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Key Issues in the Implementation of Programmes for Adolescent Sexual and Reproductive Health

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This document, unless otherwise indicated, the term "adolescent" follows current WHO convention and refers to any individual aged between 10–19 years. "Very young adolescent" is taken to refer to 10–14 year olds.

The broader term "young person" follows WHO usage and refers to any individual between 10–24 years. However, the term "youth" is used predominantly in the current document in a more generalized sense and does not necessarily correspond with the United Nations definition (i.e., any individual aged between 15–24 years).

CONTENTS

Preface

Over the past five years, significant efforts have been made to identify the major determinants of the outcomes of adolescent sexual and reproductive health (ASRH) interventions, and analysing "what works" in ASRH programming. A growing body of evidence is therefore being generated globally on the important determinants of early sexual initiation, safer sexual behaviours, and other important ASRH issues. A number of meta-reviews of programme effectiveness have been, and are still being, undertaken. However, despite the abundance of descriptions of programme activities, knowledge relating to the implementation of programmes ("what's working") remains limited by a lack of systematic analysis and documentation of programme experience.

At a Working Group meeting on ASRH held in Geneva on 25–26 July 2001, implementation experiences in ASRH were reviewed and a recommendation made that a broader, consultative process be initiated in order to facilitate information sharing and the identification of "Best Practice" as ASRH programmes enter into a new phase. This consultative process is envisaged to consist of four elements:

- creating a global network on ASRH to encourage information sharing and creation of new knowledge on, and knowledge management of, implementation issues
- identifying and addressing key questions and issues relevant to the implementation of ASRH programmes
- establishing an electronic forum for programme implementers to facilitate communication and information exchange
- convening of periodic programme seminars that foster face-to-face interaction, sharing of tools and approaches, and critical thinking about programme implementation.

To assist in this process, the current paper provides an overview of implementation issues in ASRH programming, and raises a number of the key questions and issues which need to be addressed. The review has been based upon the published literature and upon programme reports, curricula and articles on the implementation of ASRH programmes produced since 1996. Insights have also been drawn from discussions with programme managers.

Executive Summary

The Department of Child and Adolescent Health and Development (CAH) is one of the technical departments of the WHO Family and Community Health (FCH) cluster and as such has continued to identify adolescent sexual and reproductive health (ASRH) as a priority area of work. Promoting ASRH has in fact been a central theme in WHO's work to improve the overall health and development of adolescents for the past three decades, with the main objectives being to:

- prevent the early initiation of sex
- promote safer sex when sexual activity starts
- reduce the morbidity and mortality associated with sexual and reproductive activity among adolescents.

There is a now a need for a WHO-wide framework for action in the area of ASRH to provide coherence and direction for current and future activities. This requires among other things a review of past experience in implementing programming aimed at improving ASRH, and the current paper outlines such experience in three broad areas:

1. Responding to adolescent needs and developing innovations
2. Identifying the inputs and processes needed to carry out and sustain successful programmes
3. Expanding the scale and reach of interventions.

Information on each of these areas has been derived from the published and grey literature (including programme reports and training curricula) available since 1996. Key questions for each area have then been raised, with the intention that these can be addressed through an electronic forum and series of seminars, with programme implementers as the primary audience.

1: Responding to adolescent needs and developing innovations

In responding to adolescent needs, programmes need to recognize the diversity of adolescent populations, and segment their intervention programmes accordingly. The issue of gender is crucial, with power differentials being a fundamental element of the relationships that adolescents have with adults and peers alike. While research has pointed to the differences in the socialization of male and female roles, few interventions have attempted to change gender roles or address power differentials in relationships. The few exceptions have demonstrated mixed results, with positive changes for one sex having negative consequences on the attitudes, self-esteem and behaviours of the other. Further attention to gender and sexual relationships should be a priority in ASRH efforts, given that adolescence is a formative period for learning about gender roles and expected behaviours in interacting with the opposite sex. Programmes should foster more open discussions of gender and sexual roles and relationships, refine curricula to address gender differences, and explore new avenues to achieve gender equity.

A range of tools and methodologies are currently being applied to better understand and characterize adolescent needs, and to provide information on the diversity of young people in a given area. Popular approaches include needs assessments; surveys; participatory appraisal techniques; the narrative research method; and assessments of programmes and services. While many programmers and researchers engage in collecting data about adolescents, greater attention to the application of findings is needed for almost all programme types.

As the field of ASRH is relatively recent, innovations that address specific adolescent populations and trends are currently being developed and tested. Innovations should be appropriate for the particular

segment of the youth population; available to those most in need; and affordable and acceptable to young people and the communities in which they live. Examples of innovations in the field include participatory teaching and learning methodologies; interactive media; entertainment education; the use of pharmacies as first point of contact for health service delivery; integrating ASRH interventions into livelihoods programmes; and media advocacy and activism. Many of these innovations have yet to demonstrate effectiveness through rigorous evaluation but have shown promising results in reaching and engaging young people.

2: *Identifying the inputs and processes needed to carry out and sustain successful programmes*

Despite the multitude of reviews on "what works" in ASRH programming, very little attention has been paid to "what's working" or to how successful programmes are implemented. Key questions related to the design, systems functioning and implementation of specific programme types are raised in this section. In the design phase, many programmes have yet to adequately articulate their goals and intended outcomes. One principle of effective behaviour change programmes is that they are based on theory. Tools based on the logic model (such as the one being developed by WHO on mapping adolescent programming and measurement) that enable programmers to explicitly state the theory of change, and facilitate the application of needs assessment findings, can contribute to measurable success.

Political and administrative support is also a core element of successful implementation, particularly in light of the sensitive nature of some ASRH approaches. A number of examples from Latin America illustrate how systems were mobilized to support the widespread adoption of ASRH programme elements, such as sexuality education curricula. In other examples from Asia, support was gained at the pilot project level and once successful, programmes were able to extend this support to reach a broader population. Key questions in gaining political and administrative support are raised at two levels: the *organization* seeking to integrate ASRH programming into its existing operations; and *adult gatekeepers* such as school administrators, employers and policy-makers.

Designing or adapting curricula and educational materials is another common element of programme implementation for most programme types. The primary content of many ASRH curricula is shifting from an emphasis on didactic teaching of anatomy and physiology to more participatory methodologies that emphasize life skills, sexuality and HIV/AIDS prevention. Large-scale programmes in Asia and Africa indicate that adapting curricula requires setting up a consultative process and then tailoring content to the community's specific needs and values. Key questions relate to the core content; review and adaptation processes; and to the pedagogical approaches required to ensure that the major issues are addressed and the necessary information leading to acquisition of skills and modification of attitudes is provided.

Selecting teachers, health personnel, counsellors, peer educators and others working with young people is equally important for the successful implementation of any programme. Adults working with youth programmes must have a solid understanding of young people's needs, and an opportunity to explore their own values and attitudes toward young people and sexuality. Furthermore, due to the shift from didactic to learner-centred approaches, adults working with young people need to be empathetic and skilled in communicating with them. By developing an understanding of young people, adults will create programmes that are respectful of their rights and of their ability to make healthy decisions. Key questions relate to selection criteria; skills; screening processes; definitions of roles and responsibilities; and ongoing support to professionals.

Once selected, programme staff require training and orientation to content, teaching methodologies, activities, referrals and other information provided in a curriculum. Curriculum and training content vary according to who will be delivering the programme: whether teachers of a sexuality-education curriculum; health providers in a service-delivery setting; or young people in a peer-education strategy. Participatory learning and facilitation, in particular, are skills required for most curricula, but the underlying principles may be unfamiliar within many cultural settings. Key questions for training relate

to objectives; training requirements; structure of training processes; and the monitoring and evaluation of skills and competencies.

Finally, management and human-resource systems are essential to effective programme implementation of any type. Integrating ASRH programmes into ongoing operations may pose management challenges, with new roles and functions required by programme staff. Managers undertaking ASRH programmes must assess their own systems, staffing and resource needs in order to ensure programmes are implemented according to plan.

While the processes outlined above are generic to all programme types, specific issues apply to different programme strategies. Programmes that provide information on sexuality and life skills address sexual development, interpersonal relationships, gender roles, body image and reproductive health. Some approaches emphasize HIV/AIDS prevention education, while newer generation approaches integrate life-skills education, HIV/AIDS prevention, and sexuality education. Gender differences have yet to be adequately taken into account in many curricula. Delivering information and life-skills programmes, particularly in school settings, requires going through the processes outlined above. In addition, key questions remain as to when to provide information, how often, and how much; and what skills to emphasize.

Sexual and reproductive health services for young people aspire to be "youth-friendly", assuring access and acceptability, quality and equity in utilization. The greatest barrier to access in most cases is the perception by young clients that they cannot utilize the services. Negative attitudes toward young clients from providers may inhibit access and reinforce perceptions that young people should not receive services. Quality of services refers first and foremost to clinical safety, and to the clarity of information given, as well as responsiveness to the expressed developmental needs of adolescents. To many young clients, however, the nature of the contact and interaction with providers, confidentiality and privacy determine whether or not they use a service again. The COPE approach (EngenderHealth, 2002) and the evolving WHO tool for promoting adolescent-friendly health services, provide frameworks for quality in terms of client rights and staff needs. Standards and guidelines are essential to achieving quality of care, and should be developed within a health system accordingly. Service utilization is influenced by many factors, including cultural models of health-seeking behaviours. A supportive social environment can promote the utilization of services by young people, as can employing a strategy that reaches young people at their first point of contact, such as pharmacies. Key questions relate to elements of an essential package of services for young people; tapping their existing demand for services; modifying provider attitudes and values, and strengthening their counselling and interpersonal communication skills; developing standards and guidelines; and considering service provision in the context of health sector reform.

Involving young people themselves in ASRH programmes gives them a voice to influence the delivery of programmes and services, and builds on the influences that young people have on each other. Most youth involvement occurs in the context of peer education, with the assumption that relationships among young people influence what they learn and how they behave. There is now greater attention given to involving young people in a broader range of decision-making roles. Recruiting young people into programmes, or facilitating their involvement and creation of their own programmes, should take into account the natural social networks and role models in a given network. Young people should be involved in adapting curricula and support materials, developing interpersonal skills, and learning factual information about HIV/AIDS, reproductive health, and gender issues. While young people are actively involved, the responsibilities of programme management still mainly reside with adults. Thus, providing mentoring, supervision and support remain key issues for adult managers of youth programmes.

