a single positive strategy might 'drown out' the many competing influences.
- Skills-based health education should be considered but one of the many strategies necessary to promote pro-social and healthy behaviour, and reduce risky behaviour. Every effort should be made to combine this strategy with other complementary strategies such as policy development, health services, and community development

Handout 11

Evaluation & Indicators

Process and Outcome Indicators

- both process and outcome indicators are necessary for evaluation
- Process indicators focus on questions like:
  -"Did the program reach the intended audience?"
  -''Was the program acceptable to the audience?"
  -"Was the program implemented in the intended way?''
- Outcome indicators focus on questions like:
- How did the audience or issue change as a result of the program?
- To what extent were the objectives achieved?
- To what extent was the ultimate goal reached?

Handout 12

Process Indicators for Program Level

- In addition to process indicators about acceptability of the program or client satisfaction, there is need to consider whether the program actually reached the intended audience, and whether the program elements were ever implemented at all, or were implemented in the intended way. Coverage and quality of the program are two key domains of inquiry for program level process evaluation.
- Some ideas for quality standards are provided

Handout 13

Outcome evaluation

- Outcome evaluation is possible at a number of levels, but the choice of evaluation should depend on the purpose.
- Three levels of evaluation are represented through more detailed *examples*

Handout 14

Barriers to effectiveness

- *poorly understood*: As explained earlier, the term 'life skills'' is used in many different ways, however UNICEF uses the term to describe ''psychosocial and interpersonal skills'' which help people to communicate better, to make more informed and balanced decisions, to avoid risky situations, or to cope with stress. Along with the necessary knowledge, these skills are considered important because they can shape attitudes and ultimately lead to healthy and pro-social behaviours and productive lifestyles.

- *competing priorities:* HIV/AIDS, other health issues and social sciences, are often considered the 'soft subjects' and not given the same status as tradition academic subjects like science or mathemetics. In addition, HIV/AIDS requires people to face issues that may not be openly discussed, and some sectors of society would perhaps prefer not to address.
- *poor policy support:* Skills-based health education for HIV/AIDS prevention will work best where it is supported by other reinforcing strategies. Appropriate policy can be one of the most influential strategies for creating a conducive environment. Unfortunately, programs are often implemented 'vertically'or without sufficient linkages to policy, which ultimately limits the potential for success.
- *poor and uneven implementation*: Ongoing support to facilitators (teachers) is essential to ensure that implementation can be achieved with quality. Many programs provide only brief, or one-off training workshops and expect the trainees to go back to their schools or communities and implement, in effect, single-handedly. Practical experiences suggests over and over, that support during implementation is a critical success factor. In addition, although sufficient evidence exists to support 'going to scale', few programs make national coverage a priority from the outset, and many do not progress past pilot level.
  Utilising the expertise of the community and non-formal approaches can enhance the capacity of the school to provide good quality programs.

Handout 15

How to implement skills-based health education in schools

3 main options: 1. "Carrier" Subject alone 2. Separate Subject 3. Integration/Infusion alone

- Of the three ways, the 'carrier' subject emerges as the most feasible short term option especially where little already exists, however some countries, where the conditions are amenable, have had good success with the separate subject approach
- It is also possible to combine options, over the long term. For example, carrier subject plus infusion across the curriculum to reinforce the core concepts presented in the carrier subject, however this is complex and time consuming to achieve. Once the issue/s have been established within the "carrier" subject, infusion of HIV/AIDS issues and the skills-based approach can be infused across other subject areas. It is more realistic that the approach will be implemented well in the carrier subject first, and later aspects may be reinforced by infusion across other subjects usually in the very long term.
- **Other settings** also need to be considered in order to reach more young people, including non-formal settings and approaches, peer education, and school clubs.