An Assessment of Sexual and Reproductive Health and Rights Curricula for Youth in South Africa

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Introduction

The South Africa Government with assistance from and collaboration with development partners is invested in programs to address the sexual and reproductive health needs of youth. At the center of this response has been an effort to reduce HIV acquisition and transmission while increasing access to care and support. A key intervention has been to raise awareness and knowledge about HIV and HIV preventive behaviors among in-school and out-of-school youth through a wide range of educational and training activities. To this end, many local and international organizations have developed training programs to address a wide range of sexual and reproductive health challenges.

Despite these efforts, youth continue to exhibit high-risk behaviors and poor knowledge of key sexual and reproductive health issues. For example, the loveLife 2012 Impact Assessment Study conducted in collaboration with the Human Sciences Research Council (HSRC) in KwaZulu-Natal, Mpumalanga, Gauteng, and Eastern Cape provinces found that many youth were still unaware or unable to change their risk behaviors. Only 52% had ever been tested for HIV, and condom use, while high with casual partners, was lower with main partners and very low in cases of transactional sex. A high proportion of youth did not consider themselves to be at risk for HIV. Nearly one-half of the girls aged 18-24 had had at least one pregnancy. As many as 80% of these pregnancies were unintended, and 70% of the girls reporting a pregnancy said they did not understand the risks involved when they engaged in sex that led to pregnancy and had no knowledge on how pregnancy occurs. Findings from this and other studies and surveys demonstrate that behavior change is a slow process and there are still major challenges to be addressed.

In 2013, USAID-SA requested FHI 360 through the Umbrella Grants Project to conduct an assessment of curricula used by programs in South Africa to train youth on sexual and reproductive health and rights (SRHR), including, but not limited to, HIV/AIDS and pregnancy prevention. More specifically, USAID was interested in assessing whether the curricula are: 1) comprehensive and technically accurate; 2) relying on appropriate training methodology; 2) supporting clear health goals such as prevention of STI's, HIV infection, and pregnancy; 3) facilitating behavior change; and 4) based on evidence and have had some effects (including how these effects were being measured).

This report discusses the findings, including strengths and weaknesses of the available training materials, identifies gaps, and provides some recommendations for improvement. It also includes a curricula inventory with detailed information for all main curricula assessment criteria (Appendix 1).

Key Findings and Recommendations

Technical Accuracy:

Overall, most cognitive and gender related topics are covered reasonably well in all curricula. However, all the curricula reviewed in this assessment that cover technical information on puberty, fertility, pregnancy, AIDS, HIV and other sexually transmitted Infections (STIs) introduce many mistakes and misconceptions or miss some important information. Some of these inaccuracies and information gaps have a potential to affect the way adolescents may act on what they learned, making it difficult to achieve desired behavior change. Overall, all curricula that include technical information will benefit from careful technical review.

Consistency with Country Policies and Guidelines:

Many curricula appropriately refer to the relevant country policies and guidelines, such as Sex Description and Sex Status Act, The Bill of Rights, The Choice of Termination of Pregnancy Act, The Civil Union Act, Sexual Offenses Act, Domestic Violence Act, Children's Act, and South Africa's Schools Act. However, Information on contraception is often not reflective of South Africa's Contraceptive Guidelines, which were revised in 2012 and have a section on Youth. Also, information on prevention of mother-to-child transmission of HIV (PMTCT) is not consistent with South Africa's PMTCT Guidelines, which were revised in 2010. Any review for technical accuracy will also ensure consistency with South Africa's technical guidance documents.

Training Methodology:

All curricula rely on experiential learning approach; most are highly participatory, employ a wide range of activities, and have a limited didactic component. However, many activities can benefit from better instructions for how to implement them, how to process the discussion questions, and what the key messages are, especially considering many facilitators are youth peer educators and do not have a lot of experience in facilitation or sufficient background knowledge of the issues. Another improvement would be to revise the objectives so they all are measurable and achievable. Because most curricula do not rely on pre- and post-tests to assess changes in knowledge, attitudes and skills, facilitators should be able to measure changes informally by listening and observing. However, when assessing informally, it is necessary to have the objectives that are measurable and activities that are designed to support these measurable objectives.

Facilitators:

Many curricula rely on youth facilitators for implementation. While peer education for HIV/AIDS and other sexual and reproductive health (SRH) issues has been a best practice for a long time, leading a curricula-based training is more complex than routine peer education activities. Being an effective trainer or facilitator requires a combination of skills and knowledge, which could not be acquired and maintained without proper training, support and supervision. It also requires a detailed facilitator guide, which includes necessary background information and careful instructions on how to process all key activities. Not every curriculum meets these criteria, and supervision/support is often limited or absent during trainings led by youth facilitators. Careful selection, preparation, and supervision of youth facilitators are critical. Developing additional facilitator resources may also be needed, such as "Questions and Answers" for each session, so facilitators can be better prepared to address the most common participant questions during the training. Currently, the curricula are not clear regarding how facilitators should handle the discussions and possible questions. Without such guidance, youth facilitators and others lacking solid training may create more misconceptions when addressing difficult questions.

Skill-building Component:

A majority of the curricula have a weak skill-building component. Even when skill-building is included, these elements tend to emphasize knowledge, with more focus on "what" rather than "how," and allocate very little or no time for practicing new skills. More attention is given to communication and decision-making skills while skills for how to refuse sex, negotiate condom use, or use condoms correctly are often omitted. Curricula could be improved by covering a better mix of skills, particularly those related to condom use, allocating sufficient time to practice these skills, and continuing reinforcing them throughout the training by designing activities with certain key skills in mind.

Support for the Life Orientation Program:

Many of the curricula have been developed in support of the Life Orientation Program in schools and are aligned with some of the goals and objectives laid out in the Curriculum and Assessment Policy Statement (CAPS) by the Ministry of Basic Education. However, there has been no coordination between the different programs and organizations to avoid duplication and ensure uniformity. It would be more efficient to streamline these efforts, especially now that the Sexual HIV Prevention Program (SHIPP), led by the Futures Group, is tasked with the development of the lessons on sexual and reproductive health for the Life Orientation Program at the national level.

Social and Economic Empowerment of Youth:

Most of the programs focus on behavior change models, which try to increase knowledge about SRH, motivate participants to adopt safer behaviors, and address some needed skills (although the skill-building component is weak). However, many young people who are facing SRH challenges are unemployed, come from poor communities and may have limited power to act on what they learn. A pilot program using a combination of Stepping Stones and Creating Futures curricula has demonstrated that empowering youth to address their socio-economic challenges while improving their SRH knowledge and skills can lead to positive outcomes. While it is not possible to follow this model in all cases, programs should explore opportunities to add a livelihood component where appropriate.

Referral Networks:

Although the goal of the training programs is to increase knowledge and build skills for behavior change, a strong referral network is needed where youth can seek services. While some curricula provide information on where to access services and some programs also implement provider training in youth SRH, better linkages with health services are needed. This is especially true because some preventive behaviors cannot be fully realized without accessing health services (e.g. HIV counseling and testing, contraception). Youth training events may foster these linkages by including "get to know your provider" sessions, which could be accomplished by inviting providers to the training, taking youth for a tour of a local clinic, or both.

Assessment Methodology

Through a consultative process with USAID-SA, it was agreed that the assessment would be conducted in two phases. The first phase included the identification of the programs that conduct training for in-school and out-of-school youth on SRHR, using some form of training curriculum for these activities. Training curricula were loosely defined for this assessment and were not limited to those that had been certified by the relevant government bodies or authorities. Any material and tools that programs used for the training was considered eligible for the review. The choice of programs was not limited to those funded by USAID but included all major youth serving programs in the country. After selection of the program, key informants for each program were identified, agreement to participate in the assessment confirmed and arrangements made for an in-person interview. The interviews were conducted by a team from FHI 360 using the discussion questions in the Curricula Assessment Tool that has been developed by the team and reviewed and approved by USAID (See Appendix 3).

All identified programs were invited to submit any training materials they were currently using or had used in the recent past to train youth in sexual and reproductive health and rights. Using the criteria in the Curricula Assessment Tool, the materials were reviewed to answer the key objectives outlined in the Introduction.

Findings and Observations

The assessment team met with total of 17 organizations with most of the meetings taking place in-person but some being done over the phone (for the full list, see Appendix 2). Not every organization had training materials for youth, even though most of them had youth focused programs and/or services. For example, Foundation for Professional Development (FPD) has training curricula on SRH topics geared towards either health care professionals or medical students, but not towards youth overall. The Population Council was involved in the development of *It's All One*, which is a global level curriculum for youth, but has no involvement in youth SRHR training in South Africa. Ibis Reproductive Health has a curriculum only for health care providers who offer services to youth, and Marie Stopes supports awareness generating activities and youth friendly services through the Blue Light program but does not train youth in SRHR. Futures Group is in the early stages of developing materials for school-based youth, but nothing is available for review yet.

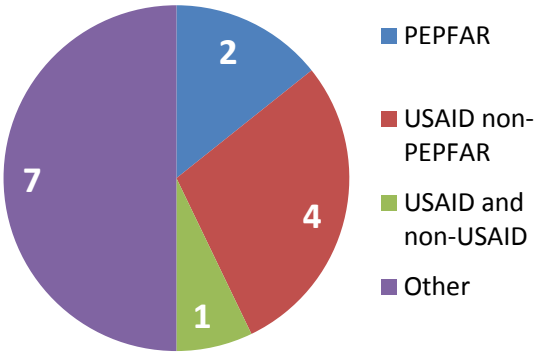
At the same time, two organizations – Medical Research Council (MRC) and Grassroot Soccer – had more than one curriculum. Total of 14 curricula were collected for assessment. Great variations existed across the curricula included in the analysis, such as the target populations, number of SRH topics addressed, and the degree to which information was covered. It was also apparent that there was no standardized approach to curricula development, testing and implementation, as well as no coordination among organizations when they developed similar materials for similar target audiences.

Curriculum Title	Developer	Year
Love4life Healthy Sexuality Manual	LoveLife	2013 (update)
Stepping Stones: A training manual for sexual and reproductive health communication and relationship skills	Medical Research Council (in collaboration with the Planned Parenthood Association of South Africa)	2010 (update)
Respect4U	Medical Research Council	2011
PREPARE	Medical Research Council	2013
Vhutshilo 2	Center for Support of Peer Education	2012 (update)

Curriculum Title	Developer	Year
Generation SKILLZ	Grassroot Soccer	2013 (update)
SKILLZ Street	Grassroot Soccer	2013 (update)
SKILLZ	Grassroot Soccer	2013 (update)
Generation SKILLZ "Utshintsho"	Grassroot Soccer	2013 (update)
Young4Real. Young People's Sexual and Reproductive Health Information and Services: Advocacy Training Handbook	SAfAIDS	2012
Working with Men and Boys: Gender and Sexual & Reproductive Health Manual	Sonke (in partnership with Pathfinder)	2009
Positive Sexuality Program (PSP)	Child Welfare	2013
Gender or Sex: Who cares?	IPAS	2001
May'khethele Psychosocial Support Manual: Grade 8, 9 & 10	Youth For Christ (under the CINDI umbrella)	2012 (update)

Funding Sources

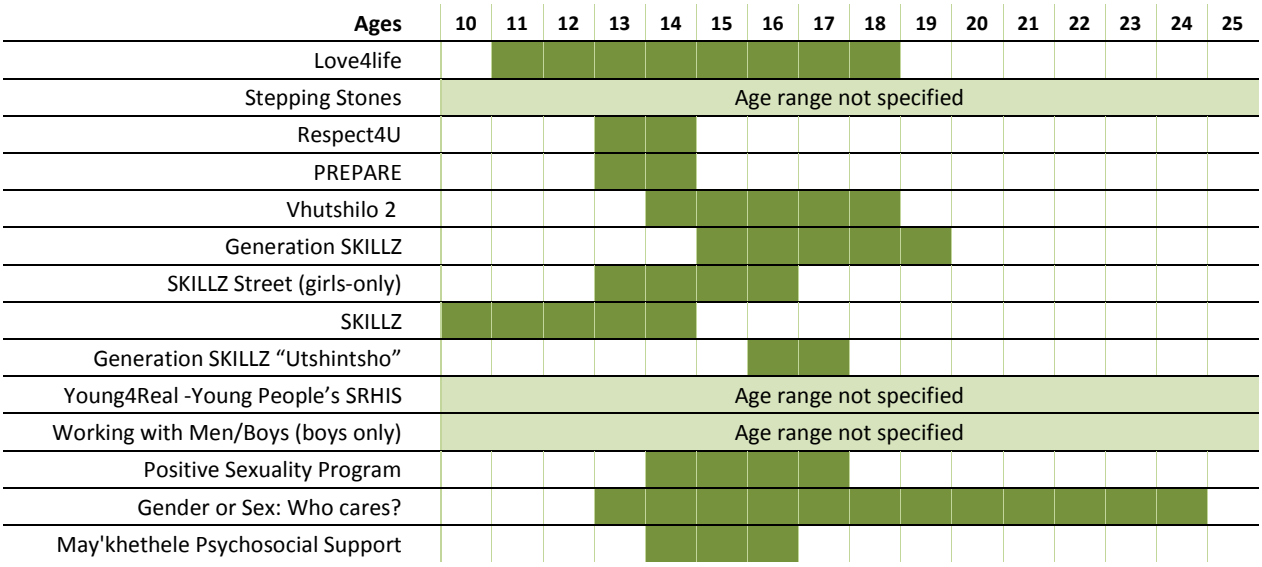
Funding for the curricula varied across the programs. Out of the 14 curricula reviewed, 2 were supported by PEPFAR, 4 were developed with USAID non-PEPFAR funding, and 1 was developed through a combination of non-USAID and USAID funding, which was provided indirectly through collaboration with Pathfinder. Another 7 curricula were developed with funds from the Department of Basic Education, European Union, NIH, private foundations, or in collaboration with Planned Parenthood/South Africa.