Multisectoral approaches reinforce the Common Agenda (WHO, UNFPA, UNICEF, 1997) and the WHO Technical Report on programming for adolescent health (WHO, 1999) that call for programmes to provide support for adolescents to receive information, build skills, have access to counselling and health services, and live in a safe and supportive environment. The critical issue for multisectoral programming concerns less the elements of the individual components and more the establishment of the complementary programmes, collaborations and cooperation required to bring about linkages among

components. Partnerships and networks play a crucial role in multisectoral programming. Key questions relate to the added value and benefits of a multisectoral strategy; and to the effective management of partnerships and networks.

3: Expanding the scale and reach of interventions

While there are many pilot programmes for ASRH around the world, few systems deliver them at scale. A number of models for scaling-up and institutionalizing programmes have been described and developed, and processes for expansion proposed. These include organizational expansion, institutionalization, building on existing institutions and infrastructure, diffusion to other systems or through media, influencing policy and gaining commitment and support from leadership. In order to effectively scale-up programmes, institutions need a strategic plan, structures and systems through which to implement programmes; technical and managerial skills; and financial support. The core skills and competencies for programming are proposed in this section. The key issues related to scaling-up and sustaining programmes are resource allocation and mobilization; defining scope and coverage; determining the readiness of an organization to scale-up; and involving young people and community members in planning and implementation.

Sustaining programmes also depends upon a number of considerations, among them government and donor objectives and policies; economic conditions; and well-articulated demand for programmes and services. A sustained programme also requires that institutions have long-term commitments and are well managed. When institutional capacity is strengthened, programmes will more likely continue to function and be operational after the initial start-up period, assuming they receive continued financial support. ASRH programmes face particular challenges in achieving financial sustainability as they are rarely able to generate revenue. Furthermore, young people do not represent a constituency that can influence policies and resource priorities. Thus, sustainability is contingent upon the external environment, institutional commitment, and operational processes.

ASRH programmes are facing greater demands for accountability and impact on youth behaviours by parents, communities and organizations that allocate resources. While the basic elements of these programmes are known, further in-depth examination, discussion and experience-sharing is needed in order to move the field beyond pilot programmes into a phase of expansion and institutionalization. The proposed electronic forum and the discussion points raised in this paper aim to contribute to such a process.

Conclusion

As the field of ASRH matures, further discussion and documentation of programme implementation will be needed if small-scale programmes are to be successfully expanded to reach larger numbers of young people. Such efforts will also be needed if we are to bring about beneficial shifts in resource allocation and in the prioritization of youth programmes in health and education systems, in communities and in workplaces. The issues discussed in this review are intended to provide a starting point for broader consultations with frontline programme staff, programme managers, policy-makers and others interested in improving the well-being, and sexual and reproductive health of adolescents.

1
Responding to adolescent needs and developing innovations

The dynamic and heterogeneous nature of adolescence requires innovative responses. Youth across the globe exist, and experience the transition from childhood to adulthood, under varied circumstances and conditions. A growing body of evidence shows that interventions that are targeted towards specific needs and subgroups of adolescents, while combining an understanding of adolescent development with attention to the contextual factors shaping their lives, have been most effective in promoting health (Blum, 1999; Kirby, 1999; Bond and Magnani, 2000). In this section, approaches to identifying and responding to the diverse needs of young people are explored, along with the development of innovative ways of addressing such needs.

1.1 Responding to the diversity of adolescence

Demographic and social patterns of adolescents differ by country and region. Segmentation of interventions is needed to address the diverse needs and contexts of adolescents' lives. Programmes are most effective when appropriately targeted and tailored to the contexts in which young people live, and to their life circumstances. Programmes should be designed and differentiated by age, sex, urban or rural residence, marital status, education, employment, and sexual experience. For sexual and reproductive health programmes, it is especially important to prioritize the areas of programme focus according to marriage and childbearing status, and to the background HIV prevalence in a given setting.

The issue of gender is crucial when responding to adolescent needs. Power differentials are fundamental in defining the experience of adolescence. Addressing gender concerns relating to youth behaviours requires effort at multiple levels including: challenging gender bias within communities, institutions, and health systems; recognizing the impact of family pressure and norms on how girls and boys are socialized into adult roles; and fostering positive interactions between boys and girls as they grow into adulthood.

Adolescent girls are even more vulnerable than adult women to disparities of power based on their age, gender norms, and lack of economic options (Gage, 1998). Programmes therefore need to focus on pre-sexually active, sexually active unmarried, and married girls to raise awareness of health and human rights, build self-efficacy and self-determination, and increase the opportunities for livelihood and structured recreation. Young married women are often socialized to defer to their husbands in all aspects of life, including sex. Attempts to influence the balance of power in the relationship could lead to violence without simultaneous attention to the male partner. Married youth can be reached in the community and through the workplace with human rights and leadership training that addresses the necessary preconditions for maintaining reproductive health, including safer sexual practices and violence prevention. While boys and girls experience adolescence differently, and thus require different interventions, it is ultimately their interaction that leads to safer (or unsafe) sexual and reproductive behaviour. Effective ASRH programmes promote communication between young males and females, and this has been shown to be a prerequisite for the successful adoption of protective reproductive health behaviour (Mane, Gupta and Weiss, 1994).

Few interventions explore their differential impact on behaviour among boys and girls, even though such impact is often mixed. For example, in Zimbabwe an intervention aimed at improving the sexual and reproductive health of urban youth resulted in improvements in some reported behaviours, including reduced alcohol consumption and improved communication. However among females, attitudes toward

condoms improved in most aspects, while among males attitudes appeared to become increasingly negative (Moyo et al., 2000).

Similarly, in Thailand, a university-based sexuality education curriculum increased reported condom use among unmarried young women, while no significant change was reported among young men (Baker et al., 2003). Conversely, an intervention in northern Thailand that aimed to address gender inequities in relationships resulted in reductions in reported self-esteem among young women, and increases in self-esteem among young men, despite the intervention's intention to strengthen self-esteem in both sexes and improve gender relations. Young women reported that prior to the intervention they had not been aware of the extent of stigma and double standards placed on young women, particularly those who were sexually active. This awareness may have resulted in short-term reports of lower self-esteem, but were clarified by young women's reports of feeling more "realistic" about expectations in relationships, and feeling more determined to become self-sufficient (Athamasar et al., 2000).

Gender differences are however not the only primary factor that needs greater exploration and attention in intervention development. Addressing the needs of younger adolescents, exploring developmentally appropriate teaching and learning approaches, and reaching vulnerable adolescents all remain priorities.

1.2 Needs assessment and evidence-based programming

Needs assessments, surveys and service data all provide evidence on the diversity of youth in a given area, and a variety of tools and methods have been developed to assist in the collection and analysis of data on a variety of topics. Before selecting and using assessment tools, programme staff must consider the purpose of the results; e.g., to persuade officials to cooperate; to develop programme messages; or to identify specific groups for involvement. It is then important to have a "toolbox" for data collection which may include[1]:

- Interviews with policy-makers, other key stakeholders and service staff and users
- Reviews and analysis of policies and laws
- Monitoring of media coverage and reporting, and analysis of content
- Youth surveys
- Focus group discussions
- Client exit interviews
- "Mystery client"
- Observations of interactions and set-up
- Facility inventories
- Provider self-assessment tool
- Informal discussions with youth
- Body mapping
- *Coming of Age: From Facts to Action for Adolescent Sexual and Reproductive Health (WHO, 1997)*

Needs assessment: Youth development and behaviours

In order to develop appropriate strategies and interventions, programmes need to define clearly the behaviours, and the risk and protective factors they aim to influence. To achieve this, information may be required on any or all of the following topics:

- Family context and background
- Mobility history
- Socioeconomic status
- Knowledge

1 These tools are described in Adamchak et al., 2000.

- Attitudes, norms, tastes, preferences and opinions
- Self-esteem
- Skills
- Relationships and communication
- Peer norms and activities
- Sexual behaviours
- Health-seeking behaviours.

Participatory assessments, surveys or other sources of data can provide the basis for determining which behaviours and factors to include in a strategy. *Participatory Learning for Action* (PLA) is one such approach and is based on qualitative research tools[2] to enable programmers to:

- Develop an in-depth understanding of the life circumstances, concerns and priorities of young people
- Create an environment for reflection, analysis and participation
- Identify choices and generate solutions, drawing on the creativity of young people directly
- Promote participation and ongoing involvement by youth and adults.

Researchers and programme staff are often surprised at the level of openness, closeness and communication they are able to achieve with young people by using these techniques. For many who are used to a more didactic approach, adapting to a participatory process may be challenging. However, for programme staff the experience of conducting PLA can lead to important changes: adopting more positive attitudes toward adolescents; becoming more responsive to adolescent needs; and appreciating the importance of youth participation (Program for Appropriate Technology in Health and the Chinese Family Planning Association, 2002).

Such an approach has been used as a preliminary programme activity in Bangladesh, Cambodia, China, Nepal, Thailand, and Viet Nam. In China, for example, PLA was conducted in 14 provinces and revealed very different needs, values, attitudes and behaviours among youth across China (Program for Appropriate Technology in Health and the Chinese Family Planning Association, 2002).

In Cambodia, the use of PLA with factory workers yielded important lessons about what challenges may be encountered with the approach. For researchers, observation, note-taking and analysis is often most challenging, with rich and detailed information getting lost because the note-taker was not consistently active. Visual outputs from mapping were often unwieldy and difficult to manage. Adequate time also needed to be budgeted, with researchers, programme staff and participants wanting to spend more time on PLA activities (CARE International in Cambodia, 1999).

Findings from PLA can be used to improve targeting and increase the participation of young people; understand youth perspectives, needs, attitudes and behaviours; develop key messages; prioritize activities; and ensure a basis for ongoing youth involvement. PLA techniques are now being integrated as a foundation for reaching young people and for planning and designing programmes.

In **Box 1** some of the issues related to conducting a *national youth baseline survey* are described by SAVE the Children, Bhutan.

The *narrative research method* is yet another methodology that allows us to understand how young people perceive the "scripts" and social rules that govern behaviour. This can be conducted by convening young people, and developing role-plays that result in a storyline that illustrates a typical pattern of behaviour. The story is then converted into a questionnaire and analyzed statistically (WHO, 1993).

