Evaluating Complex Interventions
(focus on sexuality education)

some important challenges as a discussion starter

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Background: SE in Europe & US

Europe

- Early start (1950s Sweden)
- Other countries from 1970 on
- Hardly Abstinence education (only Sweden initially)
- Gradual evolution towards “HSE” (2010)
- Rather implicit objectives: sexual well-being
- Very few evaluation studies
- More process oriented; long duration

US

- Late start (1980s HIV/AIDS)
- 1990s: Abstinence education dominant (heavily subsidised)
- “CSE” develops as a counter movement (initially mostly called “Abstinence+”)
- Public Health objectives (HIV/STI & pregnancy)
- Many evaluation studies
- More impact oriented; short duration

Gent 2014
Objectives: Policy makers vs SE specialists

Challenge: How to reconcile the two?

<table>
<thead>
<tr>
<th>Policy makers</th>
<th>H/CSE specialists</th>
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<tbody>
<tr>
<td><strong>Preventing:</strong></td>
<td><strong>Promoting:</strong></td>
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<tr>
<td>• (Sexual contacts before marriage)</td>
<td>• Satisfactory, pleasurable sexual life</td>
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<tr>
<td>• Unwanted pregnancy &amp; abortion</td>
<td>• Accurate information about sexuality</td>
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<tr>
<td>• HIV infection</td>
<td>• Self-esteem, communication &amp; negotiation skills, etc.</td>
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<tr>
<td>• STI infection</td>
<td>• Preventive attitudes</td>
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<tr>
<td>• Sexual abuse and violence (sometimes)</td>
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What makes good SE programmes complex?

• Spread out throughout the curriculum over several school years, and starting at a young age
• Age and development adapted; recurring themes, gradually dealt with in more depth
• Often integrated in more than one main teaching subject (biology, health, social orientation, etc.)
• Often integrated in wider “life skills” programmes; impossible to tell where SE starts and ends, because the same skills are needed for a wide variety of life challenges

Discussion Statement: Good sexuality education is a process, not an intervention
Characteristics of HSE that make use of (c)RCT for evaluation difficult

- HSE programmes have often been nationally rolled out: no control groups available
- Pre- and post evaluation does not make sense if programme runs from age 6 till age 14 (useless to ask 6 year olds if they intend to use a condom at age 17)
- It is questionable if ‘behavioural intentions’ at age 12 have any predictive value for actual behaviour that starts 4-8 years later
- (c)RCTs are often far too “laboratory-like”; real-life outcomes/impact are usually less positive

Discussion statement: (c)RCT methodology should not be used for evaluating complex, long-term HSE programmes (not an “intervention”)

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Three types of HSE evaluation are needed:

1. Programme evaluation (or assessment): How good is the programme in theory and on paper? (Quality criteria are now available)

2. Implementation (or process) evaluation: How good is it implemented in actual practice? (Because that is where it mostly goes wrong)

3. Evaluation of outcomes (and later on impact)

Discussion statement: There is a need to focus evaluation on programme and implementation quality
Methodologies needed instead of (c)RCTs

- Long-term international comparative trend analyses of different SE programmes (or absence of them)
- Qualitative methodologies (participant observation, FGDs with teachers and learners, etc.)
- Retrospective behavioural/attitudinal studies comparing students that have participated in different programmes (or none at all)
- Studies on students’ evaluation of programmes and teaching methods used: attractive?; fun?; useful?; interesting? Etc.

Discussion statement: Students are the most relevant evaluators of SE programmes
Summary: Discussion statements

1. How to reconcile the different SE objectives of policy makers and SE specialists?
2. Good sexuality education is a process, not an intervention
3. (c)RCT methodology should not be used for evaluating complex, long-term SE programmes (no “intervention”)
4. There is a need to focus evaluation on programme and implementation quality
5. Students are the most relevant evaluators of SE programmes