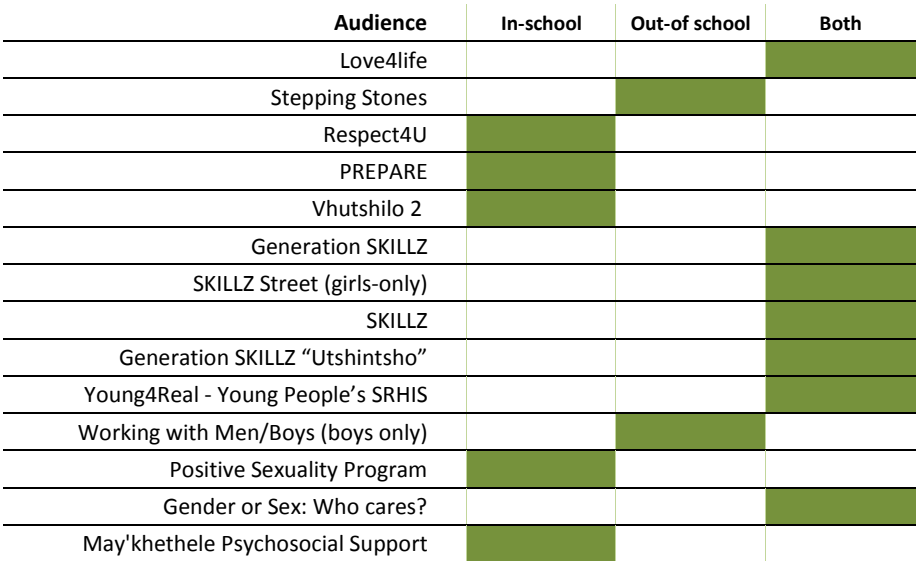
Target Population

Although all programs have activities targeting youth, there are some variations both across the programs and within the same program in the age groups they are trying to reach. For example LoveLife's *Love4Life* curriculum and supporting materials were designed with all ages in mind and rely on facilitators to choose the most appropriate activities to meet the needs of a particular age group. The target audience for this curriculum includes in-school youth (grades 5 to 12, ages 11-18) and out-of-school youth as old as 25 years. *Stepping Stones*, developed by MRC, is not at all age specific and could be used with youth of various ages as well as with adults. However, when combined with the *Creating Futures*, which is a curriculum addressing jobs and income generation, it specifically targets young people age 18-25. Grassroot Soccer's four *SKILLZ* curricula build on each other and target four different groups: boys and girls ages 10-14, 15-19, and 16-17, and girls only ages 13-16. Grassroot Soccer is the only organization that has a curriculum designed specifically for girls. Sonke, on other hand, is the only organization that has a curriculum designed specifically for "men and boys." Most remaining curricula target adolescents ages 13-14 or ages 14-18, both boys and girls. Not included in the table are the materials from two organizations. One is FPD, which develops materials for health care professionals that could be used with college students in pre-med settings, but are too technical for general youth. Another one is Soul City's Soul Buddyz Club program, which is designed for youth as young as 8 years old, but could be used through the age of 14. This program relies on information booklets/units to

facilitate learning about various issues, including SRH, but could not be assessed due to the lack of access to all relevant booklets published over several years (three copies provided as examples contained very limited information on SRH issues).



In terms of targeting in-school vs. out-of-school youth the curricula are split with 5 targeting only in-school youth, 2 targeting only out-of-school youth, and 7 targeting both (4 out of these 7 are Grassroot Soccer SKILLZ curricula). The reach varies widely across the programs. For example, LoveLife's school based program is currently implemented in 6,000 out of the 27,000 schools in South Africa. Grassroot Soccer also has a wide coverage, reaching about 50,000 youth per year. Some other curricula have a limited reach either because they were developed to support a specific time-limited intervention or because they were developed only recently and are still in a pilot stage. The example of the former would be Sonke's *Working with Men and Boys: Gender and Sexual & Reproductive Health Manual* that was developed for one year-long community project on termination of pregnancy (TOP); the example of the latter would be *Positive Sexuality Program* lessons, which were recently developed by Child Welfare and will be rolled out in about 100 schools.



Curriculum Development Process

The development of a training curriculum is driven by the needs of the program and funding sources. Some of the curricula are adaptations from existing materials developed for use by other in-country

programs or in other countries with similar experiences. Most programs use in-house capacity to develop their training materials but often draw on technical assistance from international development partners. Some programs use curricula developed by other institutions. For example, World Vision uses the *Vhutshilo 2* curriculum in its school-based programs, which was developed by Center for Support of Peer Education (CSPE).

All curricula for use within the school settings are developed in close consultations with the Department of Basic Education to ensure that they conform to the goals of the Life Orientation Program. The Department of Health is also consulted by most programs during the curriculum development process. There is little involvement of youth and/or parents in the development or review of the curricula, but some are revised based on the feedback from youth who participated in pilot programs.

In some cases, the curricula were developed or/and implemented within the research framework, as part of a study. These include the curriculum that was part of the MRC pilot study implemented in urban settlements in Durban, which used a combination of the Stepping Stone and Creating Futures curricula to train youth on SRH issues and career development/income generation. This curriculum has been implemented and evaluated in the study setting and found to be effective in enabling youth to improve their economic status and achieve positive behavior change, including increased focus on their main sexual partner, improved communication, decrease in transactional sex, and decline in alcohol and drug use. The Respect4U and PREPARE curricula developed by MRC-Cape Town have also been part of a research process. Although these curricula have shown great potential, the feasibility and impact when implemented outside the research environment remains unknown.

Most of the reviewed curricula were developed or updated within the last three years, many as recently as 2013. One exception is Ipas curriculum *Gender or Sex: Who Cares?*, which was developed in 2001, but it is very gender focused and has little technical information that could change over time, so most of it doesn't require updating.

Implementation

Many organizations rely on peer educators to implement their training programs. The selection and preparation of peer educators varies across the programs, although the selection criteria, preparation, and compensation (if any) of youth peer educators is not always well defined. For example:

- LoveLife relies on more than 1,200 full-time peer educators known as "groundBREAKERS" – young people between the ages of 18-25 recruited from the *Mpintshis* who have been volunteer leaders and previously participated in LoveLife's training program targeting 12-17 year olds. The groundBREAKERS are trained in both content and facilitation skills and receive ongoing support.
- World Vision Vhutshilo 2 curriculum is implemented by teams of 3 or 4 peer educators aged 16-20. The preparation of these peer educators focuses on facilitation skills and does not include training on the content they are expected to cover. The assumption is that they learned the content as part of the Life Orientation Program in high school.
- The MRC-Cape Town relies, at least partially, on young facilitators to implement their PREPARE curriculum. The facilitators have to have a high school diploma and some experience in reproductive health, and receive a week-long training on curriculum content followed by two days of practice conducting the sessions.
- The Grassroot Soccer uses volunteer coaches ages 18-25 to implement their interventions. Coaches are required to have community work experience and a high school diploma. They are trained for 5

days, which includes going through the curriculum the same way the participants would, preparing and delivering one session, and learning skills for how to be a good coach.

- Some programs, such as SAfAIDS, rely on their staff to deliver training or, as Child Welfare does, on salaried social workers to implement their school-based Positive Sexuality Program. These social workers are experienced facilitators who also receive a month-long training on curriculum content.

In addition to the curriculum quality, the selection, preparation, and compensation of the persons responsible for implementation will determine how successful the program will be. As discussed above, wide variations exist across the programs, and in many cases programs make major assumptions about how knowledgeable facilitators are in content areas of curriculum, which may or may not be correct. Apart from *Vhutshilo 2* facilitators and coaches for Grassroot Soccer programs, who are tested upon completion of the training, the assessment could not determine how other programs evaluate their efforts to prepare facilitators.

Also important to note is the fact that 6 out of 14 curricula (see Text Box) are implemented in support of the school Life Orientation Program and are aligned with the goals and objectives laid out in the Curriculum and Assessment Policy Statement (CAPS) by the Ministry of Basic Education. While the current efforts to support Life Orientation Program are very fragmented and not coordinated, the Sexual HIV Prevention Program (SHIPP), led by the Futures Group, recently initiated an activity at the national level in support of the Life Orientation Program and is in the early stages of developing lesson plans for grades 7 to 9 on issues of SRH, including contraception (particularly condoms and injectables). Topics for 30 lessons were chosen based on the discussions with Department of Health and Department of Basic Education.

Curricula that Support the Life Orientation Program

- Love4life Healthy Sexuality Manual
- Respect4U
- PREPARE
- Vhutshilo 2
- Positive Sexuality Program (PSP)
- May'khethele Psychosocial Support Manual: Grade 8, 9 & 10

Training Methodology

All curricula rely on an experiential learning approach and almost all are highly participatory. Even school-based curricula that are structured as lessons combine didactic and interactive learning techniques. Discussions, reflections, role plays, case studies and games are examples of the activities that are present in every curriculum. Some are very creative, tying learning activities to a game itself. For example, Grassroot Soccer uses soccer practice sessions as a platform for learning and effectively explains many SRH concepts, such as HIV transmission, multiple partners, or preventive behaviors, using soccer analogies. However, there are some common limitations:

- While all curricula have learning objectives for each session, they are not always measurable, realistic, or achievable. Since most curricula do not use pre-test/post-test questionnaires, facilitators should be able to assess changes in knowledge, attitudes, and skills by listening and observing. However, to conduct an effective assessment solely by listening and observing, the objectives must be measurable (e.g., explain, list, demonstrate how to) and activities should be designed around these measurable objectives. For example, the objective that states: the participants will be able to demonstrate how to use a condom correctly, should be supported by an activity that includes an opportunity for participants to practice a condom use demonstration that can be observed by the facilitator.

- Many activities are followed by discussion questions with no or little guidance for facilitators on how to process or summarize the answers. Considering that many facilitators are young people themselves and may not have enough background knowledge or experience needed to process complex and often controversial questions, curriculum can be strengthen by including more guidance for facilitators on how to address complex questions, including providing key points to emphasize in giving possible answers.
- Many curricula state how long each session should take but do not break the session time down by activity. Because some sessions are fairly complex and may include 7 to 10 activities, a time breakdown would assist facilitators in pacing the session if each activity is timed.
- Some activities are too ambitious for the time allocated and require having more background knowledge before learners can engage in these activities effectively. Moreover, the necessary knowledge is sometimes offered only two or three sessions later, highlighting the need for a logical sequencing of the material.
- The majority of the curricula have very weak skill-building components. This is particularly true with the school-based curricula where learners have very little or no time to practice any skills. The focus is mostly on "what" and not "how". Areas for skill-building covered include critical thinking, decision-making, some aspects of communication when in relationships, etc. While all are very important, a participant cannot develop these skills in the short time provided, and the curricula does not revisit any of these skills later with more time allocation for skill building. Very few curricula include skills for how to put on a condom; those that do have very little or no time built in for actual practice and condom negotiation skills. Also, skills needed for refusing sex are rarely addressed.

Technical Content

Having correct information does not guarantee behavior change, but not having it guarantees that learners will not be able to effectively apply what they learned. It is important to note that all assessed curricula could be divided in two categories: those that cover a broad range of SRH topics, including more "technical" areas, such as fertility, pregnancy, contraception, HIV transmission and prevention; and those that focus on issues of self-esteem, sexuality, gender relations and gender-based violence, relationships, and decision making, but leave out more technical areas, such as HIV and pregnancy prevention. In addition, two curricula are built around a single topic – one covers exclusively gender issues and how they relate to reproductive health (Ipas), and another one deals with male involvement in decisions around pregnancy termination (Sonke). For the full list of topics, see the table on the next page.

Contents ⬇ / Curriculum ➲	Love4life	Stepping Stones	Respect4U	PREPARE	Vhutshilo 2	Generation SKILLZ	SKILLZ Street	SKILLZ	Generation SKILLZ "Utshintsho"	Young4Real	Working with Men/Boys	Positive Sexuality Program	Gender or Sex: Who cares?	May'khethele Psychosocial Support
Sexual/reproductive rights	■						■			■	■			■
Gender issues	■	■	■	■		■	■	■	■		■	■	■	■
Gender-based violence/ intimate partner violence	■	■	■	■	■	■			■	■			■	■
Communication	■	■	■	■	■	■	■	■	■	■	■	■		■
Decision-making	■		■	■	■	■					■	■		■
Sexuality/sexual development/puberty	■	■					■			■	■	■		■
Fertility and pregnancy	■	■			■		■							■
HIV/AIDS	■	■		■	■	■	■	■		■				■
STIs (other than HIV)	■	■		■	■		■			■				■
Safe sex practices	■	■		■	■	■	■	■	■	■		■		■
Contraception	■	■			■		■			■				■
Termination of pregnancy	■	■			■		■				■			
Alcohol and substance abuse	■		■	■	■	■		■	■		■			
Stigma and discrimination	■					■		■						

Overall, most cognitive and gender related topics are covered reasonably well in all curricula, and most curricula address both heterosexual and same-sex relationships (although many sessions can benefit from having more information on how to process some of the activities). Those that do contain more technical information introduce many inaccuracies and mistakes because they often use old resources or rely on information obtained through Google search when they develop the materials. Not all of these mistakes are equally important, but some are critical because of their potential to affect behavior change. For example, if fertile time is explained incorrectly, a girl won't know when during her menstrual cycle she is at risk of becoming pregnant. Or if the timeframe for using emergency contraception is presented as 3 days (72 hours) instead of 5 days (120 hours), some girls may not access emergency contraception even though they are still eligible. Or if safe and effective methods of contraception are described as not appropriate for adolescents, this incorrect information can reduce the chances that they will seek effective contraceptive options from health centers. The table in Appendix 1 provides more examples of inaccuracies that have a potential to affect the way adolescents may act on the information they learn from these curricula.

Condoms: Most curricula discuss correct and consistent use of condoms as a means to protect from both STI/HIV and pregnancy. While focus on condoms is entirely appropriate, it is also necessary to discuss other dual protection options. Although the concept of dual protection is mentioned in some curricula, it is not discussed fully and has no clear explanation of what it is (outside of condom use) and how it may be achieved. Ideally, girls should be given an option and encouraged to use an effective method for pregnancy prevention in addition to a condom for STI/HIV prevention. Many women may lack the power to negotiate condom use; even when they want to use a female condom, a partner's cooperation is generally required. If a curriculum focuses mostly on the two safest options – abstinence and consistent condom use – it leaves out many adolescent girls for whom these two best options may not be an option at all, or at least not a consistent option. Any discussion of HIV and pregnancy prevention should make clear that if girls are using another effective contraceptive method in addition to condoms, they at least have control over pregnancy prevention when their partner refuses to use condom. In some cases dual protection will involve being in mutually faithful relationships with an uninfected partner (which requires being tested to know infection status) and using a contraceptive method other than condoms to avoid pregnancy. Additionally, incorrect condom use is discussed as the main reason for method failure, when the focus should be on inconsistent use. This is because condoms rarely break; when they do, it is primarily not because they were put on incorrectly, but because they were expired, stored incorrectly, or damaged when the package was opened by sharp objects like teeth or nails. However, these reasons for incorrect use are rarely discussed.

Contraception: Contraceptive options are often not discussed at all, barely discussed, or discussed incorrectly. Some contraceptive methods are listed as not appropriate for youth (e.g. the IUD) or not included into discussion at all (again the IUD); side effects are often described incorrectly; health risks are overstated or stated incorrectly; and occasionally when contraceptive methods are listed, they are "dismissed" because they do not provide protection from STI/HIV. At the same time, some curricula include methods not available in South Africa, such as the diaphragm and cervical cup. Most contraceptive discussions also include spermicides either alone or as a mean to improve condom use in spite of the fact that they have low efficacy for pregnancy prevention (and are not recommended by SA Contraceptive Guidelines), do not improve condom effectiveness, and can increase HIV risk if used frequently. The main two contraceptive messages for youth are not prominently emphasized in the curricula: first, that the majority of modern methods are appropriate and second, that all modern methods are safe for young people. Rare complications, which could theoretically occur with some

contraceptive methods, happen in a small category of women with serious health problems, such as severe diabetes, heart disease, stroke, hypertension, deep venous thrombosis, and so on. These conditions are extremely rare in younger age group, which means the chance of complications is practically zero.