2 See Shah, Zambezi and Simasiku, 1999.

Box 1: Conducting a National Youth Baseline Survey in Bhutan

We completed a baseline assessment in December 2000 with the National Youth Health Service. We looked at issues and constraints faced, and the context and need for the survey. The Bill and Melinda Gates Foundation gave some money for a three-year project involving Bhutan, Malawi, the Philippines and Nepal. But we were not sure about the resources in our office as we did not really have experience of targeting youth. We started the process by talking with other counterparts about what data were available, and investigating where the entry points were. In Bhutan, 53% of the population is below 18 years of age, but we found little available data, other than data regarding education, but not about health. We felt it was important to do baseline research to find gaps and get a firm condition on which to do youth programmes. We looked at government agencies as counterparts and looked for interested agencies, e.g., Information Education Unit (IEC), Food and Drug Administration (alcohol and drug groups were in need of data), Department of Health (also in need of data). We felt we should work together. When we opened the first Youth Information Centre (YIC), we talked with the Secretariat in IEC. This created two advantages:

1. We got a lot of media publicity
2. We associated with people involved with policy support (a lot of lobbying).

We needed to be flexible with protocols. We had our own questions, but had to make room to get the data that other groups required. The survey was accepted by the government and was released. It got Ministry of Home Affairs approval and clearances and lobbying. Issues addressed were quite sensitive (e.g., age of first sex). We kept putting our questions on questionnaires and they kept being struck off.

SAVE the Children, Bhutan, at the NGO Networks Capacity-Building Seminar for Youth Sexual and Reproductive Health, August 2001.

Assessments of programmes and services can also be done using a mixture of methods. In order to improve the service delivery system and make it more responsive to youth needs, it is necessary to examine and describe:

- Characteristics of services
- Staff attitudes
- Administrative characteristics
- Community support.

Findings from such assessments can contribute to the modification of services, policies and administrative procedures; training for staff; and development of community outreach activities. Service assessment tools include the FOCUS guide on youth-friendly reproductive health services (Nelson, MacLaren and Magnani, 2000) and the COPE self-assessment guides (EngenderHealth, 2002).

Although programmes may invest considerable resources in conducting assessments, they may not always analyse, report on, or utilize the data adequately due to shortages of skill or time, or because of other management pressures. In many instances, programmes are overwhelmed with a high volume of information and no staff capacity to discern how to use it. In other instances, the data may have been collected by an outside research partner without a clear sense of programme mandate or objectives. Greater attention to the application of findings is needed in almost all programme types.

1.3 Innovation development process

Shepard, Garcia Nunez and Helfenbein (2001) in their review of programmes in the Bill and Melinda Gates Foundation's Global Health Programme outlined several types of innovations in the field of ASRH:

- New intervention models
- New tools to improve a model or to create an easily replicable intervention
- Innovative strategies to reach previously inaccessible populations
- New institutional networks to increase access or to incorporate multisectoral strategies[3].

As the field grows and expands, newer generation models are being developed and tested. These models, based on theory and evidence, extend beyond the provision of information and services to young people, and address their social context and developmental needs. Different organizations and programmes have their own approaches to developing innovative models. For example, PATH's guidelines and framework for developing and promoting technologies and innovations (Program for Appropriate Technology in Health, 2000) provide some guiding questions that apply to the development of new programme models for youth.

Is the innovation appropriate for resource-poor settings and particular segments of the youth population? In designing innovative models, the level of resources, foundations in level of education, school-enrolment rates, availability of technologies, gender differences, cultural values, and institutional structures, rules and norms must all be considered in determining how to develop appropriate models. Involving users or youth groups and communities in developing models, conducting audience research and developing community advisory groups can help to ensure that models are appropriate to local needs.

Is the innovation available (or will it be) to those most in need? In order to assess availability, some of the assumptions made about access to programmes and services may need to be considered. In a review of access to programmes and services, FOCUS have looked at the conditions needed to ensure access across a broad range of intervention approaches (Bond and Magnani, 2000). In almost every case, those at greatest risk were found to be under-reached by the programmes, for example:

- Access to mass media approaches requires access to radio or television, or the ability to read – programmes in Peru and Zambia indicated that the lower socioeconomic strata, out-of-school youth, females from 15–24, and all youth from 10–14 were all under-reached by mass media programmes.
- Youth centres and recreation centres in West and southern Africa indicate that females do not gain access for a variety of reasons.
- Access to information in peer programmes and social mobilization efforts depends upon where and by whom they are initiated and the social networks or connections that people in a given group may have – in some cases, peer educators talk to a limited number of their own friends and do not reach higher risk networks.
- Out-of-school networks have been mobilized and demonstrate the feasibility of reaching young people in less-structured environments – education programmes that provide information and life skills based in schools will only reach those enrolled. In settings where enrolment is high, this is an appropriate strategy. However, where school enrolment is low, alternative mechanisms are required.
- Health services have yet to demonstrate that they can reach unmarried or younger adolescents, particularly females. It is thus important for programmes to identify informal channels that are already being used and to strengthen service quality and delivery.

Is the innovation affordable? The question of the cost and affordability of youth programmes and services has been defined in terms of "willingness to pay". In many cases young people do not have any income and are unable to pay for programmes and services. Thus, cost of the programme to donors, governments, families and others must be considered to ensure sustainability and utilization – an issue dealt with further in part 3.

3 To be addressed later in part **3: Expanding the scale and reach of interventions.**

Is the innovation acceptable? Acceptability of programmes for young people relates to content, format, language and terminology used, developmental phase, service mix, and their interactions with people involved. Acceptability is increased when young people and other stakeholders are involved in the design, creation and delivery of the model.

1.4 Examples of recent innovations

In recent years, there has been an explosion in the number of innovative models designed to reach young people in diverse circumstances. Although many of these have yet to demonstrate effectiveness through rigorous evaluation, they have shown promising results in terms of reaching young people, creating dynamic and engaging messages and activities, utilizing natural channels of communication and health-seeking resources, and responding to the broader economic and social concerns of young people.

1.4(a): Teaching / learning methodologies

Teaching and learning methodologies such as participatory learning and life-skills pedagogies have infused the practice of ASRH education in some areas. Research has found that individuals learn best in an environment of active participation. The principles of participatory learning hold true for both adults and young people[4]. Many of the participatory activities that are used for training adults in sexual and reproductive health can also be used in helping young people to acquire the basic knowledge and skills they need to protect themselves from STIs (including HIV/AIDS) and unintended pregnancy.

Ideally, effective training in sexual and reproductive health is an experiential process that involves learners, and facilitates dialogue and collaboration. In order to achieve this ideal, trainers must utilize participatory training methodologies that actively involve the learner in his or her development. Participatory learning approaches embrace beliefs such as:

- Participants learn best in an atmosphere of active involvement and participation.
- Participants tend to retain 10% of what they read, 20% of what they hear, 30% of what they see, 50% of what they hear and see, 70% of what they are asked to say themselves, and 90% of what they are asked to say and do themselves.
- Learners are a knowledgeable group who should be utilized as a resource in a learning environment.
- Learning is not usually an outcome of formal teaching. Instead it comes from a process of self-development through experience[5].

The life-skills pedagogy has also received greater attention and application in ASRH programmes. This pedagogy develops sets of activities and issues that correspond to sets of life skills. The learning process is four-staged:

- Discovery – during which participants identify issues and concerns
- Connection – during which the issues are connected to real-life circumstances and conditions
- Practice – during which skills and solutions are generated for different situations
- Application – during which new awareness and skills are put into practice in real-life experiences.

An innovative life-skills curriculum for sexuality education was developed to train peer leaders in northern Thailand based upon concepts in culture and art (Athamasar et al., 2000). Teachers and peer leaders involved in curriculum design and development felt that the process of training (based upon real examples and cases from within their classroom) provided an effective way to learn more about youth needs and

4 Drawn from Bond, Pownall and Levack (2003).

5 Ibid.

circumstances. The programme resulted in improvements in self-esteem among girls, reductions in reports of alcohol consumption and drug use, increased communication with teachers, friends and adults, and safer sexual behaviours among sexually active participants. However, analysis of life skills also revealed nuances in addressing gender inequality in interventions, with some self-esteem scores decreasing among females when they first became more conscious of gender stereotypes. The programme evaluation revealed that more attention needs to be given to strengthening the sense of autonomy, goals and clear principles for decision-making among girls, and for developing a sense of empathy and responsibility among boys.

1.4(b): Interactive media

The increased presence of computer technologies in developing-country settings has allowed for the development of innovations in interactive media. Such innovations aim to promote healthy adolescent behaviour through interactive computer games and CD-ROMs. The digital revolution currently reaches millions of young people every day and the number of those being connected for the first time is growing exponentially. The internet is increasingly being used to entertain and inform people; to expand the dissemination of (and access to) information; as a learning tool; and as a cost-efficient vehicle for connecting and mobilizing people. Thus, interactive games and educational tools have the potential to deliver intensive, interpersonal communication approaches on a large scale and at relatively low cost both in their own right and as tools in more structured learning environments.

In Peru, JHU/PCS, the Population Council and the Peruvian Institute for Responsible Parenthood (INPPARES) developed a computer-based interactive format to anonymously provide young people with sensitive information. The programme was entitled: "Isabel: Your Electronic Counselor" and was distributed through more than 100 MOH clinics throughout Peru. Evaluation data were gathered at terminal sites, and showed that highly educated young women, aged 13–24, utilized the programme. Effects of utilization on other health and behavioural outcomes were not reported (Palmer, 2002).

1.4(c): Entertainment-education approaches

Popular and folk media and culture provide excellent channels to raise awareness of ASRH issues; address cultural norms; and provide role models for healthy behaviours and responsible relationships. In response to the HIV/AIDS pandemic, entertainment-education efforts directed toward educating young people about HIV and sexual and reproductive health have dramatically increased worldwide (Klotz, 2002). The types of media used include community theatre groups, popular magazines, television soap operas, drama, puppetry, music concerts, comedians, and street performances. Many entertainment-education programmes involve young people in research, message and story design, and implementation. Young people use puppets to demonstrate life skills in real-life situations (Schutz and Bilbrough, 2002). In community settings, some theatre performances are often followed by discussions regarding cultural norms, information, and situation assessments (Bharath, Balaji and Jeevanandham, 2002).

1.4(d): Pharmacy models

Drugstores and pharmacies are primary points of contact for many young people seeking reproductive-health advice and care. The ***RX Gen*** Programme developed by PATH Thailand was designed to improve the quality of services through training and consumer education; to strengthen drugstores and pharmacies as primary points of contact for youth; and to develop referral networks to social and health services.

Capacity building among pharmacists and drug sellers was achieved through a series of meetings and training sessions, and guidelines for youth-friendly pharmacies were created for use as a resource. Any pharmacy showing the ***RX Gen*** logo was required to adhere to the guidelines, which provide information (about products, history-taking and referral) and guidance to improve interpersonal communication with young clients. Final assessment results showed a significant improvement in the quality of services in the drugstores. The participating personnel were more likely to perform well, practise history-taking, demonstrate improved interpersonal communication skills, and provide accurate information and useful advice. Furthermore, they demonstrated respect for privacy, communicated in a non-judgemental manner, expressed positive attitudes toward clients, and made appropriate referrals to sources of further help. The improved performance of participating drugstores was also observed in field observations.

Consumer education and outreach activities were also conducted at Red Cross fairs, in shopping centres and on radio. Information booklets and referral cards were distributed, along with information about a web page with links to the Ministry of Health's service network. After the referral cards were disseminated widely during late August, the number of young clients utilizing the services at participating drugstores increased, with a significant increase in the number of clients who sought reproductive-health advice from the pharmacists.

The referral network for services in the ***RX Gen*** project is comprised of several types of organizations: drugstores; public counselling clinics and hotlines; and social services such as shelters, emergency homes, orphanages, and vocational training centres. A referral protocol was developed with the agreement of the network members. Data from government health centres indicated a two-fold increase in the number of young clients seeking related services following the establishment of the referral network (Program for Appropriate Technology in Health, 2001).

1.4(e): Linking ASRH programmes to livelihood interventions

In many settings, the needs expressed by the community are forcing programmes to link reproductive health and livelihood interventions. The International Centre for Research on Women (ICRW) has conducted reviews of linked programmes in Asia, Africa, and Latin America, and its assessments in India, Kenya, and Colombia, suggest that programmes that link reproductive health and livelihood interventions are currently being designed on an *ad hoc* basis, without adequate organizational investment and capacity building in specific skills. Such "linked" programmes, however, have the potential to significantly improve reproductive-health outcomes if they receive adequate support for organizational, managerial and technical capacity. Experience from livelihood programmes shows that using existing networks of groups and individuals within communities may be the most promising way to link livelihood programmes with reproductive-health initiatives (Grierson, 2000). As such, information and support for reproductive health becomes integrated into the livelihood activities (and other types of support) provided within these networks.

1.4(f): Media advocacy and activism

Media advocacy is the strategic use of mass media to advance social or public policy initiatives (Waisbord, 2001). These initiatives aim to stimulate debate, promote responsible portrayals and coverage of health issues, and engage media as partners in defining new social messages.

Media advocacy promotes social rather than individual change in order to legitimize certain behaviours or to change social perceptions or norms about particular behaviours or issues. Since media largely shape public perceptions and public debate, influencing the media portrayal of issues should be a key component of a broader intervention strategy.

In the field of ASRH, media advocacy has been used to stimulate debates on positive sexuality; to portray youth as responsible, contributing members of society; to address stigma; and to stimulate social debates on reproductive-health and rights issues such as abortion and access to emergency contraception. Media advocacy has also been used to create messages about responsible parenting and responsible sexual behaviours.

In some cases, media advocacy is tied to activism. Growing networks of youth activists are involved in advocating for youth representation and engagement in policy and programme formulation, and for increased resource allocation to youth programmes. YouthForce, a group of youth activists from around the world, raised awareness of youth needs during the Xth International AIDS Conference held in Barcelona. In South Africa, Groundbreakers, a youth corps dedicated to addressing HIV/AIDS, was established as a joint initiative by "loveLife" and the Nelson Mandela Foundation. These and other networks of young people promise to invigorate the field with energy, new ideas and more innovative programme strategies. With mentoring and guidance, they provide a substantial level of potential support to programming efforts.

2
Identifying the inputs and processes needed to carry out and sustain successful programmes

The literature on "what works" in adolescent sexual and reproductive health and development has emphasized the reporting of behavioural and health outcomes in defining programme effectiveness. Reviews have included reports and studies based on evaluations that use experimental or quasi-experimental designs with adequate sample sizes to measure changes in programme outcomes. While these reviews have made important contributions in helping to distil what programme types produce certain outcomes, there remains an enormous gap in understanding how and why effective programmes work. In this section a number of key questions on the design, systems functioning and implementation of targeted interventions for and with young people are presented. The types of interventions discussed have, in some settings, demonstrated "effectiveness" in bringing about changes in behavioural, health and development outcomes. They include sexuality/life-skills/HIV/AIDS education, improved service delivery for young people, and peer education and outreach programmes.

2.1 Programme design – defining outcomes, strategy and approach

One of the most important factors in the success of any programme is design, particularly in terms of programme strategy, stated outcomes, and activities that are clearly linked to those outcomes. For small pilot programmes it is often easier to define and control these aspects than in larger scale programmes. In many cases, programmes fail to define or articulate a clear definition of programme outcomes and corresponding activities. One of the core elements of effective programmes is the explicit use of behaviour change theory in the design process (Kirby, 1999). There are several explanations as to why such theories may contribute to more effective programming, including:

- *The checklist effect* – models are useful in planning interventions because they include a detailed list of elements that need to be considered in designing and implementing the interventions; such an approach results in fewer mistakes.
- *The thoughtfulness effect* – having a model implies that more thought has been given to why the intervention might work; this leads to a more detailed plan of action and reproduces the checklist effect.
- *The Hawthorne effect* – having to prove a model to justify an intervention ensures that greater effort is given to the intervention.
- *The donor effect* – in an effort to support social and behavioural sciences, donors may demand a model (Houvras and Kendall, 1997).

Programmes that have successfully measured behavioural changes have applied one of the several theories of behaviour change; and these theories share common elements, including:

- Understanding risks and benefits – these may include both health and social risks and benefits.
- A focus on outcome expectancies – this focus makes explicit the behaviours and norms to be modified.
- Self-effficacy in carrying out behaviours – an individual must feel confident that he or she can overcome barriers to the behaviour.
- Recognizing social influences – assessing how relationships with others can influence an individual makes them more aware of how best to manage negative social influences, and to seek social support for positive change.
- Changing individual values – involves an individual's recognition that detrimental behaviours, and the values underlying them, lead to negative consequences.

- Changing group norms – norms are the expected and appropriate rules of behaviour, and there are positive and negative sanctions, or costs and benefits, associated with following or violating those rules. Programmes can work with small groups to identify and modify norms that contribute to risk and promote norms that lead to positive, healthy behaviours.
- Building social skills – because sexual and reproductive behaviours are embedded in relationships with others, learning social skills such as negotiation, communication, and respect for others can help to reduce an individual's levels of risk and vulnerability.

Other theoretical models, such as structural, community-based, social-marketing or social-network models have not been evaluated using experimental or quasi-experimental designs, but the possibility of them having an effect cannot be excluded. Given that almost all theoretical approaches utilized in carefully implemented interventions have, in one form or another, achieved successful outcomes argues that having a theory about how behaviour is changed (and implementing it through a well-designed intervention) is more important than which particular theory is selected. To that end, tools such as the Logic Model Framework and the forthcoming WHO resource manual on mapping adolescent programming and measurement are increasingly used in the design phases of many youth programmes.

The Logic Model Framework shows the relationship between programme activities, risk and protective factors for reproductive-health behaviour among young people, and behavioural and health outcomes. Programmes based on such explicit theories of behaviour change tend to be more effective at influencing health behaviours than those done with no theoretical framework (Kirby, 1999). The Logic Model is a simple tool that allows us to:

- clearly define desired health and behavioural outcomes
- identify the protective and risk factors that influence those outcomes
- use programme strategies that respond to more than one of the factors that impact on adolescent sexual and reproductive health and development behaviours and outcomes.

Inherent in constructing a good logic model is the use of empirical data on risk and protective factors, and such data can come from a variety of sources.

References to youth programmes frequently refer to the importance of needs assessments and appropriate targeting during the development and design phase (Senderowitz, 1997; UNFPA, 2000). However, even when programme staff have adequate resources to conduct needs assessments or collect data, the findings are not always adequately incorporated back into the programme design, but rather the proposed activities "default" to an older menu of providing information and services. The Logic Model provides a framework that encourages programme planners to draw clear links between assumptions about programme actions and achievable outcomes.

2.2 Gaining political and administrative support

Once a programme is designed to achieve outcomes, it requires the systems in place to ensure it is successfully implemented. Many of the issues and questions regarding planning, design and implementation raised in a review of key elements for successful school-based programmes (Birdthistle and Vince-Whitman, 1997) are relevant to a broader set of programmes and remain unanswered in many developing-country settings. The review pointed to a number of obstacles to implementing programmes for adolescents, including legal, financial, cultural and religious barriers, as well as opposition from school administrators, teachers, parents and students. At the policy level, obstacles included: lack of commitment and coordination among the relevant ministries (including health and education); limitations in skilled personnel, materials and other resources; weak or non-existent mechanisms to supervise, monitor and evaluate programmes; lack of well-defined national strategies for promotion, support and coordination; and a lack of innovative approaches in developing instructional materials (WHO, 1995).

Programmatic efforts to address these obstacles are ongoing in many countries, although they tend to be more common at local rather than national levels, and on the smaller rather than larger scale. At the national level, the core of experience in policy advocacy for youth programmes comes from Latin America. For example, Bolivia approved a national youth policy in 1998, in large part due to the initiative of the then First Lady Ximena Iturralde Sanchez de Lozada. However, due to a change in leadership, a formal decree was never issued. In 1999, under new leadership a Presidential Decree was passed, stating in Article 7 that:

Youth have the right to be informed responsibly and opportunely about …comprehensive health, and sexual and reproductive health.

(Banzer Suarez, 1999 in Rosen, 2001)

Following this, the Ministry of Health established a national adolescent health programme. Moving from policy to implementation, however, has been challenging, with funding limitations, problems with coordination and lack of commitment.

In the Dominican Republic, the process of developing a national youth programme began with the formation of a national intersectoral committee on youth, generated by nongovernmental organizations. Under new leadership in 1996, a national youth forum was convened that set in motion an inclusive process that led to the approval of a national youth policy. The involvement of young people was crucial in setting the agenda. With greater awareness of youth, and an interest in appealing to the constituency of 18–35 year olds, newly elected leaders passed a law that established a cabinet-level youth ministry and assigned 1% of the national budget to it. At the same time, the Ministry of Health established the National Adolescent Health Programme that has supported an intersectoral committee on youth, developed national service-delivery guidelines, and trained a cadre of health professionals in adolescent health.