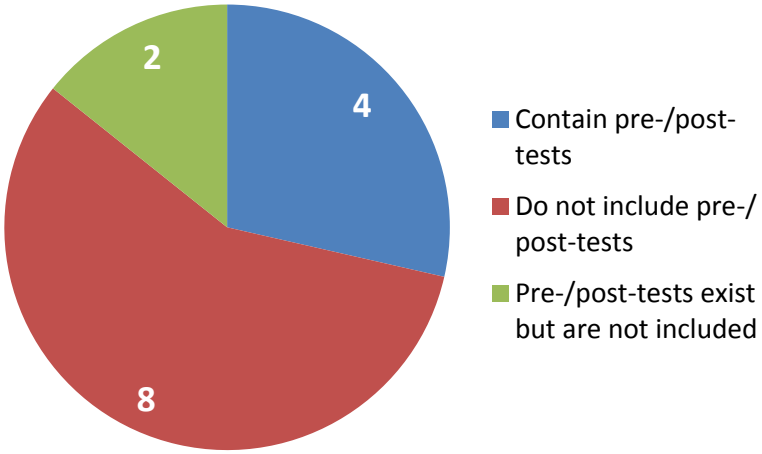
Risk behaviors: Risky behaviors such as not using condoms, multiple sexual partners, or older partners are addressed in most curricula, but there is very little information about risky sexual practices. For example, only one curriculum explains that anal sex is much riskier than vaginal sex for HIV transmission. Adolescents may consider anal sex safer because it does not carry a risk of pregnancy, but they need to know that HIV risk is 18 to 20 times higher with anal sex. HIV prevention messages should always include accurate discussion of risks associated with various sexual behaviors. In addition, all curricula that talk about HIV risk when having multiple sex partners and the safer alternative of having sex only while in stable relationships, disregard the nature of adolescents' relationships. Young people's definition of a "stable relationship" differs from that of most adults. In one study, 58% of teenage boys and 43% of teenage girls considered a one- or two-month relationship as stable. For monogamy to be an effective strategy against HIV transmission, it must be a long-term monogamy, not a "serial monogamy", which is very common among adolescents. Having a new girlfriend or boyfriend every couple of months is as risky as having multiple partners over the same period of time; however, these nuances are completely lost in all discussions of risky and preventive behaviors.

Another point to note is that most curricula mention circumcision as a mean to reduce HIV risk in boys, but none of the curricula provide information about availability of HPV vaccine as a mean to prevent cervical cancer in girls.

Overall, all curricula that include technical information of fertility, pregnancy, AIDS, HIV, and other STIs will benefit from a careful technical review.

Knowledge Assessment, Monitoring and Evaluation

Only 4 training curricula are measuring changes in knowledge and attitudes of the learners by administering pre- and post-tests; an additional 2 curricula say that pre- and post- tests are done, but they are not included in facilitator manual. Programs conducted in schools in support of the Life Orientation curriculum rely on inclusion of some SRH questions in quarterly school exams, but it is not clear what questions appear in the exams and how the improvements are measured in an absence of the baseline. Grassroot Soccer administers the pre- and post-training tests only to a small sample of the participants (about 10%). Although pre- and post-tests are useful for assessing immediate changes in knowledge and attitudes, they provide no insight on knowledge retention and are not necessarily predictive of behavior change.



Only two curricula provide participants with training evaluation forms (Sonke's *Working with Men and Boys: Sexual and Reproductive Health Manual* and Ipas's *Gender or Sex: Who cares?*). Stepping Stones curriculum offers participants an opportunity to provide feedback in an informal discussion format and some programs (such as SAfAIDS) rely on participants' feedback from pilot testing to inform further improvements.

Most of the programs do not have a formalized mechanism for evaluating the impact of their training curricula. As mentioned earlier some of the training curricula have been evaluated using a research design in relatively small study populations under strict research conditions. These include the Stepping Stones/Creating Futures evaluation described in the Curriculum Development section as well as another Stepping Stones study, which confirmed positive changes in preventive behaviors by showing a decrease in the rates of new HIV and genital herpes infections. Grassroot Soccer is currently conducting a 3-year long randomized controlled trial to assess post-intervention behavior change, including the increase in numbers of youth who opted for HIV testing and male circumcision. PREPARE curriculum is part of the study, which will measure behavior change indicators such as age at sexual debut, condom use, and number of sex partners. While studies provide information on how effective the training program is when implemented as designed, it is not clear how easy it will be to replicate outside of the research settings.

Outcome-based evaluation, which was conducted by CINDI for *May'khethele Psychosocial Support Manual*, showed some improvement in knowledge about HIV transmission and prevention, but no significant differences between intervention and control groups in HIV testing rates (even though intent to practice safe behaviors was higher in intervention group). Training using Vhutshilo 2 curriculum had a limited monitoring and evaluation component, and the LoveLife program was evaluated recently in 4 provinces. Because the LoveLife program has many components other than training on SRH, isolating the impact of the curriculum is difficult.

Potential Barriers to Scale Up

Funding: Development of the training curricula is funded through specific projects and grants which limit their scope to the goals of the primary project or sponsor. The result of this is the multiplicity of training materials that are not consistent in terms of the content, standards, and quality. In addition, projects have defined timelines and milestones. Once these have been achieved, the funding ends and there are no other mechanisms to continue with the activities or take them to scale.

Coordination: Although many of the curricula have been developed to strengthen the Life Orientation Program in schools, there has been no coordination between the different programs and organizations to avoid duplication and ensure uniformity. Different organizations indicated that they consult the Departments of Basic Education and Health, but this is done on a program by program basis resulting in different groups of schools being exposed to different curricula and approaches. This has implications for standardization and scale up of these individual efforts.

Ownership: Most of the curricula have been developed through projects funded by development partners or have been commissioned by individual clients, which often limits sharing and adoption for use of these materials beyond the specific programs. Government leadership and ownership is critical if these efforts are to be scaled up and sustained at a national level.

Sharing of lessons learned: Most of the curricula are tied to a specific program, and these programs are often not required to document and report on their implementation processes. Although some

have been evaluated, the focus of the evaluation has been on outcome indicators. The programs that may be interested in adapting these strategies have no access to information on how these curricula were implemented to achieve the impact. In addition, there is no common place and/or database that can be used to share the different program experiences.

Peer facilitators and staff turnover: High turnover of staff within the programs, including peer facilitators, was raised by a majority of the programs. The reasons for this include poor or absence of remuneration and lack of career development opportunities. In addition, youth peer educators can work in this capacity for a limited time only as they grow out of their cohorts and move on with their educational or professional careers. Programs that have retained their skilled staff have had to invest significantly to ensure job satisfaction and continuous training of new generations of peer educators, which is labor intensive, require sufficient funding and thus, may be hard to replicate at larger scale.

Stakeholder involvement: Stakeholder involvement in the development of the programs and training materials varied across the programs, but generally was limited. Many said youth were involved, but this was mostly through pre-testing of the materials. While some of the curricula were revised based on the results of the pre-testing, youth were not involved in the development process. Few programs had involved parents. Even those programs that were to be implemented in-school did not involve the school teachers in the development of their materials. Buy-in from stakeholders at all levels is critical for the successful implementation of any intervention.

Motivating youth to attend trainings: Most of the training programs involve attending 10 or more sessions. If they are done in out-of-school settings, the process may require motivation and involve additional time and/or cost (e.g. traveling to the training site). Programs have used different incentives to motivate youth to attend the trainings. Grassroot Soccer provides meals and reimburses transport for participating youth. The MRC-Cape Town has used loyalty cards and gift vouchers to encourage youth to attend the full course. Provision of incentives can easily be implemented in pilot or research programs but would be difficult to sustain as the programs begin to scale up. Also once donor funding ends these programs may not able to continue with the incentives, leading to high drop out.

While not all of the parameters above can be addressed or controlled by each program, better coordination and sharing of lessons learned will help to avoid duplication and allocate limited funds more efficiently. At the same time, stakeholder involvement and ownership may offer a better chance that government officials at national and provincial levels will invest in continuation and scale up of the effective interventions after an external funding ends.

In Conclusion

This assessment identified a number of limitations in the areas of technical content and training methodology as well as in the processes followed by programs to design, implement and evaluate their SRH training interventions for youth. The assessment also makes key recommendations on how these limitations could be addressed.

Most of the key informants interviewed appreciated the opportunity to participate and contribute to this assessment. The vast majority felt that it will provide useful information and are interested in seeing the results. They also expressed a hope that this would lead to a more coordinated and collegial collaboration in the development and implementation of SRH curricula for youth in South Africa.

APPENDIX 1

SRHR Training Materials/Curricula Inventory

Training materials and/or curriculum	Criteria	Comments
Love4life Healthy Sexuality Manual (developed by LoveLife, with no PEPFAR or USAID funding)	**Development process criteria**	
	Developed or updated within the past 5 years	Developed in 2013, however from the Reference Materials section it is clear that the development team relied on outdated resources (1998-2001). This may explain why some of the technical information is outdated (e.g., information on appropriate contraception for youth, emergency contraception, access to ART, etc.).
	Addresses SRH challenges in South Africa	Addresses the following challenges: • HIV and STIs • Early sexual debut • Teenage pregnancy • Reproductive rights • Gender-based violence
	Consistent with relevant country policies and guidelines	Refers as appropriate to: • South African Constitution • Sex Description and Sex Status Act • South Africa's Civil Union Act • The Choice of Termination of Pregnancy Act • The Bill of Rights
	Target audience is clearly defined	The manual is designed as a "tool box." It is not targeted to any specific age group, but offers a wide range of activities. The facilitator is expected to choose which activities and topics are appropriate for a particular audience. Serves both in-school and out-of-school youth. The in-school program covers grades 5-12 and complements the Life Orientation curriculum. Out-of-school settings include Y-Centers, clinics settings with adolescent-friendly services and community-based organizations.

	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	Each module within the manual includes clear goals and objectives, but individual sessions within the modules often do not (some, but not all sessions, state "aims"). The lack of objectives for individual sessions could make it harder for facilitators to keep track of what they are trying to achieve with each session. Skills-based objectives are included as appropriate (e.g., identify and practice effective communication skills in different contexts). In some cases, objectives are listed, but not addressed in the module. For example, in Module 8 on teenage pregnancy, the first three objectives are not addressed Some objectives are not measurable because they cannot be observed (e.g., use "understand" or "know" rather than observable measures such as "explain" or "list" or "discuss").
	Relies on effective and appropriate learning/training methodology	The manual integrates methodologies and content from the dance4life South Africa program run by the RedZebra Foundation. It incorporates performing arts into discussion of SRHR issues. All sessions have a strong interactive component and engage learners effectively through the use of case studies, role plays, discussions and reflections. However there are some limitations: • Discussion questions for each session have little or no guidance for facilitators regarding how to process participant responses. Because participants may answer in many different ways, it is important to highlight the key messages facilitators should emphasize when summarizing the discussion. This is necessary because facilitators are young people themselves and may not have sufficient experience/knowledge to process complex and often controversial issues without guidance. • Some activities need refinement. The Agree/Disagree exercise (page 64) is usually very effective for discussion of issues which are <u>not</u> black-and-white and depend to a large degree on values and attitudes. However, if the facilitator starts (as manual suggests) by saying there are no right or wrong responses, he/she should make sure that the "agree/disagree" statements solicit opinions about "grey" issues. For example, the statement, "If a boy hits a girl in a relationship it means that he loves her" is a black-and-white issue; it is always wrong and should not be prefaced with "there are no right or wrong responses." Used with appropriate statements, this activity can be a very effective means of initiating discussion around challenging issues; however, the facilitator must set up the activity correctly and process it appropriately. • The activity on the topic of safe sex (page 82) is both confusing and misleading. It lumps contraceptive safety with safe behaviors and asks participants to grade them all from most safe to least safe without defining what "safe" means. It may create the incorrect impression that some common contraceptive

		methods are not safe for adolescents. Also it doesn't provide guidance to the facilitator about how to process the activity effectively. • The "Agree/Disagree" exercise on page 125 deals with statements about HIV. With a couple of exceptions, all the statements fall in misconception category (Disagree). It is good to have a better balance of "right" and "wrong" statements.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	Many sessions are skills-based to a certain degree and encourage practical application of lessons learned in day-to-day life, however some of the skill-based objectives are stated, but not addressed during the sessions
	Builds towards behavior change model	Includes knowledge, motivation and skills components, which are reinforced throughout the manual. Unfortunately, some of the information is incorrect, which may affect how young people act on this knowledge and in turn, negatively affect desired preventive outcomes.
	Has no serious barriers to adaptation and scale-up	• Includes fairly detailed facilitator guide, which incorporates all key technical information to be covered during sessions • Activities are supported by instructions about how to implement, but more guidance is needed on how to process each activity • Does not require any specialized equipment • Individual sessions are limited to 45 min., which would be appropriate for school-based delivery and for delivery in out-of-school settings
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	Not part of the curriculum.
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	Overall appropriate, however facilitators are responsible for selecting the most appropriate activities from the offerings in the toolkit based on their audience — some activities are more appropriate for younger youth and some for older age groups. The language is mostly non-technical, but occasionally technical terms are used without explanation (e.g., pelvic inflammatory disease, colposcopy, cryotherapy, LEEP). It is potentially confusing and unnecessary for youth to learn these technical terms; especially when these terms could easily be avoided. Participants do not need to know that cryotherapy and LEEP are used to treat cervical abnormalities; rather, they simply need to know that there are some conditions that can be treated and getting treatment is important.

	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	Covers: • Sex, sexuality, and sexual orientation • Gender and gender identity • Sexual health, sexual development, puberty, conception • Reproductive rights • Sexual rights and responsibilities • Relationships, peer pressure, communication and negotiation skills • Safe sex and contraception • Sexually transmitted infections • HIV and AIDS, including myths, risk and risk reduction, counseling and testing, and rights of people living with HIV • Teenage pregnancy, including right to termination of pregnancy • Rape and abuse • Stress and alcohol use • Taking care of your body
	Content is technically accurate and up-to-date	Overall there are many small mistakes throughout the knowledge-based portions of the curriculum; some mistakes are more significant than others because they may have practical implications that affect an adolescent's decision-making process. Examples of errors include: • A lack of clarity in the descriptions of male and female reproductive organs. Sometimes there is too much information (e.g., descriptions of organs such as seminal vesicles or the prostate gland that are not critical for basic understanding of human reproduction). At the same time, important information is missing (e.g., men produce sperm constantly starting with puberty and can cause pregnancy anytime they engage in unprotected sex). The section on the female reproductive system incorrectly includes the anus as part of the reproductive system, but the anus is appropriately not mentioned in the description of the male reproductive system. • The description of the timing of when a girl may become pregnant is confusing and partially incorrect. This could have serious implications, effectively hindering girls' ability to protect themselves from pregnancy when it matters most. • Douching is described incorrectly and the distinction between washing external genitalia (a good practice) and vaginal douching (a not so good practice) is lost. • The timing for initiation of emergency contraception is incorrectly stated as within 72 hours (or 3 days) after unprotected intercourse (rather than 120 hours or 5 days). This reduces access to EC by increasing the chance that some girls will not use it believing erroneously that it is not effective after 72 hours.