In addition to these national-level successes however, implementation also requires ownership of the policy at local levels, and towards this a phased approach to implementation was introduced in three municipalities, with the establishment of local intersectoral committees (Rosen, 2001).

Advocacy efforts by a Mexican NGO (IMIFAP) led to support from the Mexican Ministry of Education for the integration of a comprehensive sexuality education programme into the standard school curriculum in 1998. As a result of their experience, IMIFAP has identified several key strategies in their successful advocacy efforts (Pick, Givaudan and Brown, 2000):

- Negotiate by compromise – in order to convene a conference of head teachers for sexuality education, IMIFAP had to drop an element on homosexuality in the formal training.
- Start by proposing programmes with less controversial topics – focusing early efforts on more acceptable and less controversial issues (especially those programmes that emphasize improving life skills) may be easier to promote than those that focus specifically on sexuality.
- Collaborate and negotiate with individuals and organizations at different levels – when negotiating with ministries of education, it is important to communicate at different levels and to keep people informed throughout the process.
- Include parents and other stakeholders – parents, teachers and civil servants who will remain in the system despite changes in political administrations can serve as a foundation of support. Parents need to feel involved in order to be able to keep up with what their children are learning.
- Establish representatives and allies in different regions of the country – people who are familiar with local-level politics and bureaucracies provide valuable input and are vital to advocacy efforts below the national level.
- Develop age-appropriate curricula – a broad perspective on sexuality that looks at development through the life cycle is more likely to lead to positive changes and be developmentally appropriate.
- Use polls in countries where they are uncommon – in Mexico, opinion polls showed that the majority of parents supported sexuality and life-skills education. These findings were disseminated using a broad range of media.

- Meet with opponents and emphasize common goals – small group and one-to-one meetings allow the opportunity to openly discuss concerns and recognize common areas of agreement.
- Win the support of the moderate opposition first – with the support of moderate opposition, it is easier to build networks and a broader base of support.
- Reinforce learning and training with long-term follow-up whenever possible – this is important for both teachers/trainers and for the young people participating in training who may otherwise relapse into risky behaviours.
- Rigorously evaluate programmes and disseminate results – strong evidence that a programme can achieve its desired outcomes can help in negotiating with officials and making a case for the programme.

Although these strategies have helped in advocating for the inclusion of sexuality and life-skills education into the work of the Ministry of Education, the actual implementation of programmes presents a number of additional challenges, and these are discussed further in section 2.7 (Pick, Givaudan and Brown, 2000).

In programmes initiated at the local level, programme staff tend to approach decision-makers individually, in the community, or within institutions such as a factories and schools to gain access to the young people in those settings. While this approach works for local-level programming, it can result in gaps in national-level policy support when the time comes to scale-up the programme. Working with institutional structures from the beginning, whether at local or national levels, will be more likely to lead to sustained programmes.

For example, workplace programmes are often initiated by visits to factory management in order to gain permission to conduct activities. In Cambodia, CARE initiated sexual and reproductive health programmes among young women in factories. The Garment Manufacturer's Association of Cambodia (GMAC) provided a broader scale entry point through which to contact individual factory managers. Although initial interest did not translate into thorough commitment by the managers, gaining access to, and building relationships with, a few factories allowed the project to demonstrate to managers that the educational activities would not deter from the quality of work and life among workers but would improve their situation. The influence on some factory managers then diffused to others, thereby allowing the programme to gradually expand its reach from five factories to 25 (Care International in Cambodia, 2001). Since then, CARE has worked at a broader policy level, linking the programme to policies related to workers' rights.

In contrast, an intervention with the Royal Thai Army mobilized the command structure to support a comprehensive HIV/AIDS prevention programme. A Technical Advisory Group consisting of senior commanders, Ministry of Health officers and community groups was established to provide guidance and build ownership. With support from commanders, intervention activities were then integrated into all aspects of daily life among conscripts, and were subsequently sustained and expanded to other military camps (Celentano et al., 2000).

Key questions in gaining political, administrative and management support

What is the mission (and goals) of the institution, organization or programme?

Would incorporating ASRH programmes help to achieve this mission and these goals?

Is senior management support assured?

Is the institution, organization or programme positioned to address the complex range of issues facing young people?

Would ASRH programming have a positive impact on the image of the institution, organization or programme?

What are the possible positive and negative impacts of integrating ASRH activities?

What processes are required to gain commitment and support?

What are the key concerns and priorities among relevant stakeholders?

Where in the structure is resistance strongest?

Where in the structure is support strongest?

What processes can be initiated to strengthen support and diffuse resistance?

What type of data or evidence is required to make a compelling case?

What roles do the media and other institutions play in shaping public opinion and support? How have the media successfully developed public support?

What roles and activities can youth play to stimulate support? How can youth activism be strengthened?

What sensitivities do teachers, workplace owners/managers and other stakeholders face? What support is needed and how can it be provided to those who take an active role?

What processes are required to gain ownership by teachers, workplace owners/managers, and other decision-makers?

What are teachers' and managers' primary concerns with participating?

What concerns are there regarding workers' or students' access to information, and their behaviours and conduct?

How do they perceive their own role in education, particularly as it relates to ASRH programmes?

2.3 Designing and adapting curricula and training materials

Effective curricula promoting sexuality education, life skills and HIV/AIDS prevention have shifted from didactic teaching approaches that provide information and facts about anatomy, physiology and disease transmission to more holistic and interactive approaches that explore values, attitudes and strengthen skills. In many countries, this shift is only beginning and represents a challenge to traditional education approaches that emphasize teacher-centred lectures and learning by rote. Introducing skills-based curricula with comprehensive information content thus requires broad participation and consultation and a careful adaptation process. As noted by SIECUS:

The characteristics of the local situation determine the exact content of the local curriculum. Community attitudes, developmental differences in children, local socioeconomic influences, parent expectations, student needs and expectations, and religious and other cultural perspectives must be paramount in the design of the local sexuality education programme.

(SIECUS, 1996).

The challenge in developing and adapting curricula is how to be consistent with local culture and values, while not compromising the integrity of the content and teaching approaches (Birdthistle and Vince-Whitman, 1997).

In Bangladesh, the Bangladesh Rural Advancement Committee (BRAC) introduced Family Life Education curricula into its Non-Formal Education Programme in two phases. In the first phase, the curriculum addressed primary health concerns. As the programme evolved, it introduced more information about marriage; pregnancy; sexually transmitted diseases; contraceptive methods and the responsibilities of adolescents; smoking and substance abuse; and gender issues. It has since included participatory learning techniques such as body mapping into the curriculum. Due to the sensitive nature of adolescent health programmes, it was first introduced in a less conservative area before being replicated and adapted in more conservative areas. During the adaptation process, a group of mothers raised some objections to the content. After some discussion with the project officer, they were convinced of the importance of the information and the relevance to their communities. Likewise, in more conservative areas, religious leaders convened community members to review the curriculum, and determined that none of its content was offensive to their religion (Barkat, Ali Khan and Bond, 1999).

In China, the Chinese Family Planning Association and PATH convened a curriculum review and adaptation process to tailor a comprehensive life planning skills curriculum to different groups of youth in different provinces, ranging from Shenzhen and Shanghai in the South to Harbin in the North. Programme staff and education experts from several provinces reviewed the curriculum and determined which content would be appropriate for different age groups and settings. The process was informed by results from a participatory learning for action process that was undertaken in each province. This resulted in tailored packages for secondary school students, mobile workers and community-based settings. Future evaluations will determine the extent to which the content and delivery is adequate in bringing about improvements in behavioural and health outcomes (unpublished PATH-CFPA annual project report 2002).

In the Masaka District of Uganda, the WHO/UNESCO School Health Education to Prevent AIDS and STD programme has been implemented. When adapting the curriculum, teachers found that the use of English allowed for sensitivities to be addressed, and avoided the discomfort of discussing such matters in the mother tongue. Furthermore, certain activities such as role-play exercises presented challenges to students who were not accustomed to expressing themselves. In some cases, students were allowed to practise and then perform role-play exercises. Finally, the provision of condoms and demonstration of their use created controversies. Some teachers refused to include information about condoms for fear of losing their jobs, or because of religious convictions. Discomfort with the topic was reduced by having male teachers talk to male students and female teachers talk with female students (Kinsman et al., 1999).

Key questions in designing and adapting curricula and training materials

What core content is required in order to bring about desired changes in outcomes?

What review and adaptation processes will contribute to ownership and responsiveness to local needs, values, interests and concerns?

What informational content, techniques, games, and learning approaches contribute to acquisition of skills, improvements in relationships and communication, and changes in behaviours?

What length of time and organization of sessions is adequate in ensuring that core components are provided?

2.4 Skills and selection criteria for facilitators, teachers, counsellors, health workers and peer educators

It is well recognized that young people should be centrally involved in the design and implementation of youth sexual and reproductive health programmes. At the same time, it is important to acknowledge that adults will usually be the ones primarily involved in programme management; from initial conceptualization until final evaluation. Therefore it is essential that adults working in the field of youth sexual and reproductive health have a solid understanding of young people and sexuality. It is also important that adults have an opportunity to explore their values and attitudes towards young people and sexuality (Bond, Pownall and Levack, 2003).

Due to the shift from didactic teaching to learner-centred approaches and to the need to be empathetic and understanding of youth needs, many teachers, facilitators, health workers and others involved in youth programmes may not be adequately equipped to carry out their roles. One of the main tasks of an effective programme is to create an environment of openness, based on respect, trust and listening. In many settings, this approach contradicts the traditional environment of formal learning.

A programme will have a much greater chance of success if it has taken the time and effort to improve the knowledge of adult staff and their attitudes towards youth and sexuality. Adults will learn that human sexuality is a natural life-long process, and will therefore understand the need to provide healthy messages about sexuality beginning at an early age. Adults will also see human sexuality in a positive light, and will therefore develop youth sexual and reproductive health programmes that carry positive messages rather than simply focusing on problematic behaviours. By developing a better understanding of youth, adults will create programmes that are not judgemental and that will respect young people's rights and their abilities to make healthy, informed decisions. In short, helping adults better understand young people, human sexuality and their own values and attitudes will have a significant impact on the success of a programme.

It is also important to select teachers, facilitators, health workers, peer educators, counsellors and so on based on certain characteristics, and to equip them with the information, attitudes and skills to deliver a programme. Broadly, selection criteria for "youth-friendly" programme staff include:

- Ability to treat young people with respect
- Respect for (and ability to maintain) confidentiality
- Credible role models
- Open and non-judgemental
- Comfortable discussing issues of concern to young people
- Possessing a belief in (and commitment to) the education programme
- An understanding and commitment to maintaining the rights and dignity of youth.

In school and clinic settings, there may be less flexibility in selecting educators. In that case, it is important to orient teachers and health workers to their roles and to the principles of working with youth. PATH Thailand clearly distinguishes between the roles of "Instructor" and "Facilitator" in the delivery of a comprehensive sexuality and HIV/AIDS prevention curriculum (**Table 1**) with profound implications for selection and training (Program for Appropriate Technology in Health, 2001).

Table 1: Characteristics of Instructor versus Facilitator

Instructor	Facilitator
A presenter who explains the course contents and gives information	A leader who encourages participation in discussions and debates
Provides instructive, judgemental direction	Assists by stimulating questions or asking relevant questions
Usually employs one-way communication	Usually employs two-way communication
Directs and assigns activities by determining who should do what	Coordinates and facilitates activities for participants
Presents objectives of the learning process based on the formal curriculum and course contents, and follows the outline closely	Links individual interests and goals to develop the group's common interests, and identifies real agenda
Teacher-centred	Learner-centred

Where selection criteria are not established, and people are uncomfortable with the new roles assigned to them, the quality of a programme may be compromised. As one facilitator in the programme above expressed:

My role has changed from teacher to listener – I don't know what to expect when facilitating – it's very challenging.

Female teacher
PATH-HORIZONS School-based Sexuality Education Project
(Program for Appropriate Technology in Health, 2001)

In this case, adequate coaching and support are critical to the delivery of the curriculum.

In Masaka District, Uganda, many teachers put their reputations and jobs at risk by teaching about sexuality and life skills deemed inappropriate by authorities and community members. Such social sensitivities are one of the key barriers to broader implementation of youth programmes. However, despite the social risks, teachers recognized the importance and value of the content. They also found an increased level of openness and trust among students, with students asking them for additional support and advice in caring for parents with AIDS (Kinsman et al., 1999).

The issue of provider discomfort with their roles and mandates as educators or counsellors has been best documented in the arena of "youth-friendly services" where young people have reported being scolded by health workers, turned away from services, or treated with disrespect. In Zambia, introducing "youth corners" and increasing service access to young people created a sense of conflict among some nurses who, although realizing the need to provide such services, could not bring themselves to do so because of their religious values (Nelson, 2000).

Key questions for skills and selection criteria

What selection criteria have been established for facilitators, teachers, counsellors, health workers, and peer educators?

What skills are required for selection of teachers/facilitators?

What screening processes have been established?

How have roles and responsibilities been defined?

How are shifting roles and new responsibilities best managed?

What types of support are needed for professionals working in these sensitive areas?

What types of support can be provided and how?

2.5 Training

Once selected, programme staff require special training and orientation to content, teaching methodologies, activities, referrals and other information provided in an ASRH curriculum. A training package is often developed to orient trainers through a Training of Trainers process. As illustrated in **Table 2** the objectives and core content of training varies according to the different types of programme staff.

Despite such differences in objectives and content, there are common patterns for training, including an understanding of youth, key content areas, and techniques for participatory learning and facilitation. These techniques and principles have been introduced in multiple settings, with varying degrees of success.

In Cambodia, CARE found that the introduction of participatory learning, facilitation and counselling techniques were initially challenging to national staff due to different cultural styles of learning and communication. In fact, in many settings these skills are more challenging than the provision of reproductive health information alone. In the Khmer context, staff understood the concept of counselling to involve providing advice or instruction. Consistent practise, coaching and guidance resulted in the acquisition of stronger skills, the ability to train others, and the recognition that the shift in approach led to greater involvement of participants (CARE International in Cambodia, 2001).

Key questions for training

What are the key objectives of training, content and methods/approaches?

What minimum training requirements are needed, how often and by whom?

What structure of master trainers needs to be established and how?

Table 2: Illustrative Objectives and Core Content of Training Materials for Different Groups

Group to be trained	Teachers/facilitators (PATH, 2001a)	Health providers (PATH, 2001)	Peer educators/ Connectors (PATH, 2002)
Objectives	Participants will: • Be more understanding of young people's lifestyles • Be able to analyse personal and social attitudes about sexual behaviour of young people • Be aware of risks and consequences of HIV/AIDS and unintended pregnancies • Be more aware of HIV/AIDS situation • Have developed facilitating skills • See themselves as facilitators.	• Orient health providers to RH issues relevant to young clients • Increase understanding of youth development and needs among providers • Improve communication skills • Increase referrals to services	• To develop peer educators as catalysts for changes in norms and behaviours • To provide guidelines for the broad management of peer programmes
Core content	• Understanding young people • Information about HIV/AIDS, risk situations and prevention • Attitudes toward sex education • Facilitating skills • Practice modules from curriculum for delivery to youth	• Adolescent reproductive health • Emergency contraception • STIs • Contraceptive management	• The art of facilitation • Understanding behaviour change • Experience, behaviour, feelings • Listening skills • Continuum of inquiry • Techniques such as asking questions, use of role play, timelines, and conducting discussions • Recruiting peer educators • Forming dissemination groups • Feedback and quality assurance

How is the training delivered? What challenges are encountered?

How is the training evaluated?

How is performance monitoring conducted to assess skills and competencies?

2.6 Developing management and human-resource systems

The delivery of effective programmes requires strong systems of management, monitoring, supervision and support. The integration of ASRH programming activities into any existing effort requires staff to fulfil new roles and functions, as both programmers and trainers. The ability of staff to effectively do this will depend upon their acquiring new skills, competencies, values and relationships. The challenge for team leaders is to create and maintain operating systems, and an environment in which staff continue to operative effectively though a period of change while learning and building the confidence needed to undertake their new roles and functions (Bond, Pownall and Levack, 2003).

In all programme types, management support, adequate staffing, and supervision are vital to success. Other requirements can however vary considerably according to the type and nature of programme being delivered.

Key questions on management support

Are the management systems and capacities adequate to support the introduction of ASRH programming?

What additional support is needed to integrate ASRH programming into existing operations?

Would current funding be supportive of introducing ASRH programmes, or would other sources of support be needed?

Key questions on human resources

Could the current staff manage the increased workload?

Does the existing staff team have the knowledge and skills required for ASRH programming?

What additional knowledge and skills need to be developed in the staff team? And how will their capacity be developed?

Does the management team support ASRH programming?

What concerns do they have regarding ASRH programming?

Will new staff need to be recruited and trained?

Will additional technical assistance be needed? In what areas? Where is it available?

2.7 Implementing information, sexuality and life-skills education programmes

Promoting healthy decision-making and safe behaviours among young people is at the heart of most youth programmes. A number of education approaches have been developed, ranging from life-skills education that emphasizes refusal skills; to basic anatomy and physiology; to HIV/AIDS prevention. Approaches that address the developmental, cognitive, emotional, physical and social elements of sexual development offer the greatest promise in promoting healthy development and relationships, and preventing unwanted sexual and reproductive health consequences. Life-skills education is a strategy employed to enable young people to act on information, and can be incorporated into school-based, peer or community-based programmes. The five foundation skills areas are:

- Decision-making, problem-solving
- Critical thinking, creative thinking
- Communication and interpersonal skills
- Self-awareness and empathy
- Coping with emotions and stress.

Sexuality education emphasizes holistic development. Departing from more traditional approaches that teach only anatomy and physiology, sexuality education curricula usually address the following content:

- Sexual development
- Reproductive health
- Interpersonal relationships
- Body image
- Gender roles.

SIECUS has developed a long list of criteria (*Life Behaviors of a Sexually Healthy Adult*) in recognition of the fact that sexuality education is a life-long process of discovery and interconnectedness (SIECUS, 1996).

HIV/AIDS Prevention focuses on preventing specific behaviours. The urgent need for HIV/AIDS education has stimulated concerns about sexual risk among young people, and allowed for the introduction of more explicit approaches to teaching about sexuality. HIV/AIDS education provides information on the risks of HIV transmission, methods of prevention, condom promotion, and in some cases caring for people with HIV/AIDS and reducing stigma. HIV/AIDS education programmes have been found to decrease the number of sexual partners, increase condom use, and increase communication between partners about HIV and safer sex practices.

Newer generation approaches to sexuality education incorporate life-skills education and HIV/AIDS prevention. This approach combines learning experiences that develop not only knowledge and attitudes but also the skills that are needed to make healthy decisions and take positive actions to promote health and safety, and reduce disease risk. Sexuality, HIV/AIDS and life-skills education programmes can increase levels of knowledge, change attitudes and promote positive behaviours.

Reviews of evaluations and studies from the US and developing countries indicate that school-based sexuality education and life-skills programmes can bring about all these benefits, promoting positive behaviours such as delayed sexual initiation and increased condom use among sexually active youth. Initiating education programmes in school settings can reach a large number of young people where school enrolment rates are high. There are however a number of implementation challenges to introducing and implementing such programmes, including:

- Gaining commitment and support from policy-makers
- Establishing ownership by (and confidence in) teachers
- Development and adaptation of curricula for different ages and local sociocultural conditions
- Setting minimum training requirements

- Organizing a master training structure
- Testing and adapting training techniques and content to achieve high quality and performance by trainers.

Programmes promoting information and life skills have, to a lesser extent, taken into account gender differences between boys and girls. The examples provided in section 1.1 indicate that gender role socialization during adolescence has different implications for boys as opposed to girls, and sexual and reproductive health interventions may lead to differential results. One review of the health and development of boys (WHO, 2000) has indicated that boys and girls have different potential "crisis points" during their development. Boys tend to socialize more outside the home and with their peer groups than girls, and may face challenges to their educational and school performance. They may also face pressures related to sexual initiation and performance relating to their masculine identity; and may be more likely to drink, smoke or use drugs.

A survey of organizations working with boys (WHO, 2000a) indicated that they require the same types of general support as girls, including counselling, health information and services, life and livelihood skills, and alcohol and substance use counselling. However, programme content and delivery also needs to take into consideration the different elements of socialization and the power relationships that emerge between boys and girls. Some programmes for boys may need to focus on high-energy, physical activities, whereas for girls, programmes may emphasize building self-esteem and strengthening social support.

Key questions for the delivery of school-based information, sexuality and life-skills programmes

Where and when in the existing school course (and by whom) should the curriculum be delivered?