- The discussion of abortion procedures is not accurate and not helpful for making an informed decision. For example, asking "Do you want to have surgery or would you prefer a medical (drug) option?" is pointless unless it is explained in a manner that facilitates the client's understanding of the advantages and limitations of each option.
- The question, "Can you fall pregnant when you are menstruating?" is answered correctly (yes), but the explanation is wrong. The reason given is that girls who have irregular cycles for the first few years may get pregnant during menses. This implies that girls who have regular cycles are not at risk, which is incorrect. The actual reason is that for some women with short cycles but long periods, ovulation may occur very close to menstruation. Given that sperm can live in the reproductive tract for five days, it is possible for it to survive until ovulation even though intercourse occurred during menstrual bleeding. Without an understanding of menstrual cycle and fertile time, girls cannot protect themselves from pregnancy effectively.
- The explanation of how contraception works is partially incorrect.
- The concept of dual protection is introduced without clearly explaining what it is; and then, later in the module, where it is discussed in greater detail, the description is confusing. "Male and female condom" is listed as one of the dual protection strategies; inferring that male and female condoms should be used together, rather than clarifying that each type of condom provides dual protection by itself. In fact, if used together, there is a greater chance of breakage. The instruction not to use male and female condoms together is included in a different section of the manual but there is no explanation about why this practice should be avoided.
- The description of contraceptive methods appropriate for youth is partially incorrect. For example, it states that the IUD is not appropriate (while SA family planning guidelines clearly state that adolescents can safely use the IUD), but spermicides (which are very ineffective and generally not recommended) are included as appropriate methods.
- It strongly recommends that COCs be taken at the same time every day, inferring that they are ineffective otherwise. While COCs should be taken daily, precise timing is not really important. Insisting on such strict schedule may turn some girls away from an otherwise very appropriate method.
- It incorrectly suggests that women who take injectables have light and irregular periods. In fact, most women have very heavy and prolonged irregular bleeding for the first 3-6 months after starting injectables and it is important to let young women know that this is normal and not harmful. It is also suggested incorrectly that "injection users may run slightly higher risk of developing certain forms of cancer, and some have had problems becoming pregnant when they wanted to after stopping the method." There is NO increased risk of cancer with injectables and there is no permanent effect on a woman's ability to become pregnant, only a delay by a few months. This misinformation may contribute to fears and make it less likely that adolescents will choose this safe and effective contraceptive method.

- In several places throughout the manual it is suggested that condoms are more effective if used with spermicides, which is not true and can have a negative effect for those at risk of HIV. Spermicides were shown to increase the risk of acquiring HIV when used frequently.
- Abstaining from sex play that involves skin-to-skin contact is presented as a strategy to prevent HPV. This is unrealistic because any sex involves skin-to-skin contact to some degree. Even sex with a condom is not very effective in preventing HPV because the condom does not cover all of the genitalia.
- The argument that you cannot get HIV from mosquitoes "because if you could, there would be people of all ages with HIV" is not very convincing. In fact, there are people of all ages with HIV. Humans cannot get HIV from a mosquito because mosquitos cannot get infected with HIV and do not carry the virus from one person to another.
- In the discussion of anal sex, it should be mentioned that when it comes to HIV, anal sex is a much riskier practice than vaginal sex (the risk was shown to be 18 times higher).
- The activity on page 119 comparing the sexual practices with highest and lowest risk of HIV transmission is a good activity; however, there is no guidance for the facilitator about which practices to include and where a practice falls in continuum of "most risky to least risky." The facilitator notes mention only PEP and male circumcision, which are not sexual practices at all, but approaches to HIV risk reduction.
- The facilitator notes for HIV counseling and testing (page 127) provide confusing and somewhat incorrect information (some mistakes are due to typos). When discussing the need to test for HIV during pregnancy, pregnancy termination is mentioned as an option to consider if someone tests positive for HIV; however, nothing is said about PMTCT as an option for those who want to continue with pregnancy (although PMTCT is discussed in a different section of the module). In addition, there is no mention of access to ARV therapy as one of the reasons to get tested for HIV.
- When discussing access to ART, the module creates the impression that access is very limited by suggesting that ARVs are available only through a national medical aid scheme, but not in any government-run medical facilities. This seems to be wrong as ARVs are offered free of charge in the SA public sector. Clear guidance on access to ART is needed.

Training materials and/or curriculum	Criteria	Comments
STEPPING STONES: A training manual for sexual and reproductive health communication and relationship skills (developed by Medical Research Council in collaboration with the Planned Parenthood Association of South Africa with no PEPFAR or USAID funding)	**Development process criteria**	
	Developed or updated within the past 5 years	The latest, third edition of Stepping Stones came out in 2010 (the first edition was developed in 1998 and the second in 2002). Currently it is used in combination with Creating Futures – a manual based on a livelihood framework, which covers jobs and income generation.
	Addresses SRH challenges in South Africa	• HIV and STIs • Gender-based violence • Unplanned pregnancy • STIs and HIV
	Consistent with relevant country policies and guidelines	• Choice of Termination of Pregnancy Act • Sexual Offences Act • Domestic Violence Act
	Target audience is clearly defined	The manual states that Stepping Stones alone is not age specific and can be used with young people as well as with adults. However, when used in combination with Creating Futures, it targets young people (mostly those who dropped out of school), age 18-25. While age is not specified, it is suggested that the group of participants be small (fifteen to twenty people) and of a single sex (men or women). It also suggests that the age ranges be limited and that the participants' key characteristics be similar (e.g., younger vs. older, sexually active vs. those who have never had sex). Also, if there are great differences between married and unmarried women, they should also be separated into different groups.
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	The manual doesn't have measurable objectives, but each session has a purpose (e.g., to understand our fertility, how to protect our fertility and how to ensure we plan our children). Each activity within a session has aims (e.g., to learn about when someone can get pregnant and to reflect on when we may want to have children).
	Relies on effective and appropriate learning/training methodology	Relies on participatory learning approaches by exploring and supplementing existing knowledge of participants. Employs a variety of games, exercises and role plays to process information and build skills.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	Skill building is the main focus of the curriculum/program. The skills built during Stepping Stones include critical reflection, communication, negotiation and condom use skills.

	Builds towards behavior change model	Includes the following components: knowledge, motivation, skills, and empowerment by enabling participants to analyze a situation and work out the best choices for oneself.
	Has no serious barriers to adaptation and scale-up	The format of the workshop allows for replication and scale-up at the community level; however, availability of qualified facilitators is key and training facilitators requires careful planning and resources. The manual instructions suggest that facilitators should undergo a three-week long training (experience the program themselves as participants, acquire technical knowledge necessary to address content areas, and practice facilitation of individual sessions). The manual includes clear guidance on how to conduct the sessions, basic information to be covered in the sessions and ways to process this information. The program is labor intensive: Stepping Stones content is delivered over a period of 5-10 weeks in three-hour sessions, two sessions per week. It doesn't require any specialized equipment, but requires a long-term commitment from the participants.
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	While the Stepping Stones curriculum doesn't include a formal pre-/post-workshop assessment, the impact of Stepping Stones on sexual behavior was evaluated in a randomized controlled trial (2002-2006). Although it was not possible to measure a reduction in new HIV infections, the incidence of genital herpes was 33% lower in men and women in the Stepping Stones program. In addition, Stepping Stones effectively changed men's gender-related behavior, with a significant reduction in the perpetration of intimate partner violence, which was sustained two years post-intervention, and a reduction in transactional sex and problem drinking.
	Includes participant evaluations to inform review	No formal evaluation, but at the end of the workshop, participants' expectations are discussed and they are given an opportunity to provide feedback.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	Because the manual is not targeted to any particular age group or gender, it is the responsibility of the facilitator to decide how to present information based on a make-up of the peer groups. Overall, the language and activities are appropriate for wide audiences but may require adjustment when working with younger youth.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Communication skills • Self-esteem • Gender and gender roles • Gender violence • Sexual relationships • Conception and contraception

		• Unplanned pregnancy, including discussion of TOP • STIs and HIV • Safe sex/risk reduction • Caring for people with HIV • Loss and grief
	Content is technically accurate and up-to-date	• The explanation of the menstrual cycle is incorrect: the menstrual cycle is not the same as menstruation. The menstrual cycle is a monthly sequence of changes in woman's reproductive tract, which starts on the first day of menstrual bleeding and ends one day before the next menstrual bleeding. Women cannot estimate their fertile time unless they have a basic understanding of the menstrual cycle. • The explanation of fertile days is also incorrect. To estimate fertile days in her menstrual cycle, a woman should count two weeks from the last day of her cycle—not the first day of her cycle. This (mis)calculation is inconsequential for women with 28-day menstrual cycles but makes a big difference for women with shorter or longer menstrual cycles. It is also important to emphasize that 28 days is the average cycle length; it is normal to have cycles of 24 days, or 30, or 32, etc.). The session infers that only 28-day cycles are normal. • It is incorrectly stated that an egg can survive for 2 days and the sperm can survive in woman's reproductive tract only for 24 hours. This is not so. The egg can survive only for 24 hours, but the sperm can survive for 5 days. This means that the number of fertile days is 6 and not 3 as explained in the manual. If couple has sex 4 or 5 days before the egg is released, pregnancy still can occur. • Some explanations for "True/False" statements on page 42 are incorrect. For example: - It is not true that couples who desire pregnancy can reduce the likelihood of conception if they have sex too often because the sperm become too few. This is a common myth and just the opposite is true; the evidence shows that the more people have sex, the better the chances of getting pregnant. - It is not accurate to say that "A woman can get pregnant as soon as she has had her first menstruation." Because ovulation occurs prior to menstruation, a girl who has not had her first menses can be fertile and become pregnant. - While explaining in which situations a woman who is breast feeding cannot get pregnant, one important fact is omitted: the age of the baby. It should be explained that when the infant is six months old, a woman is at risk of pregnancy even if she breastfeeds exclusively. • The game about which contraceptive method is the best should be processed carefully. Following the instructions, the condom will be the only method left at the end of play because it is the only method that provides protection from both pregnancy and HIV. This may discourage women from using other methods. It is important to point out that different people have different views on which method is "best" based on their preferences and life circumstances. And condom can be used in addition to any

method to gain protection from STI/HIV.

- The IUD and male and female sterilization are not presented as contraceptive options. While sterilization is usually not appropriate for young people (although it is not medically contraindicated), it is still a valid option. For example, someone who is HIV-positive may decide he or she does not want to have children. Also the manual is meant for people of all ages—some of the participants may have already had their desired number of children.
- The explanation for COCs states that they do not provide protection from pregnancy until the second pack and that women must also use condoms while taking the first pack of pills. This is not true. Pills are effective immediately if a woman started the pack within the first five days of her menstrual cycle. If not, she should use condom as a backup only for one week, not for the entire month. It is also stated that women who take an antibiotic will also need to use additional protection (condoms) for two weeks. This is not true—regular antibiotics do not interact with COCs and have no impact on their effectiveness. However, antibiotics used for TB treatment do interact with COCs. In this case, using condoms for two weeks is still inappropriate guidance; women taking drugs for TB need to switch from COCs to another contraceptive method.
- When discussing male condom disadvantages, the most important issue is not mentioned: partners' cooperation. Women often have no control over condom use. Incorrect use is NOT the main reason condom may fail; in fact, condoms rarely break. The main reason for condom failure is non-use.
- The explanation for ECP dose partially incorrect. The manual says two COC pills should be taken per each dose. This is only true if high-dose COCs are used. When using low-dose COCs (which are more common), four pills should be taken for each dose.
- The curriculum states "A woman who gets genital warts (icauliflower) is at greater risk of developing cervical cancer and so needs to visit a clinic for regular Pap Smears". This is highly misleading because the types of HPV that can cause genital warts are not the same as the types of HPV that can cause cancers. Women need to know that they can be at risk of HPV/cervical cancer without having warts or any other visible symptoms and a Pap Smear is the only way to diagnose it in a timely manner. It would also be good to mention that a vaccine is available to prevent infection with HPV that can cause cancer (condoms are not very effective at preventing HPV or genital herpes)
- In the section on HIV transmission, it is suggested that saliva is one of the body fluids that can transmit HIV and that sharing a toothbrush may result in HIV transmission. Both statements are incorrect. Sometimes the virus can be detected in saliva, but only in extremely low quantities. Contact with saliva alone has never been shown to result in transmission of HIV and sharing a toothbrush, while not considered a good practice, is NOT a means of HIV transmission.

Training materials and/or curriculum	Criteria	Comments
Respect4U (developed by the Medical Research Council with funding from NIH)	**Development process criteria**	
	Developed or updated within the past 5 years	Developed in 2011 to pilot-test a school-based intervention to prevent intimate partner violence. The intervention is based on a theoretical model derived from existing research about IPV, and three relevant evidence-based programs (Stepping Stones, Safe Dates, and Our Times Our Choices). The 17 lessons are divided into 7 Units and each lesson is derived from specific aims of the study.
	Addresses SRH challenges in South Africa	• Intimate partner violence
	Consistent with relevant country policies and guidelines	• Sexual Offences Amendment Act of 2007 • Domestic Violence Act of 1998
	Target audience is clearly defined	It is designed for Grade 8 learners (age 13-14) to be implemented in the Life Orientation classes; it meets several Grade 8 Life Orientation learning outcomes.
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	Each 45 min. lesson has clearly defined aims and objectives; however, not all of the objectives are measurable.
	Relies on effective and appropriate learning/training methodology	The lessons are delivered in the classroom and contain both didactic components and participatory components, such as discussions, reflections, case studies, role plays, worksheets, and skill-building exercises. Materials include a Learner Workbook that includes all the activities and key information.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	There is a skill-building component, but it is relatively weak as students have very limited time to practice. The skill-building objectives include: • Practice addressing and resolving relationship problems using assertive communication skills • Develop skills to assess their relationship and the problems they are facing within that relationship • Develop skills to end a relationship respectfully.
	Builds towards behavior change model	Includes knowledge and motivation components with a somewhat weaker skills component—used in combination, they may have potential to facilitate behavior change (e.g., reduction in intimate partner violence).
	Has no serious barriers to adaptation and scale-up	The guidance is detailed and the lessons can be easily replicated and scaled up as long as teachers/facilitators have appropriate training in the subject area.
	Has a mechanism for	The manual was developed to pilot-test a school-based intervention to prevent intimate partner violence.

	assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	Although the pilot test showed promising results, the efficacy and effectiveness of this program have not yet been established under rigorous testing. Lessons do not include pre-/post-test questionnaires; however, relevant questions may be included as part of the school Life Orientation tests.
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	The information covered is appropriate for the target population (ages 13-14). It is delivered in a format that is relevant for in-school youth.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Assertiveness and Communication • Gender and Power • Relationships and Sexual Decision-making (includes recognizing and dealing with problems in relationships, such as alcohol and violence, or pressure to have sex) • Violence in Different Contexts • Support
	Content is technically accurate and up-to-date	The information covered is accurate although no “technical” information, such as HIV, STI, pregnancy prevention, is included. The manual deals narrowly with issues around communication, relationships and intimate partner violence.

Training materials and/or curriculum	Criteria	Comments
PREPARE (developed by the Medical Research Council with funding from EU)	**Development process criteria**	
	Developed or updated within the past 5 years	Developed in 2013 by adapting Respect4U, keeping about 80% of the content and adding preventive behaviors components such as condom use and partner reduction. It was developed for the PREPARE study, which is an acronym for *Promoting sexual and reproductive health among adolescents in southern and eastern Africa—mobilizing schools, parents and communities*.
	Addresses SRH challenges in South Africa	• Intimate partner violence • STIs and HIV
	Consistent with relevant country policies and guidelines	• Sexual Offences Amendment Act of 2007 • Domestic Violence Act of 1998
	Target audience is clearly defined	Designed for 13-14 year old students (the same as Respect4U curriculum), but conducted as afterschool program within school settings. It is expected to complement the Life Orientation curriculum.
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	Each 45 min. lesson has clearly defined aims and objectives; however, not all of the objectives are measurable.
	Relies on effective and appropriate learning/training methodology	Same as Respect4U, the lessons are delivered in lessons format, but not in the classroom. The curriculum was originally implemented as afterschool program in school settings. The lessons contain both didactic components and more participatory components, such as discussions, reflections, case studies, role plays, worksheets and some skill-building exercises. Materials include a Learner Workbook that includes all the activities and key information.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	There is a skill-building component, but it is relatively weak as students have very limited time to practice. The skill-building objectives include: • Practice addressing and resolving relationship problems using assertive communication skills • Develop skills to assess their relationship and the problems they are facing within that relationship • Develop skills to end a relationship respectfully. The condom game is tied to the objective "To reinforce learners' knowledge on how to use condoms correctly", but doesn't include condom negotiation skills.
	Builds towards behavior change model	Includes knowledge and motivation components with a somewhat weaker skills component–used in combination, they may have potential to facilitate behavior change.