How often should sessions be offered in order to be effective? (What is the adequate "dose"?)

When is the best time to offer sessions?

What competing needs and interests may interfere with attendance?

2.8 Delivering health services, including counselling

In the field of adolescent reproductive health, much of the discussion relating to health services is whether or not they are "youth-friendly". Youth-friendly services have been defined as those with:

policies and attributes that attract youth to the facility or programme, provide a comfortable and appropriate setting for youth, meet the needs of young people and are able to retain their youth clientele for follow up and repeat visits.

(Senderowitz, 1999)

Services have traditionally been appraised in terms of access, quality and utilization.

2.8(a): Access

Barriers to access can be considered in four categories:

- physical access or other characteristics pertaining to the physical structure of the facility – this category encompasses opening hours and days; location; available space and privacy; appearance; and supplies and equipment

- economic access or other characteristics pertaining to the cost of the service
- administrative access or other characteristics pertaining to rules and restrictions of access – includes policies relating to services for males and females; arrangement of appointments; and publicity and recruitment
- psychosocial access or other characteristics pertaining to young people's perception of service usability – may include perceptions of privacy; of the provision of services appropriate to gender or sex; of confidentiality; of service availability to unmarried youth; of costs; and the perception that providers are aware of (and sensitive to) youth needs (Nelson, 2000).

In a review of service evaluations in Brazil, Bolivia, Côte d'Ivoire, Togo, and Zambia, FOCUS on Young Adults summarized the implementation issues relating to service access (Bond and Magnani, 2000):

- Negative attitudes towards ASRH remain a major constraint to service provision.
- Psychosocial barriers as perceived by young people are related primarily to a lack of privacy and confidentiality – services are perceived as intended for married adults and young people fear being stigmatized if seen using them.
- There is a concern that mere modifications of the services to make them "youth-friendly" will not be able to adequately address young people's health-service needs.

This final conclusion was supported by the findings of an evaluation of youth-friendly services in Zambia that demonstrated that although training providers to become "youth-friendly" improves the quality of the clinical experience for young clients, it does not in itself necessarily increase utilization. Social and community norms and beliefs about the provision of reproductive-health services for young people may be more significant in determining patterns of utilization (Nelson, 2000); an issue discussed further below in section 2.8(c).

2.8(b): Quality

Quality of services has several meanings. First and foremost is the safety of the services received. To many clients, especially youth, interaction with providers and the privacy afforded are key elements in deciding whether to use services again. Having to wait a long time or finding that services are unavailable after seeking them may also be serious disincentives to returning. Similarly, receiving poor or ambiguous information may frustrate and deter clients, and leave them unable to follow instructions or use medications and contraceptives correctly.

To improve the services they provide to adolescents, service-delivery sites should consider the rights of the client and the needs of staff. In their efforts to improve quality, sites can obtain guidance from existing frameworks[6] and from direct client and community input.

Table 3: Framework for Client Rights and Staff Needs

Framework for Client Rights and Staff Needs	
Youth have the right to:	**Staff have a need for:**
• Information • Access to services • Informed choice • Safe services • Privacy and confidentiality • Dignity, comfort and expression • Continuity of care	• Facilitative supervision and management • Information, training and development • Supplies, equipment and infrastructure

6 Developed by EngenderHealth, 2002. Drawn from Bond, Pownall and Levack (2003).

The COPE self-assessment guides for adolescent reproductive-health services (EngenderHealth, 2002) suggest areas in which managers, supervisors, doctors, nurses, pharmacists and other staff can work together to ensure the rights of clients and meet staff needs. Table 3 is a list of the rights and needs that apply to any service-delivery setting that targets young people.

Within the context of the COPE quality-of-care framework, safe services refers to the behaviour of staff in ensuring client safety through attention to infection prevention and appropriate clinical practices. This entails compliance with up-to-date service delivery standards and guidelines, including counselling, and instructions on (and treatment of) complications. In addition to safety-of-treatment standards, adolescents must feel that they can safely seek out services without facing negative social consequences.

Standards and guidelines provide a means to improve access to (and quality of) sexual and reproductive health programmes. As discussed in earlier sections, there are many aspects of quality of care, including clinical care, management of health services and client satisfaction. Box 2 lists the criteria for adolescent-friendly clinics, as derived from a consultative process, which should be encouraged within health systems.

Standards and guidelines are essential to achieving quality of care. Standards are expressed as a statement of the ideal and of what is required to achieve it. These may be developed nationally or locally within an institution. However, they should always be evidence-based, using the findings of rigorously conducted scientific studies (especially randomized controlled clinical trials) to determine the most effective and safest form of treatment. Unfortunately, care is often "authority-based" – i.e. based upon the opinions and experience of health staff that may at one time have been evidence-based but may now be outdated. Youth-friendly health services should, as a minimum requirement, have standards and guidelines written for:

- Infection-prevention practices
- Contraceptive services

Box 2: Ten Adolescent-Friendly Clinic Standards

1. Management systems are in place to support the effective provision of adolescent-friendly health services
2. The clinic has policies and process that support the rights of adolescents
3. Appropriate adolescent health services are available and accessible
4. The clinic has a physical environment conducive to the provision of adolescent-friendly health services
5. The clinic has the drugs, supplies and equipment necessary to provide the essential service package for adolescent-friendly health care
6. Information, education and communication consistent with the essential service package is provided
7. Systems are in place to train staff to provide effective adolescent-friendly health services
8. Adolescents receive an adequate psychosocial and physical assessment
9. Adolescents receive individualized care based on standard case-management guidelines and protocols
10. The clinic provides continuity of care for adolescents.

(Dickson-Tetteh, Pettifor and Moleko, 2001)

- Abortion complications and post-abortion care
- Care during pregnancy and childbirth
- STI diagnosis and treatment
- Support for healthy sexual development.

2.8(c): Utilization

As mentioned above, service utilization is influenced by a variety of factors, and can be better informed by considering cultural models of health-seeking behaviours. Nelson (2000) found that in the catchment areas of youth-friendly services in peri-urban Lusaka, young people were more likely to use clinics in those communities that demonstrated most awareness and acceptance of adolescent reproductive-health services. Given that health-seeking behaviours in the young are influenced within the context of multiple sectors of society (folk, popular, professional) a broader social environment that is supportive of service provision results in higher utilization rates. Activities designed to improve quality of services focus primarily on the professional sector (nurses, providers and so on) while young people are more influenced within the popular sector.

In Thailand, efforts to address different patterns of health-seeking behaviour also focus on pharmacies. Thai adolescents often use drugstores as their primary sexual health service providers. Drugstore services are attractive to adolescents because they are generally fast, relatively affordable and anonymous. However, drugstore personnel may be judgemental about adolescent sexual activity, and some of the products and drugs provided to young clients are dispensed improperly or without sufficient information on their risks and side-effects. PATH's ***RX Gen*** project, outlined in section 1.4(d) built a network of drugstores and pharmacists, provided training on adolescent needs and health issues, and conducted consumer-education activities in several municipal settings in Thailand. The project was able to demonstrate a consistent increase in adolescent clients at participating drugstores over the period of time for which data were collected. Clients sought a range of services, including emergency contraception, pills, pregnancy tests, and abortifacients/menstruation inducers. An increased number of clients also used telephone-counselling services at drugstores (Bond, Firestone and Francis, 2003).

Reducing barriers to access and improving the quality of provider interactions is only half of the equation. In order to increase demand and thereby utilization, broader social mobilization and public-education approaches are also needed.

Key questions for delivering health services

What elements are included in an essential package of services and products for youth? How comprehensive are the services? How were they determined?

To what extent are providers aware of youth concerns and needs?

What attitudes and values do providers hold about youth? How are they transmitted? How do they influence service provision?

Where is the existing demand (or potential for demand creation) for services among youth? How can it best be tapped?

To what extent are counselling and communication skills applied?

How do providers deal with difficult questions and sensitive topics?

What standards and guidelines exist to guide providers and ensure safety and quality?

What supervision mechanisms or means for sustaining quality are established and how?

How does health-sector reform influence cost recovery and cost sharing? To what extent does this exclude vulnerable populations, including youth?

What impact does health-sector reform have on staffing? How does this impact upon quality of services?

2.9 Involving youth in programmes

Involving youth in ASRH programmes is a strategy that gives voice to young people so that they can influence the delivery of programmes and services. Such a strategy builds upon the influences that young people have on each other. Involving youth in the management, decision-making and governance of programmes allows for representation and for a youth perspective. Youth involvement in programme implementation, however, most often occurs in the provision of education and support to peers.

Young people's active involvement in peer programmes can take advantage of the relationships among young people that influence what they learn and how they behave. Peer programmes also assume that peers get information about sexuality and reproductive health from each other, and that peer groups and membership influence expected behaviours and norms. Building on their existing social networks, young people are generally involved in one or more of the following activities:

- counselling
- holding group activities
- exchanging coping and communication skills in small groups
- learning to model or "role-play" behaviours
- building communication, negotiation and refusal skills
- engaging in interactive techniques like media, puppets, simulation exercises
- challenging and changing group norms
- providing commodities
- making referrals for services.

Programmes that involve youth as peer educators or promoters have been described anecdotally as effective in creating a demand for family planning and HIV/STI services; distributing contraceptives; referring youth to other services; and changing social and cultural norms leading to risk behaviours. Although peer programmes have demonstrated measurable changes in protective behaviours, the benefits are often greatest among the peer educators themselves (Flanagan, Williams and Mahler, 1996).

Measuring the impact of participation and involvement in programmes is indeed challenging, and rarely included in evaluations of behaviour-change trials. One intervention among army recruits in Thailand mobilized commanders and recruits alike, leading to a seven-fold reduction in sexually transmitted diseases and a complete decline in HIV incidence. The change was not mediated by behavioural factors reported in the study; however changes in group norms were associated with the declines. It is possible that widespread participation and mobilization may have contributed to this change, although no measurement was created to verify this inference (Celentano et al., 2000). Interviews with recruits indicated that they placed greater confidence in their commanders than their peers.

Evidence about how to best manage the involvement of young people is still weak, and only a limited number of peer programmes have undergone systematic evaluations (Bond, 2003). In one UNAIDS needs assessment conducted worldwide, peer-education programme managers stated that, among other things, they wanted more information on how to select peer educators and how to measure programme effectiveness (Kerrigan, 1999; Kerrigan and Weiss, 2000).