	Has no serious barriers to adaptation and scale-up	The guidance is detailed and the lessons can be easily replicated and scaled up as long as teachers/facilitators have appropriate training in the subject area. In the original study, facilitators were trained for one week and allotted additional time for practice. They also had meetings each Friday to discuss challenges and receive support. Thus, scale up would require supervision, follow-up and mentoring for facilitators, which could be time consuming and expensive. However, these lessons can also be implemented by teachers as part of the Life Orientation curriculum (the same as Respect4U).
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	Lessons do not include pre-/post-test questionnaires; however, relevant questions may be included as part of the school Life Orientation tests. The study will measure indicators reflective of behavior change. Primary outcomes include age of sexual debut, condom use and number of partners; secondary outcomes include intimate partner violence and pregnancy.
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status:	The content of the sessions/lessons is appropriate for the target population (age 13-14) and delivered in a format that is relevant for in-school youth. Some information included in the Learners Manual should be simplified for this age group. For example, the HIV Fact Sheet mentions practicing only non-penetrative sex as one of HIV preventive behaviors, but doesn't explain what "non-penetrative" sex means. Or talks about how ART can slow the disease progression by decreasing an infected person's viral load, but never explains what "viral load" means. For 13-14 year olds the language needs to be simplified (e.g., viral load can easily be changed to the amount of HIV virus in a person's body).
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas.	• Assertiveness and Communication • Gender and Power • Relationships (includes recognizing and dealing with problems in relationships, such as alcohol and violence, or pressure to have sex) • Sexual Decision-making (covers sexual debut, number of partners, STIs/HIV, and condom use) • Violence in Different Contexts • Support
	Content is technically accurate and up-to-date	This curriculum contains a good explanation of what condoms can and cannot do (e.g., provide protection from HIV and some, but not all, STIs; less effective for preventing STIs transmitted through skin-to-skin contact). It would help, however, to provide a better idea of the level of protection that condoms provide. In the sexual decision-making section, every time HIV or STI transmission is discussed, it is stated that

"Abstinence is the only 100% method of preventing it. Condoms when used consistently and correctly can reduce the risk of transmission." It is important to let learners know that condoms can significantly reduce the risk of transmission—close to a 100% reduction in cases of HIV was achieved in studies among serodiscordant partners if condoms were used every time. Vague information about the effectiveness of consistent condom use is not a good motivator and could make it less likely that adolescents will use condoms when they become sexually active.

The STI facts table has some gaps and inaccuracies:

- The section on HPV mentions only HPV types that cause genital warts, but not those causing cervical cancer; it also does not mention that there is a vaccine.
- The description of gonorrhea includes symptoms of pelvic inflammatory disease (PID), but description of chlamydia does not. However, both infections can progress to PID. From a practical perspective, it is important to know that delay in treatment of either gonorrhea or chlamydia can result in serious complications and that the sooner someone with symptoms goes to a clinic for treatment, the better.

Session 15 states that the main reason for a condom breaking is incorrect use and focuses only on steps for how to put a condom on correctly (e.g., condom game on page 102 of Facilitator Manual). However, factors other than "putting it on incorrectly" play a greater role in condom breakage. These factors include incorrect storage, use beyond the expiration date, or opening the package with a sharp object (i.e., teeth or nails) that damage the condom. These factors are more important for reducing condom breakage but are not discussed.

Training materials and/or curriculum	Criteria	Comments
Vhutshilo 2 (developed by the Center for Support of Peer Education with PEPFAR/USAID funding)	**Development process criteria**	
	Developed or updated within the past 5 years	Was developed in 2008 and updated in 2012. Vhutshilo 2 is a sequence of 13 one-hour sessions facilitated by teams of three/four peer educators or young adult facilitators, aged 16-20. Was originally planned for implementation in drop-in centers (or other community settings) but did not move beyond school settings.
	Addresses SRH challenges in South Africa	• Orphans and Vulnerable Children (OVC) • HIV/AIDS • STIs • Teenage pregnancy
	Consistent with relevant country policies and guidelines	Contraceptive guidelines and PMTCT guidelines are the only applicable documents. However, some information on contraception and PMTCT in the curriculum is not consistent with the country guidelines.
	Target audience is clearly defined	Groups of 10-15 OVC between the ages of 14-18.
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	Each session has a stated purpose and clear objectives (most, but not all, are measurable). Sessions also include key points which help facilitators ensure that critical information is covered. Skill-building objectives are stated where appropriate, although the length of sessions does not allow much time for practicing new skills.
	Relies on effective and appropriate learning/training methodology	• Designed as a face-to-face interaction between youth of roughly the same age. Relies on the Experiential Learning Model— starts with participants' current knowledge and attitudes and augments access to new skills and knowledge. Young people actively learn through participatory problem-solving activities (i.e., stories, case studies) that relate to their lives. • Activities are well developed, offer clear instructions to facilitator as well as key points on how to summarize or process each activity. • However, the sequence of sessions seems to be off. For example, Session 7 is titled Understanding HIV and AIDS; however, most of the basic information on HIV is covered in Session 10. Reorganizing the information more logically would facilitate completion of participant activities as some of the questions participants are expected to answer in Chapter 7 are addressed only in Chapter 10.While each session is designed to be 1 hour long, it would help to give time estimates for each activity within the session.

	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	The sessions cover mostly knowledge components. The skill-building component for pregnancy/STI/HIV prevention is very weak. Condom negotiation skills are not included and opportunities for practice (e.g., condom use) are limited by the one-hour session format.
	Builds towards behavior change model	Fosters behavior change by providing information, exploring values and attitudes, building self-esteem, and offering skill-building opportunities. Small-group format ensures support and motivation.
	Has no serious barriers to adaptation and scale-up	The inclusion of a second layer of training for youth facilitators/peer educators, in addition to adult trainers, is not readily sustainable. To effectively implement the curriculum, the infrastructure must support training of peer educators and ongoing support from adults. NGOs who work with youth need to build capacity in HIV and other content areas. Staff attrition is a commonly mentioned problem among NGO staff and among youth facilitators/peer educators.
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	There are no formal tools to assess changes in the knowledge and attitudes of individual participants; however, the last session is a review session. This session is made up of assignments that participants must complete in teams and is graded by facilitator on a scale of 1 to 5. However, pre-/post-test questionnaires are used when training youth facilitators. There is also a limited M&E component.
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status:	Overall, the format and activities seem appropriate for 14-18 year olds. However, sometimes the language is overly technical and could be simplified (e.g., “Alcohol only lessens sexual inhibitions” with no explanation of what “inhibition” means; drugs reducing “a person’s sexual response, causing premature ejaculation and making people unable to have an orgasm” when younger participants may not know what “premature ejaculation” or “orgasm” mean). Using technical terms such as opportunistic infections, viral load, immune system, circumcision, or gestational age is appropriate only if it is accompanied by an explanation. Some of these terms are explained, in later sessions, not when they were introduced for the first time.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• How to deal with feelings • Finding support • Making decisions at difficult times • Dealing with grief and loss • Coping without drugs and alcohol • Understanding HIV and AIDS • Gender violence • Having healthy relationships

		• Staying safe in sexual relationships • Unplanned pregnancy • Thinking about the future
	Content is technically accurate and up-to-date	• The fact sheet on alcohol and drugs discusses "coffee, tea and fizzy drinks" in a way that does not distinguish them from alcohol—stating that they are addictive because they contain a drug, caffeine. This parallel is incorrect because health effects caused by tea or coffee do not put young people at risk. This approach trivializes the effects of alcohol and can lead to young people to think that alcohol is "not a big deal" because it is not worse than tea. • The same fact sheet states as fact that "alcohol only affects some people and not others". This is misleading because, while alcohol can affect individuals somewhat differently, abusing alcohol has serious negative effects for everyone. • Session 7 on HIV/AIDS states: If the male partner uses a condom, but does not use it correctly, the risk is about the same as not using one at all. This is very misleading because the main reason for condom failure is inconsistent use, not incorrect use. Incorrect use increases risk of condom breakage, but breakage is still quite rare and the risk of acquiring HIV is far less than when not using condom at all. The misleading portrayal of this issue could discourage condom use among youth. • The HIV fact sheet states "There is an extremely high risk of transmitting and/or contracting HIV from any type of sex—oral, anal, vaginal". However, these three activities do not carry the same level of HIV risk. It is important to know that anal sex is at least eighteen times riskier than vaginal sex and oral sex is significantly less risky than vaginal or anal sex. Sexually active adolescents need this information to be able to choose safer practices. • The explanation of breastfeeding by HIV-positive women is confusing and partially incorrect (for example, the safest option of formula feeding is not mentioned at all even though SA PMTCT programs provide free formula to HIV-positive mothers). The section also contains many technical terms, which are not defined, such as antiretroviral treatment, prophylaxis, viral load, mixed-feeding of infants, etc. • One session states that going to a health facility, which also serves people with HIV is safe, but includes the caveat that it is important "to make sure that all the equipment they use and the conditions are clean and completely sterilized." How a young person (or any client) is supposed to ensure that a facility conforms is not clear. This statement stigmatizes people with HIV and makes it less likely that adolescents will seek help from a health care provider. • The statement—Having sex with more than one person at the same time puts both you and your partner, and the other people you are having sex with, at high risk of HIV, reinfection of HIV, or other STIs—is correct, but somewhat misleading. It was shown that for adolescents serial monogamy is more common than having multiple partners within the same time frame. Therefore, it is important to emphasize that not only having multiple sex partners increases HIV/STI risk, but that changing partners frequently is as risky.

		• The STI fact sheet states that "chlamydia can be easily cured with antibiotics". However, it is also important to mention that if left untreated, it can lead to serious complications such as affecting the ability to have children or occasionally even death. It is important to go to the clinic as soon as possible if symptoms are experienced by an individual or his/her partner. • When stating that "some types of HPV can cause cervical cancer," it is important to point out that a vaccine is available and explain where to go for vaccination if desired. The vaccine can significantly reduce the risk of getting infected with these types of HPV. • The section on contraception states "the condom is the only contraceptive available for men". This is not true because men can also choose male sterilization/vasectomy. While vasectomy may not be appropriate for young people because most of them would want children eventually, it is important to educate boys about their options so they can consider taking responsibility for family planning later in life, when they have completed their families. The fact sheet on contraceptive methods, which accompanies this section, does mention vasectomy along with female sterilization. • The statement "In addition to condoms, it may help to use a spermicide cream or jelly in the vagina as well, as this should kill any sperm that may escape" is incorrect. Spermicides were not shown to increase condom effectiveness, but may increase HIV risk if used frequently. • The main advantage of the female condom is not that "the female has control over contraception" (there are other contraceptive methods that are female controlled), but that female condoms allow women more control over STI/HIV prevention. Before the introduction of the female condom, only male condoms provided HIV protection. • The page on oral contraceptive pills contains contradictory statements about the mechanism of action. Initially it states that both types of OCs (combined and progestin-only) work by preventing egg release, but later states that POPs do not prevent egg release and thus should be taken at the same time every day. In any case, this level of detail is not necessary—it is sufficient to state that POPs are less effective than COCs unless they are taken at approximately the same time every day. COCs do not need to be taken at the same time (another incorrect and contradictory statement) as long as they are taken daily. • The description of what to do if pills are missed is incorrect. • The suggestion to see a doctor if experiencing common side effects such as nausea or mood swings is unnecessarily alarming. It suggests that something is wrong when, in fact, these side effects are harmless and often to be expected during the first few months of pill use. • Antibiotics (other than those used for TB treatment) do <u>not</u> interfere with pill effectiveness. • The window for initiating emergency contraception is stated incorrectly: it should be 120 hours (5 days), not 72 hours (3 days). Two additional days to initiate protection from an unintended pregnancy can make a big difference for adolescent girl. • The statement that emergency contraception "In very rare cases can lead to an ectopic pregnancy, which

		is one reason why you need to have a checkup after 3 weeks" is incorrect. EC does not lead to ectopic pregnancy; it actually reduces the overall risk of ectopic pregnancy. However, because EC is not 100% effective in preventing pregnancy, some ectopic pregnancies may occur. The reason to see a doctor after three weeks is to make sure you are not pregnant. Those who are pregnant will benefit from making decisions about their options as soon as possible. • The statement "The IUD lasts up to 8 years, although the effectiveness may be slightly lower after 5 years" is incorrect. The most common IUD registered in SA is effective for at least 10 years (studies have shown it is effective for up to 12 years) and effectiveness is not reduced after five years of use. It is an excellent method for those who want a long-term contraception and is a good alternative to sterilization. • There is no need to check IUD strings each month to make sure the device is still in place. In addition to being unnecessary, this may discourage young women from using it. • The information on IUD included in the curriculum makes it seem like women who use an IUD will be at risk of pelvic infection and infertility, which is incorrect. An IUD does not cause pelvic infection, only STIs do, especially when left untreated. The contraceptive section discusses the diaphragm and cervical cap in the same amount of detail as other methods. However, according to the SA contraceptive guidelines, the diaphragm is not available in the public sector and availability is very limited in private sector, while the cervical cap is not available anywhere in SA. As such, these contraceptive options should not be discussed in this section.
Training materials and/or curriculum	**Criteria**	**Comments**
Generation SKILLZ (developed by Grassroot Soccer with non-PEPFAR USAID funding)	**Development process criteria**	
	Developed or updated within the past 5 years	Reviewed every year and updated as needed. Last update occurred in 2013. The Generation SKILLZ curriculum is one in a series of four curricula. It is designed to be used after the basic SKILLZ curricula (reviewed below) and is the pre-requisite for the SKILLZ Street curriculum and the Generation SKILLZ Utshintsho (aka Boosters) curriculum (also reviewed below).
	Addresses SRH challenges in South Africa	• HIV/AIDS • Gender-based violence
	Consistent with relevant country policies and guidelines	Some of the technical information is outdated (e.g., information on PMTCT is not consistent with SA PMTCT guidelines)
	Target audience is clearly defined	Youth aged 15-19 years, both boys and girls, in in-school and out-of-school settings; consists of 11 practice sessions.

	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	Each session has clear and measurable objectives. While all objectives are knowledge-based (not skill-based), each session includes a task where participants are instructed to go out and discuss certain topics with their peers outside of Generation SKILLZ settings. Next time they meet for a session, they start by sharing their experiences from peer discussions. Although not specified, the repetition of this activity over time allows participants to develop some level of skill around discussing sensitive issues with their peers.
	Relies on effective and appropriate learning/training methodology	Eleven 45-minute practice sessions are delivered by young adult educators (between the age of 18 and 25) called SKILLZ Coaches. Sessions are designed in a very dynamic, interactive manner and include multiple activities, facilitate discussions and reflections, build on participants' experiences and provide key information for facilitators to emphasize.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	The prevention component is mostly knowledge-based. Condom practice or condom/safe sex negotiation skills are not addressed.
	Builds towards behavior change model	Knowledge and motivation components are very strong; however, skills are not adequately addressed at this level in the curriculum series but are more prominent in Generation SKILLZ Boosters curriculum for 16-17 year olds.
	Has no serious barriers to adaptation and scale-up	It has already been implemented on fairly large scale; Generation SKILLZ and SKILLZ Street currently reach about 50,000 youth per year.
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	Currently conducting three-year long randomized control trial (RCT) with Generation SKILLZ to assess behavior change and effectiveness of the curriculum. Indicators include number tested for HIV and number of males circumcised. Also within the study about 10% of participants complete pre-test and post-test questionnaires to assess changes in knowledge/attitudes/values.
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	The activities are age appropriate and suitable for both boys and girls. Some sessions require separating participants by gender so the discussion can stay focused on issues and perspectives relevant to girls-only or boys-only.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	Addresses key drivers of the HIV epidemic: • HIV • Gender and gender norms

		• Gender-based violence; connection between alcohol and violence • Decisions about safer sex, number of partners, condoms, circumcision • Stigma and discrimination • Healthy partnerships (faithfulness, trust and communication)
	Content is technically accurate and up-to-date	• The explanation for the statement "Anal sex is safer than vaginal sex", which is part of the True/False game, is inaccurate. While it is true that anal sex is much riskier that vaginal sex when it comes to HIV transmission (and it is very important for youth to know that), it is incorrect to assert that "Anal sex is not a safe way to avoid pregnancy." Anal sex cannot lead to pregnancy and may be a "safe" option for avoiding pregnancy when both partners are HIV/STI-free. • When discussing risk factors for HIV, multiple partners are defined as "having more than one sexual relationship at the same time." This definition should be broadened to include frequent partner change because serial monogamy is more common among adolescents, especially among girls, than having several partners at the same time. Similarly, the Session 5 objective "Explain why having more than one sexual partner at the same time puts you at greater risk for getting HIV" could be improved by changing it to "Explain why having more than one sexual partner at the same time *or changing partners often* puts you at greater risk for getting HIV." The risks associated with "having several partners at the same time" are reinforced throughout the manual which may lead youth to think that as long as they have one sexual partner at a time (regardless of how often they switch to a different "one partner"), they are safe. • When partner reduction is discussed later in the module, it is also important to mention partner reduction over time—encouraging youth to not change partners frequently. The take-home message should focus on reducing the number of partners—from the perspective of reducing risk, it does not matter whether that is achieved by reducing from three partners to one or two partners within the same time frame or limiting how often an individual changes partners over time. Youth need to learn that having a new girlfriend or boyfriend every couple of months is as risky as having a comparable number of partners at the same time during that period. • The answer to the question "Why is it important for a girl or woman to see a health care worker if she thinks she might be pregnant or have HIV or an STI?" is incomplete. It states that the only reason is the need for proper care so that the baby will be healthy. However, girls in SA have access to safe abortion and they should be told about this option as well. • The response to the statement "If you have HIV or an STI it is important to start getting treatment so that you can take care of the symptoms and not pass it to your child" is also incomplete. An individual can acquire a STI or HIV without getting pregnant but it is still important to be treated as soon as possible. Untreated STIs can lead to life-long health problems. • The statement "HIV-positive pregnant women can take ARVs such as Nevirapine during their pregnancy" is incorrect. The Nevirapine regimen is no longer recommended to mothers for PMTCT (the regimen is

		now reserved for infants for the first six weeks after birth or until breastfeeding stops). The SA PMTCT guidelines recommend initiating full HAART for all pregnant women either for life or throughout the pregnancy or until breastfeeding stops. For the purpose of this curriculum, it would be sufficient to state: HIV-positive pregnant women can take ARVs during their pregnancy and while they are breastfeeding their baby. It would also be good to explain what ARVs are (e.g., they are drugs, which do not cure the virus, but keep the amount of virus in the body very low, so it is harder to transmit it to others). • The statement "HIV-positive pregnant women can get a Caesarean section to reduce the transmission of blood and fluids to the baby during birthing" is incorrect. The SA PMTCT guidelines (as well as global guidance) clearly explain that Caesarean section should be performed for obstetric indications only and is not recommended to reduce mother-to-child transmission.
Training materials and/or curriculum	**Criteria**	**Comments**
SKILLZ Street (including My SKILLZ Street booklet) (developed by Grassroot Soccer with non-PEPFAR USAID funding)	**Development process criteria**	
	Developed or updated within the past 5 years	Reviewed every year and updated as needed. Last update took place in 2013.
	Addresses SRH challenges in South Africa	• HIV/AIDS • Teenage pregnancy • Gender violence
	Consistent with relevant country policies and guidelines	Guidance explains girls rights in accordance with: • The Choice on Termination of Pregnancy Act • The South African Children's Act • The Criminal Law (Sexual Offenses and Related Matters) Amendment Act (Sexual Offenses Act) • South African Schools Act Some information on family planning methods is inconsistent with SA National Contraceptive Clinical Guidelines (2013).
	Target audience is clearly defined	SKILLZ Street is designed for 13-16 year old girls (Grades 8 and 9) who have completed an activities-based HIV prevention and life skills curriculum—SKILLZ or Generation SKILLZ. It is structured as an after-school soccer league for 100 girls led by 10 female coaches and consists of 10 two-hour practices/sessions.
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	Yes.

	Relies on effective and appropriate learning/training methodology	Uses highly engaging, participatory methodology. Incorporates SMS service (Coach Tumi), which could be used to acquire contact information on local health services or community youth centers. It also allows participants to take fun quizzes that test an individual's SKILLZ Street knowledge.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	Participants learn skills for communicating with peers on issues discussed during sessions. These *micromoves*—topics to discuss with peers outside of the SKILLZ Street setting—are assigned at the end of each session. There is also a skill-building activity on how to say "No" to sex.
	Builds towards behavior change model	Knowledge, motivation and skills components are all present, with motivation being the strongest.
	Has no serious barriers to adaptation and scale-up	It is already implemented on large scale.
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	A "pre-challenge" and "post-challenge" questionnaire exist, but it is not included as part of the facilitator guide (coaches are instructed to request it from the program coordinator). The SMS quizzes provide an opportunity to test knowledge and are employed throughout the course.
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	The activities are age and gender appropriate and are conducted by female coaches which makes it easier for participants to discuss sensitive topics.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Self-esteem • Gender and gender expectations • Healthy relationships • Teenage pregnancy • Sexual abuse and rights • Family planning • HIV counseling and testing • Where to go in case of rape and services provided • ART and healthy living

	Content is technically accurate and up-to-date	• When discussing how girls can reduce gender-related HIV risk (not biological risk), it is good to be more specific. For example, instead of stating that we can challenge gender expectations, it would be good to give some examples of what girls can do to gain more power in relationships. For example, they can learn how to talk to their boyfriends/partners about delaying sex, having safe sex, condom use; they can stay in school and get good education so they are not dependent on boys/men for giving them money, etc. • The explanation "menstruation means you could become pregnant if you have unprotected sex" should also mention that a girl can become pregnant even before her first period. This is because the ability to become pregnant precedes menstruation by about two weeks. • The explanation "You may be pregnant if you are having sex and have not had your period in two months" should not include such a wide window. If a girl waits an entire month after missing her period, she may be missing the best window for pregnancy termination (if pregnancy termination is desired). It is better to give more specific and proactive guidance such as: If you are having sex and your next period does not come when expected, you may be pregnant. If this is the case, don't wait; go to the clinic as soon as possible. • The statement "Sperm can live inside a woman for up to 5 days" does not provide enough context about why it is possible for a woman to get pregnant if she has sex during her period. This statement is meaningless if participants lack knowledge about ovulation and fertile time; nonetheless, this prerequisite information is not included. • When discussing if girls can prevent teenage pregnancy, it is not enough to simply say "yes." Availability of contraceptive methods should be mentioned along with where and when they can be obtained from local health care providers. Family planning is discussed in a later session, but it is also important to link to it when discussing teenage pregnancy. It would be preferable to use the term "contraceptive services" in lieu of "family planning" services, simply because most adolescents do not think yet about planning their families and may erroneously assume that family planning services are not for them. • The terminology and some explanations are inconsistent between the facilitator/coach guide and the booklet (My SKILLZ Street). For example, ova and egg are used interchangeably without explaining that they are the same thing, menstruation is explained differently in the facilitator guide and the booklet. Also, the booklet uses many terms that are too technical and not explained/defined. It is not clear how girls are expected to work through this information by themselves. • Stating that the DMPA injection is recommended for women that have already given birth to more than two babies is incorrect. The SA Contraceptive Guidelines clearly state that "both DMPA and NET-EN are safe, highly effective and equally suitable for young women." • The table on family planning methods in the My SKILLZ booklet states that a male condom **lowers risk** of STIs and that a female condom **provides protection** from STIs. This makes it seem that male condoms are less effective than female condoms, which is not true. Also nowhere in this table is HIV protection mentioned.

		• The explanation in the My SKILLZ booklet on how to avoid trichomoniasis is very confusing and says "The best way to avoid herpes is to have one mutually faithful sexual partner who also does not have syphilis. Since it's passed in body fluids, condoms are good at preventing passage of trichomoniasis to a partner". It is unclear why the statement mentions herpes and syphilis in addition to trichomoniasis—these maybe typos (introduced by cutting and pasting this information from somewhere else), but participants won't know that. • The information on HPV in the My SKILLZ booklet does not include the fact that a vaccine is available to prevent cervical cancer. • The My SKILLZ booklet includes an inaccurate statement that it is possible to get rid of Hepatitis B (sometimes acute hepatitis B goes away, but there is no cure for chronic Hepatitis B). • The discussion of the need for HIV re-testing should provide more specific guidance. The statement "If you had unprotected sex in the past, you need another test in 3 months" is not sufficiently specific. Rather, it should specify: If you had unprotected sex within the last few months. "In the past" could mean a year ago which would not warrant retesting. It is also important to know that they should not have unprotected sex while waiting for retesting (otherwise the "window period" will shift again).
Training materials and/or curriculum	**Criteria**	**Comments**
SKILLZ (developed by Grassroot Soccer with non-PEPFAR USAID funding) Because this curriculum is for the most part a variation of Generation SKILLZ curriculum, this	Target audience is clearly defined	Designed for youth aged 10-14 years, in and out-of-school, boys and girls; consists of nine 45-minute practice sessions.
	Covers one or more of the SRHP topic areas	• HIV • Reducing risky behaviors • ARVs • Stigma and discrimination • Gender and gender norms • Peer pressure and alcohol • Saying "no" to pressure (includes skill-building)
	Content is technically accurate and up-to-date	This program provides very basic information and serves as a foundation for moving to the next level in the series (Generation SKILLZ or SKILLZ Street) • The response to the question "Can ARVs be difficult to take? Why?" is overly negative. Simply stating that yes, ARVs can be very difficult to take because it is hard to remember, and that ARVs have serious side effects, may bias youth against ARVs. It would help to give a more measured response and explain that taking pills is really not difficult; although it may be hard for some people to remember to take them every day, there are ways to help them to remember. Also, because modern ARV regimens have

review only includes criteria where there are differences between the two curricula.		significantly fewer side effects, it is better to say yes, some ARVs have side effects, but fewer than older ARVs and new, better drugs are developed every year. • The session that introduces ARVs and opportunistic infections is scheduled before the session where ways of HIV transmission are discussed. The order should be reversed.
Training materials and/or curriculum	**Criteria**	**Comments**
Generation SKILLZ "Utshintsho" (developed by Grassroot Soccer with non-PEPFAR USAID funding) Because this curriculum is for the most part a variation of Generation SKILLZ curriculum, this review only includes criteria where there are differences between the two curricula.	Target audience is clearly defined	Designed for youth aged 16-17 years, in- and out-of-school, boys and girls; consists of seven 45-minute practice sessions.
	Covers one or more of the SRHP topic areas	• Risk behaviors and making healthy decisions • Gender and gender roles • Healthy and unhealthy relationships • Gender-based violence • Alcohol and consequences of drinking • Saying "no" to sex and respecting refusal to have sex (includes skill-building)
	Content is technically accurate and up-to-date	This program builds on knowledge acquired during Generation SKILLZ – it contains no additional knowledge, but reinforces what was learned and focuses on problem-solving and skill-building. Because this program is for an older age group (16-17), it would be beneficial to incorporate some complexity into discussions rather than limiting all solutions to condoms. Having only one, uninfected and mutually faithful partner is correctly presented as one of the ways to avoid HIV. However this option is not considered when the case studies are processed. For example, the case study where two 18-year olds decided to have unprotected sex after both tested negative for HIV presents a good opportunity to fully discuss this option (e.g., staying faithful and using a contraceptive method other than condom for pregnancy prevention). However, the discussion for this case study again focuses on the condom as the only option. This undermines all other HIV prevention strategies. It's confusing to have other options available when, regardless of the situation, the condom is considered the only choice.

Training materials and/or curriculum	Criteria	Comments
Young4Real **Young People's Sexual and Reproductive Health Information and Services: Advocacy Training Handbook** (developed by SAfAIDS with EU funding)	**Development process criteria**	
	Developed or updated within the past 5 years	Developed in 2012.
	Addresses SRH challenges in South Africa	• STIs/HIV/AIDS • Teenage pregnancy • Gender-based violence
	Consistent with relevant country policies and guidelines	Seems to be consistent with policies around reproductive rights and PMTCT guidelines. The information on contraception is very basic but no age restrictions are introduced when discussing appropriate contraception for youth. Missed opportunity: a girl being expelled from school is mentioned as one of the consequences of teenage pregnancy. This would be a good place to mention the policy which states that they have a right to continue their education in spite of pregnancy.
	Target audience is clearly defined	The target audience is defined as young people who will be empowered to disseminate accurate information on SRHR to other young people and to become leaders in championing young people's SRHR rights. It is also meant to be a reference tool for others, such as teachers, who may perform supportive roles for young leaders. Although not stated in the training manual, discussions with the program staff clarified that the Young4Real program is meant for both in- and out-of-school youth.
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	Objectives are both achievable and measurable. However, objectives are stated for each module as a whole, but not for individual sessions in each module. It would have been more helpful to have a goal for the module, but separate objectives by session. For example, Module 3, includes 11 different sessions and it is difficult to keep track of which objective(s) are being addressed in a given session.
	Relies on effective and appropriate learning/training methodology	While the total session length is stated in the beginning of each session, it would be helpful to give an approximate time needed for each activity. Some sessions have up to ten different activities and it is difficult to estimate the length of each activity without prior practice.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	The skill-building component includes communication skills, leadership skills, and condom use skills.

	Builds towards behavior change model	The training is focused on knowledge and some skills as the trainees are expected to transfer knowledge and skills to their peers. The motivation component is not as prominent.
	Has no serious barriers to adaptation and scale-up	The instructions for facilitators are clear (aside from not including guidance around timing allocated for each activity). Activities are well developed and all key information is included, which should facilitate replication/scale up. If, as program staff mentioned, trainees may include out-of-school youth, literacy should be included as a prerequisite; many activities involve some reading and writing.
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	Training includes pre- and post-test questionnaires to assess knowledge and attitudes.
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	It seems that the level of information provided is appropriate for older youth (14-15 and above); however, the age of participants is not specified so it is not clear if younger youth may be involved in this training. If yes, some language may be too technical. The needs of both boys and girls are equally addressed for all topics.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Roles and responsibilities of SRHR champion • Puberty and adolescents' SRH needs • Sexual abuse and gender based violence • STIs and HIV • Contraceptive options • Understanding human sexuality • Communication and interpersonal skills • Leadership qualities • Basic principles of behavior change
	Content is technically accurate and up-to-date	Because the target audience for this training is youth who will then educate their peers on SRHR, it is particularly important that they have correct information. While most of the information is up-to-date and messages are kept simple (for the most part), there are still some technical inaccuracies: • Vaginal sex is defined as an act when the penis or fingers go into the vagina. Similarly, anal sex is defined as an act when the penis or fingers go into the anus. This is incorrect. Using fingers counts as sexual

stimulation, but it doesn't have the same consequences as actual penetrative sex (e.g., pregnancy or STI/HIV). Defining it this way makes it difficult to talk about associated risks.

- Some male reproductive organs are labeled incorrectly.
- Telling young people: Only male condoms made out of latex protect against HIV—is incorrect. Plastic male condoms also protect from HIV and can be used by those with a latex allergy. In addition, the statement creates an impression that participants should make a special effort to look for a latex condom when, in fact, latex condoms are the most common condoms on the market and are the condoms available free of charge in the public sector. Furthermore, the SA contraceptive guidelines mention only latex condoms (not natural condoms, which provide no protection from HIV) inferring that natural condoms are hard to find in SA.
- When advising not to keep condoms in the wallet, it is important to clarify: Do not keep in the wallet *for long* (e.g., several weeks). It is also helpful to explain why: if kept in the wallet or pocket for a long time, body heat makes latex condoms weak and more likely to break. Young people must keep condoms somewhere if they want to be prepared for safe sex; a wallet or pocket is a natural place. Putting a condom in a wallet when going out or keeping it there for several days will not damage the latex.
- The explanation "Adolescents who are taking the ARV called Efavirenz may need a second method of birth control, as Efavirenz may change how well some birth control pills work" is incorrect. Efavirenz does not reduce pill effectiveness by much; however, it may cause birth defects if woman who takes Efavirenz becomes pregnant. This is why women on this particular ARV should also use a reliable, highly effective contraceptive method. Pills are very reliable if woman remembers taking them every day.
- Safe sex to prevent STI/HIV and pregnancy is defined in a very "condom-oriented" manner throughout the module. Even though other safe practices are introduced, such as sex with uninfected faithful partner, safe sex is still defined as "choosing sexual practices and protection methods that do not allow body fluids to pass from one person to another." If this definition is followed, then only condoms can ensure protection from HIV and pregnancy. However, safe sex may involve preventing STI/HIV by being mutually faithful and using injectables (or pills, or the IUD) for pregnancy prevention. These practices can be considered safe sex despite the exchange body fluids. Adolescents should be aware of all their options since "one size" does not necessarily fit all.

Training materials and/or curriculum	Criteria	Comments
Working with Men and Boys: Gender and Sexual & Reproductive Health Manual (developed by Sonke in partnership with Pathfinder; no direct USAID funding)	**Development process criteria**	
	Developed or updated within the past 5 years	Was developed in 2009 in collaboration with Pathfinder for a year-long community project on pregnancy termination. The goal was to educate men on the importance of supporting a woman's right to choose TOP and to improve women's access to safe abortion services.
	Addresses SRH challenges in South Africa	• Unintended pregnancy/termination of pregnancy
	Consistent with relevant country policies and guidelines	• The Choice in Termination of Pregnancy Act
	Target audience is clearly defined	Target audience is defined broadly as "men and boys" and also as "a resource for those working with men and boys on issues of sexual and reproductive health, specifically increasing access to safe and stigma free abortion services, as well as gender and health on a broader scale."
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	The manual is divided into sections and activities. Each section has clear goals and each activity has well defined objectives; however, objectives are not always measurable (e.g., using verbs such as "understand" which is not observable, making it unclear how the facilitator knows if participants really understood). Some objectives do not match the activity. For example, the objectives for *Activity 2.6 Feeling the Shoe Pinch: Relating to Difficult Decisions* deal with existing beliefs and attitudes about abortion, stigma surrounding the issue, and educating the community on the proper and safest way to do TOP. None of these objectives have anything to do with "relating to difficult decisions." The objectives for *Activity 5.2: Exploring Our Physicality* deal with exploring problems and concerns about sex, sexuality and reproductive health as well as different gender roles that men and women have. However, the activity focuses on learning about male and female reproductive organs. In addition to being disconnected from the objectives, it is also not clear how this activity fits with the rest of the training (e.g., how the participants are expected to use this information).
	Relies on effective and appropriate learning/training methodology	Aside from some confusion around objectives, the training methodology is very participatory and builds on trainees' knowledge and experiences. Discussions, role plays and case studies are effectively utilized throughout training.

	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	Does not include a skill-building component for prevention of STIs, HIV and pregnancy but does include a skill-building component on how to discuss difficult issues with a partner and peers.
	Builds towards behavior change model	Encourages men to explore their own values and attitudes, and potentially transform their values on TOP, and to take action to address gender inequalities, unhealthy relationship dynamics and to support women's reproductive health decisions. The manual is focused on promoting action after each activity and/or section; participants are encouraged to develop a plan on how to act on the knowledge they have gained.
	Has no serious barriers to adaptation and scale-up	The facilitator guide is well developed, has clear instructions (again, aside from some mismatched objectives) and can be implemented by anyone with good facilitation skills. No special equipment is required; however, it relies on participants being able to read and write, so participant selection should take this into consideration. In addition, while the training can be adapted for use with older age groups; it would require heavy adaptation for use with younger youth. The activities and case studies do not reflect younger youth experiences.
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training questionnaires)	Includes pre- and post-test to primarily assess changes in attitude, and to a limited degree, knowledge.
	Includes participant evaluations to inform review	Yes.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	Most of the content is not appropriate for younger youth. The set of issues around pregnancy termination and life experiences will be very different for 15-year old compared to 22- or 24-year old, as is their ability to provide emotional and physical support to a pregnant women/girlfriend. Most objectives, discussion questions and case studies/role plays are not reflective of younger youth experiences but are very appropriate for men, including older youth (18-20 year olds and above).
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Knowing Yourself • Healthy Relationships • Alcohol and Contributing Factors to Poor Health • Gender, Power and Health • Taking Action Towards Change & Practical Education around Women's Reproductive Health and TOP
	Content is technically accurate and up-to-date	The information included is accurate; however, there is very little technical information in this manual. The activities deal mostly with attitudes, understanding of gender issues around TOP, and the importance of supporting women's decisions. Issues of STI/HIV/pregnancy prevention are mentioned, but never discussed in

		detail. At a minimum, pregnancy prevention should have been included since it is important for men to be able not only to support their partners in their decisions regarding TOP, but also to take some responsibility for preventing the next unintended pregnancy by using condoms and supporting women in their contraceptive choices.
Training materials and/or curriculum	**Criteria**	**Comments**
Positive Sexuality Program (PSP) (developed by Child Welfare with Department of Education funding)	**Development process criteria**	
	Developed or updated within the past 5 years	Developed in 2013 as part of the Life Orientation school curriculum with the purpose of fostering healthy and safe sexual practices among adolescents living in vulnerable circumstances. The PSP program consists of eight lessons with a delivery time of approximately 50 minutes for each lesson.
	Addresses SRH challenges in South Africa	The lessons may indirectly address risks of HIV and pregnancy by improving adolescents' decision-making skills.
	Consistent with relevant country policies and guidelines	Not applicable.
	Target audience is clearly defined	The PSP program is an add-on to the current school curriculum and is targeted at grade 9 and 10 learners (with the majority being 14-17 years old).
	Curriculum design criteria	
	Has clear goals and objectives, including skills-based objectives	All sessions have clear objectives, although most of them are not measurable.

	Relies on effective and appropriate learning/training methodology	The curriculum utilizes group based experiential learning techniques. The program ensures the full participation of young people and draws on their existing knowledge and experience through a carefully facilitated process. However, learning techniques are not always appropriate or effective. Below are some examples: • While discussing sensitive issues, it would help to maintain some level of privacy. For example, when students are asked to write on pieces of paper three things they would like to experience or avoid when they have sex, they should not be asked to stand up when later the anonymous statements are read as part of the game. The fear that they may be asked to "own" to their private thoughts may prevent them from truly participating during future discussions/lessons. • Sending students home after the class with a list of 30 questions for self-reflection on sexual relationships is not realistic. In addition, there is no time allocated in subsequent lessons to talk about what they learned about themselves through these self-reflections. • Some activities are too ambitious for the time allotted and students are not offered enough background information. For example, Lesson 6 asks them to design role plays for five risky situations/behaviors which should also include an action that will get the victim out of danger. Students are given only five minutes to accomplish the task and there is very little preliminary discussion about what constitutes risky behavior. • During the discussions, facilitators are provided examples of questions to ask (some of which are very complex with no easy answers); however, there is absolutely no information or guidance on how to process the questions/responses during the discussion. • The pre-enrollment and pre-/post-test questionnaires are too complicated and often include confusing questions and response options.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	The program aims to build skills to assist adolescents in negotiating their needs in intimate relationships; however, the skill component is very weak and superficial. Students are allotted time to reflect on some issues and think about possible real-life scenarios, but very little time is allocated for skills practice.
	Builds towards behavior change model	The knowledge and skill components are weak with motivation component being somewhat stronger.
	Has no serious barriers to adaptation and scale-up	Currently, Child Welfare staff who conduct the lessons are qualified social workers with much experience in facilitation and child development. Staff receive one month of training that covers the technical content areas and how to use the curriculum/lessons. The lessons provide very little reference information on the technical content so facilitators must possess the prerequisite knowledge or receive comprehensive training on the topics, which could be a challenge for scale-up.
	Has a mechanism for assessing change in	The program includes a pre-enrollment test, which includes a knowledge component and serves as needs assessment. However, some of the knowledge tested is not covered in the lessons (e.g., there are 20

	knowledge and attitudes (e.g., pre-/post-training questionnaires)	true/false questions about HIV but there is no lesson on HIV). There is also pre-test and post-test questionnaire. In addition, students are examined twice a year and the results are graded on a 7-point scale (from Outstanding to Not Achieved).
	Includes participant evaluations to inform review	No.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	• Some concepts are unnecessarily complicated, especially for a younger age group (14-15). For example, the presentation on Sternberg's theory of love with all its combinations (intimacy & passion, intimacy & commitment, passion & commitment, etc.) takes away from simple discussion on what constitutes good or bad relationships. • It is not clear if the very complex Cycle of Socialization graphic is meant for facilitators' reference or if it is expected that facilitators will explain it to students. In either case, it makes the issue unnecessary complicated and not age appropriate.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Sex, sexuality and love • Gender roles • Relationships • Hopes and fears about sex • Risk-taking • Coping with sexual feelings • Decision-making process
	Content is technically accurate and up-to-date	The lessons contain no technical information on HIV/AIDS, STIs or pregnancy. Some of the information included (e.g., relationships, love, values) is accurate, but not always age appropriate (see examples in "Appropriateness" section).

Training materials and/or curriculum	Criteria	Comments
Gender or Sex: Who cares? (developed by IPAS with funding from the Summit Foundation and Wallace Global Fund).	**Development process criteria**	
	Developed or updated within the past 5 years	Developed in 2001 and has not been updated since then; however, it contains very little technical information that may require updating.
	Addresses SRH challenges in South Africa	The training package was developed as a global resource (not country specific). • Gender-based violence
	Consistent with relevant country policies and guidelines	Not applicable.
	Target audience is clearly defined	The intended audience for this resource pack is twofold: • The first group includes professionals and volunteers who work with adolescents on SRH issues, such as NGO staff, youth outreach workers, teachers and health-service providers who interact with young people. • The second group is young people aged 13-24 years.
	Curricula design criteria	
	Has clear goals and objectives, including skills-based objectives	Each session lists expected results but not measurable objectives.
	Relies on effective and appropriate learning/training methodology	The training is designed in a very participatory manner and employs a variety of activities that draw on participants' life experiences. All activities have suggestions for adaptation which facilitates making the activities more targeted to specific audience needs.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	No.
	Builds towards behavior change model	The knowledge component (as it relates to gender) and, to some degree, motivation supports a behavior change model; however, the skill-building component is very weak.
	Has no serious barriers to adaptation and scale-up	The activities are well developed; however, the audience is very broad which will require adaptations to ensure that activities are suited to participants' age and background. In addition, because the manual was developed a long time ago, all visual support materials will need to be recreated. The curriculum relies on transparencies/overheads which is outdated technology that may not be supported in most venues.
	Has a mechanism for assessing change in	No.

	knowledge and attitudes (e.g., pre-/post-training questionnaires)	
	Includes participant evaluations to inform review	Evaluation form is provided at the end of the workshop.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	• Because the curriculum audience has a very broad age range, some exercises require adaptation to make them a suitable match to the age of the participants. The manual provides separate objectives for an adolescent audience and some possible adaptations for the activities; however, many activities will need to be simplified for younger youth since the target audience may be as young as 13 according to the guidance provided in the manual. • The case studies and statistic should be adapted for the SA context (the manual is intended as global resource and uses examples from all over the world). • The background information section has many definitions and concepts that are copied from dictionaries or WHO policy documents and are too technical for lay persons, especially for young people.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Gender and sex, including gender stereotypes • Gender-based violence • "Life-cycle" approach to addressing SRH needs and problems • Youth-friendly services
	Content is technically accurate and up-to-date	• While STI/HIV, pregnancy and abortion are referenced throughout the manual, there is no actual technical content dealing with these issues. The manual focuses on exploring how gender issues and lack of power can put women and men at risk. Gender issues are covered well, but it is more in terms of raising awareness, not skill-building (even though the manual has a subtitle, Skill-building resource pack). • Because the manual has not been updated since 2001, it still refers to spermicides as one of the ways to prevent infection. It has been shown since then that spermicides are not effective against STI/HIV. Other than that, no technical inaccuracies are introduced.

Training materials and/or curriculum	Criteria	Comments
May'khethele Psychosocial Support Manual: Grade 8, 9 & 10 (developed by Youth For Christ under CINDI umbrella, funded by USAID/PEPFAR)	**Development process criteria**	
	Developed or updated within the past 5 years	Developed in 2010 as part of the May'khethele program in KwaZulu-Natal; updated in 2012.
	Addresses SRH challenges in South Africa	• HIV/AIDS • STIs • Teenage pregnancy • Gender-based violence • Abuse and rape
	Consistent with relevant country policies and guidelines	Information on contraception is not consistent with SA guidelines.
	Target audience is clearly defined	In-school youth, grade 8 through 10; sessions are designed to support the Life Orientation curriculum. Each lesson is 45 minutes, conducted 2-3 times a week. Minimum of 10 hours required to complete each school year.
	Curricula design criteria	
	Has clear goals and objectives, including skills-based objectives	Each session has a set of objectives but in many instances the objectives are not specific enough or measurable (e.g., To help learners to realize the importance of having a goal, Learners will choose to engage themselves in good and healthy relationship with their peers, To provide sufficient knowledge concerning their rights, or To create awareness on the learners and the impact of teenage pregnancy).
	Relies on effective and appropriate learning/training methodology	• Most sessions have a didactic component (with some sessions relying heavily on didactic learning) and a participatory component but many activities are not adequately developed or do not provide sufficient guidance to facilitators (especially considering all sessions are facilitated by young people who may require more guidance). For example, the activity on values for Grade 8 instructs the facilitator to read value-based statements to the learners so they can decide if it is "true" or "false"; however, the statements are not provided (also note that it is inappropriate to frame values as "true" and "false" as values are very subjective by nature). Another example is the activity included in the session on teenage pregnancy for Grade 10 where learners are asked to "reflect on all the consequences of having a baby and to question the assumptions they hold about the link between sex and love, and sex and long-term stable relationships." This activity lumps several different concepts together (not just teenage pregnancy) and there is no guidance provided for young facilitators on how to process this activity and what would be the key take-home messages.

		• The curriculum consists of two separate documents (both are intended for facilitator): one includes a table of contents, session outlines and learning objectives; the second includes goals for the facilitator, additional details on activities and some background knowledge/information. It seems more practical to combine these two pieces into a single document—there appears to be no real benefit in separating this information and makes it harder to link activities to learners' objectives. In addition, the session flow and activities are inconsistent across two documents. • The objectives of the sessions are not always met. For example, an objective for the session on Love and Lust in the Grade 10 module states that the participants will be able to differentiate between the two. However, the session presents only one activity involving lust—a situation with all the negative consequences—but does not help learners to explore how it may be different in the case of love and what are the defining characteristics of love and lust. • In the document, containing session outlines, the only scenario suggested for facilitating a discussion on prevention of HIV/AIDS (Grade 10) has to do with an auto accident where two men are injured and one of them is HIV positive. The learners are asked to discuss their course of action in terms of HIV prevention. This is probably the least common way to acquire HIV and has very little value in terms of improving adolescents' understanding of HIV prevention and what actions they can take to protect themselves.
	Includes strong skill-building component for prevention of STIs, HIV and pregnancy	Skill-building component is very weak. The only instance where it is attempted is a session on HIV for Grade 10. The use of role plays is suggested for skill-building; however, the only guidance offered is "Let the learners role-play different situations in which they have to say 'no', giving reasons for why they do not want sex." No sample scenarios or different ways to say "no" are provided to help facilitators with this activity.
	Builds towards behavior change model	The knowledge and motivation components are fairly weak. A lot of technical information is incorrect and activities, which may allow for exploration of the reasons for safe, preventive behaviors, are poorly developed. The skills component is almost non-existent.
	Has no serious barriers to adaptation and scale-up	Requires a lot of additional work before scale-up could be considered. Technical information should be corrected, gaps filled and guidance for facilitators should be further developed. Discussions with program staff revealed that youth facilitators (average age 22-years old) are all trained as lay counselors, nationally accredited on child care work (NACCW), and undergo "in-service" training every year for as long as they remain youth facilitators; however, it is not clear how much support and supervision they may need. CINDI program staff mentioned not having enough trained young facilitators who are qualified to conduct sessions as one of the barriers to scale-up.
	Has a mechanism for assessing change in knowledge and attitudes (e.g., pre-/post-training	According to discussions with program staff, knowledge is measured by pre- and post-test in each grade, but the test questions are not provided in the manual.

	questionnaires)	
	Includes participant evaluations to inform review	No. However, an outcome-based evaluation was conducted by CINDI and included a primary document review, a program records analysis, a quantitative learner survey, and qualitative focus groups and interviews. A total of 849 learners were randomly selected from 10 intervention schools and 4 control schools. The evaluation showed that while knowledge about HIV transmission and prevention was somewhat better in intervention group compared with control group, the intervention group still held many misconceptions. No significant differences were found in HIV testing rates between intervention and control groups. However, the intent to practice safe behaviors was higher in intervention group.
	Appropriateness	
	Appropriately addresses various target populations in terms of age, sex, gender identity, marital status, in-school/out-of-school status	• Sometimes information provided is excessive. For example, when discussing male reproductive organs, there is no need to discuss the epididymis, seminal vesicles, or the prostate gland—these offer no additional actionable information and only confuse the matter. Rather, the information included should mention that internal reproductive organs also include several small structures responsible for storing and nurturing the sperm. Additionally, when discussing how HIV attacks the immune system, the manual tries to explain the role of B-cells, helper T-cells and macrophages. This is too technical and does not contribute to a basic understanding of how HIV attacks the body.
	Content and Technical Accuracy	
	Covers one or more of the SRHP topic areas	• Personal development/self-image/self-esteem • Gender roles • Gender-based violence • Abuse and rape • Relationships • Peer pressure • Puberty/understanding body changes and emotional changes • Choices and decision-making • Teenage pregnancy • Contraception • HIV/AIDS, including prevention • STIs
	Content is technically accurate and up-to-date	• The facilitator manual defines teenage pregnancy as pregnancy that “takes place between young people who are between the age of 13-19; therefore it is called teenage pregnancy.” UNICEF defines teenage pregnancy as a “teenage girl (13-19 years old) who becomes pregnant”. While teenage boys can also experience negative effects when they cause teenage pregnancy and it is important to talk about it, it is also important to define teenage pregnancy correctly. Otherwise young girls with older partners will be

under the impression that risks associated with teenage pregnancy do not apply to them.

- When discussing circumcision (in male reproductive organ section, Grade 9) the manual states that “Some people believe a circumcised penis is more hygienic, but if males wash their foreskins regularly, it is just as hygienic”. This would be a good place to introduce the fact that circumcision provides protection from HIV (especially because it is not discussed anywhere else in the manual).
- The menstrual cycle and fertile time are described incorrectly: the description makes it seem that the egg is fertilized on day 21 when it enters the uterus. In addition to being wrong, there is no need to provide a day-to-day egg itinerary because the time of ovulation and fertilization varies somewhat from woman-to-woman and often from cycle-to-cycle. While describing the exact day is not feasible, it is very important to describe when approximately during menstrual cycle pregnancy can occur (e.g., The egg is released from the ovary sometime around the middle of the cycle, approximately two weeks prior to menstruation. The egg survives in the reproductive tract for only one day, but sperm can survive for as long as five days. As such, any sexual intercourse that occurs on the day of ovulation and during the five days prior to the release of the egg, may lead to pregnancy).
- The table summarizing contraceptive methods (session on contraception for Grade 10) has many mistakes and fails to focus on what is important for adolescents (things like the ease of use, ease of access, privacy, ease of discontinuation). For example, it incorrectly states that DMPA causes sterility after prolonged use and that IUDs cause vaginal discharge and allergic reactions. It presents contraceptive effectiveness in terms of failure rates, which is a technical term very few lay persons understand (and could be especially confusing for adolescents). It also presents these rates incorrectly: too low for oral pills, too high for the IUD, and 12% for condoms (which is both incorrect, it should be 15% in typical use, but also misses a very important point that condoms are 98% effective when used consistently and correctly). The difference in effectiveness could be used to motivate adolescents to use condoms every time they have sex. The table also lists all side effects without mentioning that not all users experience them, they are not harmful and usually diminish or disappear after 2-3 months of contraceptive use. In addition, the table includes such contraceptive options as the diaphragm and cervical cap (which are not available in SA) and spermicides, which are no longer recommended due to very low effectiveness and the potential to increase the risk of HIV acquisition. These methods should not be presented (and they are not part of SA family planning guidelines/contraceptive method mix).
- The message “Correct use of contraceptives only protects adolescents from pregnancy but not from STIs/HIV" is not entirely accurate and should not translate (as it is done in the curriculum) into an emphasis on abstinence as the only 100% safe method of contraception. Condoms do provide protection from both STIs and pregnancy as do multiple dual method combinations. These options need be discussed as alternative to abstinence.
- In the document which contains the session outlines, the assessment for the session on contraception

		asks learners to “Take a piece of paper and write the contraceptive she or he is using and describe how dangerous they are”. This activity frames the topic in an inappropriate manner. Contraceptives are not dangerous in general, and even less so when it comes to young people because adolescents almost never have ischemic heart disease, stroke, deep venous thrombosis, complicated diabetes, or any other health condition that on rare occasions may increase the risk of complications when using contraception. This approach creates a negative bias about contraception among youth. • The session on HIV (Grade 10) states “A person infected with the virus will eventually die. There are drugs available that delay the onset of full-blown AIDS, but they are very expensive and are beyond the reach of most of the population of this country”. This statement is incorrect. ARVs are available through the public sector free of charge. Many people are accessing treatment and ARV drugs are significantly improving quality of life, as well as the life expectancy, of people with HIV. Also, there is no discussion about the importance of knowing your HIV status to facilitate accessing ARV treatment as soon as you are eligible. • It is incorrectly stated that HIV can be transmitted (in addition to other modes) through sexual intercourse between two women. According to the CDC and other experts, there are no confirmed cases of female-to-female sexual transmission of HIV. It is also incorrectly stated that HIV can be transmitted by sharing a toothbrush. • Session 11 on STIs (10 Grade) mentions the names of the most common STIs, but contains a table where only herpes, genital warts, and scabies are included. It is not clear why these three are highlighted and why scabies is there at all—while it can be transmitted through skin-to-skin contact, it is not classified as a STI because the main mode of transmission is through casual contact, such as through bed linen or water. There is no mention that a HPV vaccine is available as a means to prevent cervical cancer even though cervical cancer is mentioned as one of the consequences of HPV.

APPENDIX 2

Organizations Interviewed by FHI 360 Team

Organization	Contact person
1. Center for Support of Peer Education (CSPE)	Ms. Barbara Michel, Executive Director
2. EngenderHealth/Futures (Sexual HIV Prevention Program)	Doris Macharia, Chief of Party
3. Population Council /SOLUTIONS	Ms. Linda Du Plessis, Managing Director/SOLUTIONS
4. Foundation for Professional Development	Dr. Grace Magoka, Head of Health and Education
5. Grassroots Soccer	James Donald, Country Director
6. Marie Stopes/South Africa	Ms. Ndinatsie Mumbengegwa, Youth Brand Lead
7. Medical Research Council/Cape Town	Dr. Catherine Mathews, Chief Specialist Scientist
8. Medical Research Council/Durbin	Andrew Gibbs, Researcher
9. SAfAIDS	Maserame Mojapele, Program Manager
10. Sonke Gender Justice Network	Mr. Tim Shand, International Program Coordinator
11. Child Welfare	Ms. Marietha Johnson, Director
12. World Vision	Ms. Gloria Francis, Executive Associate to the National Director
13. Children in Distress Network (CINDI)	Ms. Esther Mungayi, Monitoring and Evaluation Manager
14. LoveLife	Ms. Grace Matlhape, Chief Executive
15. Soul City	Ms, Lebogang Ramafoko, CEO/Daisy
16. Ibis Reproductive Health	Ms. Kelly Blanchard, President
17. Ipas/South Africa	Ms. Karen Trueman, Country Leader

APPENDIX 3

Youth SRHR Curricula Assessment Tool

Criteria	Source	Discussion questions for program staff
Developed or updated within the past 5 years	Discussions with program staff Curricula desk review	• How long ago the curriculum was developed? • How often it is updated? Describe your decision-making process (how you decide the curriculum needs updating)? • What was the last time you updated it?
Addresses SRH challenges in South Africa • HIV and STIs • Early sexual debut • Early pregnancy • Parenthood • Orphans and out-of-school youth • Reproductive rights • Integration with HCT Gender based violence	Discussions with USAID and program staff Curricula desk review	• What SRH challenges do your program addresses?
Consistent with relevant country policies and guidelines - SRH services available to youth - Where to obtain youth friendly services - Any age-related restrictions/need for guardian consent - Contraceptive methods available to youth	Relevant policies and guidelines (to be identified) Discussions with	• What country policies and guidelines are relevant for the youth component of your program? • Does your curriculum reflect these policies and guidelines?

	program staff Curricula desk review	
Youth groups were involved in the development of the curriculum - Needs assessment - Feedback and review - Field testing	Discussions with program staff	• Did you conduct needs assessment prior to the development of the curriculum? • Did you involve youth in curricula design? If yes, in what way?
Documented buy-in from stakeholders, such as parents, communities and health care providers - stakeholders were involved at any stage of the development process (e.g. needs assessment, review) - stakeholders were familiarized with the content of the curriculum - Areas of possible stakeholders support were identified	Discussions with program staff	• Did you involve parents, community leaders and health care providers in the development of the curriculum? If yes, in what role?
Target audience is clearly defined - Age - Sex/gender - Marital status - In-school/out-of-school	Discussions with program staff Curricula desk review	• What are the target audiences for your curriculum?
Has clear goals and objectives - Overall goals and objectives are defined - Knowledge and skills-based objectives are stated for each session	Curricula desk review Discussions with program staff	• What are the overall goals and objectives for your curriculum? • How the goals and objectives of the curriculum contribute to the overall goals and objectives of your program?

Relies on effective and appropriate learning/training methodology - Promotes supportive, safe learning environment - Employs participatory, learner-centered approach - Uses a wide range of strategies to engage learners - Draws on learner's experiences - Fosters learners' ability to apply what they learn to their lives	Curricula desk review	• What learning/training methodology you rely upon in your curriculum?
Includes strong skill-building component for prevention of STIs, HIV and pregnancy - Decision-making skills - Communication skills - Saying "No" - Negotiation skills - Condom use skills	Curricula desk review	• What skill-building components for DTI/HIV/pregnancy prevention do your curriculum includes?
Builds towards behavior change model by including the following components: - Knowledge - Motivation - Desire to change - Skills - Facilitation - Reinforcement	Curricula desk review Discussions with program staff	• Which behavior change components does your curriculum address? • Do you have a mechanism to track/evaluate behavior change that may have resulted from the training?
Has no serious barriers to adaptation and scale-up • Has detailed facilitator guide • Includes all key technical information to be covered during sessions	Curricula desk review Discussions with	• Describe your experience with using this curriculum during training. - What worked and what didn't? - What problems (if any) have you experienced? - What would you change?

• Individual sessions are of limited length (40-60 min) for delivery in a variety of settings (e.g. to accommodate school-based delivery) • Activities are supported by clear instructions on how to implement • Activities are suitable for low-literacy learners (either oral or easily adaptable as oral activities for learners with limited or no literacy skills) • Specialized equipment (e.g. audio/video, computers and projectors) is not mandatory for implementing the curriculum.	program staff	- Do you feel there is a need for any additional topics to be covered? If yes, which ones? - What are the lessons learned? • What kind of training is necessary to be able to implement the curriculum? • Do you have dedicated staff that was trained to use this curriculum (e.g. went through TOT, had previous training experience, etc.)? How many? • Do you have any topic experts (e.g. health providers) available when necessary during the training to support some of the more technical sessions?
Has a mechanism for assessing change in knowledge and attitudes (e.g. pre- and post-training questionnaires)	Curricula review Discussions with program staff	• How do you measure changes in knowledge and attitudes resulting from trainings conducted using the curriculum?
Includes participant evaluations to inform review	Curricula review Discussions with program staff	• Do you use participant training evaluation to improve the curriculum/training?

Appropriately addresses different target population in terms of age, sex, gender identity, marital status, in-school/out-of-school status: - Information is age appropriate - Information is tailored to reflect needs of specific populations - Use of simple language/avoidance of technical terminology - Takes cultural considerations into account	Curricula desk review	
Covers one or more of the following topic areas: - Sexual and reproductive rights as part of the human rights - Gender identity, norms, roles, stereotypes, and gender impact on SRH - Intimate partner violence - Sexuality, including rights, norms, behaviors, sexual development, and sexual consent/coercion - Communication and decision-making skills - HIV/AIDS and other common STIs, - Decision about fertility, including pregnancy and contraception - Termination of pregnancy - Alcohol and substance abuse - Stigma and discrimination	Curricula desk review	• What SRH topic areas does your curriculum address?
Information covered is technically accurate and up-to-date	Curricula desk review	N/A