As our understanding of peer and adult influences on youth grows, it is important to increase our knowledge of what features of these programmes are important, and to create localized programmes that build on those influences. A commitment of resources and effort to conduct thorough evaluations is needed in order to draw firm conclusions about what really works.

2.9(a): Recruitment

In a review of effective peer programmes in the US, Philliber (1999) suggests several important aspects of peer influence that should be considered when selecting and recruiting peer educators:

- Identify and use multiple modes of influence – programmes should be aware of multiple types of influences on young people, and should target and involve them appropriately.
- Recognize that young people operate in different group "subcultures," and that these groups are heterogeneous.
- Consider using naturally occurring peer groups and networks in productive ways.
- Choose peer leaders carefully and encourage them to present curricula and messages about social situations and peer-group pressures.
- Identify important characteristics that peers relate to.

The review cautions that peers can have either a positive or negative influence on each other, so peer leaders should "model" the behaviours the programme seeks to promote.

For example, PATH Kenya has established criteria for identifying peer educators who can act as "Connectors" and who "like receiving and sharing information, and belong to a wide social network". Such people tend to be articulate; patient listeners; tolerant of other people's attitudes, beliefs and behaviours; non-judgemental; and make people feel comfortable expressing themselves (Program for Appropriate Technology in Health, 2002a). The Lifenet Project in northern Thailand has also utilized social networks in selecting peers by mapping channels of communication. Further personal criteria included willingness, availability, commitment and positive influence on friends (Athamasar et al., 2000). The Jamaica Red Cross established similar criteria, namely the capacity to appeal to peers as a group leader, ability to interact and communicate with peers, and ability to be trained (Randolph, 1996).

The recruitment of peer educators should take into account the networks and behaviours among subgroups of young people. Peer programmes that consist only of "model" students are unlikely to reach those at greater risk. Young people's subcultures are expressed in different forms of dress, entertainment tastes, and activities; all of which should be taken into account in designing programmes. This will influence the degree of reach and coverage that peer programmes have in a given area.

2.9(b): Training

In their review of peer-education experience, Kerrigan and Weiss (2000) highlight several conclusions related to the training of peer educators drawn from consultations with peer-programme managers. Resulting recommendations include:

- Involving peer educators in the design and adaptation of the training curriculum and support materials to ensure the relevance of the training and ownership of the programme
- Addressing facts related to HIV/AIDS and ASRH, in addition to sexuality and gender, interpersonal communication skills and legal and ethical issues
- Providing ongoing training and refresher training to build knowledge, skills and competencies over time
- Taking into account the personal development of the peer educator.

2.9(c): Management, supervision and compensation

Kerrigan and Weiss (2000) go on to describe supervision and follow-up among peer educators as "high maintenance". Management can however be made easier when clear and realistic expectations are established and communicated; when roles and responsibilities are determined; and when activities are consistent with training and demonstrated competencies (Flanagan, Williams and Mahler, 1996). Monitoring activities by peer educators also provides an opportunity for discussion with adult mentors or supervisors, allowing adults to recognize the types of situations encountered by peer educators, and their ability to respond (Athamasar et al., 2000). Supervision should include both field and office-based supervisory sessions (Kerrigan and Weiss, 2000).

The question of incentives and remuneration for peer educators often arises. The literature on peer programmes offers little guidance relating to compensation, but rather a broad range of experiences. In many settings, peers have limited time and availability to volunteer for activities; however, funding limitations within small programmes often prohibit adequate compensation. In some settings,

programmes have been linked to income-generating efforts such as micro-credit or sales. In others, peer educators receive in-kind support, travel funds, *per diem*, or t-shirts. In a few cases, peer educators are treated as outreach workers, and receive a salary or other monetary remuneration. The appropriateness and feasibility of different means of compensation should be determined within the context of a given programme (Kerrigan and Weiss, 2000).

The cost and time involved in supervising and managing peer programmes, coupled with the high turnover of young people, raises questions about whether or not such efforts should be the primary element of a youth programme, or complementary to other efforts. Furthermore, there is a danger that adults assume that because young people get information from their peers, peer programmes become the primary strategy, thereby neglecting their own roles in providing information, guidance and support.

Key Questions in Involving Youth in Programmes

What are the stated strategy, goals, messages and expectations of the programme?

What level of decision-making authority do youth have in programmes and services?

What youth populations is the programme designed to reach?

How can youth be recruited? What characteristics should be identified?

What type of training is offered to (and required for) young people? How is performance monitored? How is quality of performance sustained?

What mechanisms for supervision and support are in place?

How long can young people be expected to participate in a programme? What motivates participation? What frustrates or discourages participation?

What continuing education is offered to (or needed by) young people who are participating?

2.10 Developing and implementing multisectoral programmes

Preliminary research findings suggest that youth reproductive-health programmes that combine multisectoral approaches and prolonged attention to building community partnerships in which adolescents are active participants offer the most promise in sustaining behaviour change (Kirby, 2001; UNFPA, 2000; Bond and Magnani, 2000). These findings reinforce the country programming framework (The Common Agenda) which calls for programmes to provide support for adolescents in:

- receiving accurate information
- building skills (life and livelihood)
- obtaining counselling
- accessing health services
- living in a safe and supportive environment.

(WHO, UNFPA, UNICEF, 1997)

Multisectoral approaches imply that programmes employ multiple components that can target multiple risk factors. Furthermore, they contribute to a multiplicative strategy for scaling-up that leads to broader effects achieved through collaborations with other organizations (Edwards and Hulme, 1992). This approach is distinct from integration, a process of introducing elements of ASRH programmes into existing programme efforts that may be educational, vocational or health-related. Multisectoral approaches require working at the system level, and may involve shaping policies. The critical issue in

multisectoral programmes concerns less the elements of the individual components, and more the establishment of complementary programmes, with collaboration and cooperation being required to bring about effective linkages between components.

Despite the promise of multisectoral programmes, the literature is almost void of examples of effective, national-level multisectoral strategies that focus on ASRH. Youth were one component of the effective multisectoral HIV/AIDS response in Uganda, which included educational institutions, religious organizations and communities (Hogle, et al. 2002). Conversely, even though the early HIV/AIDS response in Thailand involved multiple sectors, youth were almost entirely absent from discussions of sexual risk behaviours due to the cultural sensitivity surrounding youth sexuality.

Multisectoral approaches to youth programmes require strong and enduring partnerships, and the building of networks among youth and within communities and organizations. Fostering partnerships and networks can help to improve the social environment through: policy and advocacy activities; development of systems for referral; and the identification of channels through which to scale-up innovative and effective programme strategies.

Public-sector partnerships should at the very least involve the ministries of health, education, social welfare, labour, and the interior. In practice, these partnerships present many challenges due to ideological differences, competition for resources, structural differences in the institutions involved, and the time-intensive nature of collaboration. The process of health and education reform presents another challenge to building multisectoral partnerships, as personnel are moved and power is decentralized. Ultimately, reform may contribute to the ability to form and maintain partnerships at the local level; however, the confusion of roles and systems during the process makes otherwise-interested parties reluctant to engage.

Public-private partnerships may offer more promise when a mutually identified goal is identified. In Cambodia and Thailand, PATH collaborated with CARE and others to develop multisectoral networks that linked interventions with pharmacy and clinic-based health services. This effort offers lessons as to how partnerships were established with factories and health providers:

- Develop mutual understanding and respect, including learning about what motivates each partner
- Barriers between the public and private sectors can be challenged when both partners understand the reasons for initiating and maintaining collaborative action
- Developing a common agenda can ensure equitable public-private relationships
- Persistence is a crucial ingredient of successful partnerships
- Developing close relationships with relevant government departments and influential businesses is a first step in legitimizing the effort
- Bringing health providers together facilitates the development of personal relationships and referral linkages
- Building a network takes vision, coordination, and diplomacy
- Networking across sectors can help members broaden their perspectives and strengthen commitment.

(Bond, Firestone and Francis, 2003)

Many other ASRH programmes engage informally in networking and partnership activities. However, the types of partnerships and conditions under which they are formed vary significantly, and they are rarely documented or evaluated.

Key questions in developing and implementing multisectoral programmes

What are the added benefits of a multisectoral strategy with links to services and community support?

How can the process of institutional and community mobilization strengthen links between health promotion/education and service utilization among young people?

What are the costs associated with multisectoral programming?

How are effective partnerships created, managed and maintained?

Youth programmes may additionally ask themselves two important questions in planning multisectoral strategies:

What organizations, institutions or coalitions can be used to improve systems that support the healthy development of young people?

To what extent do organizational networks and coalitions meet the needs of youth and how can they be strengthened?

3
Expanding the scale and reach of interventions

While there are many pilot programmes for ASRH around the world, there are few systems that deliver them at scale. Expanding the reach of interventions requires that they be integrated into whatever institutional systems and settings are relevant to their objectives and implementation. This section reviews models, strategies and processes for scaling-up youth programmes and outlines key system and capacity needs. The issues and challenges in sustaining youth programmes are then discussed.

3.1 Models for scaling-up

In their review of scaling-up programmes for youth, Smith and Colvin (2000) outline four main models:

- Planned expansion – the steady process of expanding the number of sites and youth served by a particular model once it has been pilot-tested
- Association – expanding size and coverage of programmes through a network of organizations
- Grafting – adding a new youth initiative to an existing programme
- Explosion – sudden implementation of a youth programme on a large scale.

Each model has advantages and disadvantages, and the selection of appropriate models is often contingent upon the type of system in which a programme is working. For example, planned expansion is more feasible in a given school or health system, or when technologies are needed, such as medical services. Association is responsive to community and youth input, and local conditions, and is often conducted among nongovernmental organizations and community or professional associations. With association, however, it may be difficult to maintain quality and adherence to a programme model, given the varying needs for flexibility and adaptation. Grafting can build on existing infrastructures with minimal additional resources; however, in order to be successful, organizations must invest in a process of building ownership and capacity in order for a programme to be adequately implemented. Finally, explosion requires that programmes quickly taken to scale be built into adequate infrastructures with sound operating structures. Without these, quality of implementation, and subsequent impact, is compromised. However, this approach can generate political will and raise awareness of a given issue.

3.2 Strategies and processes for programme expansion

Several strategies and processes crucial to programme expansion have been outlined by DeJong (2001) and Smith and Colvin (2000), including:

Organizational expansion

This strategy relates to diversifying geographical areas, social groups and functions within one organization. For example, the organization may expand its coverage into new geographic areas or to new subgroups or populations, or open branches in other areas. For example, the Chinese Family Planning Association (CFPA) is gradually expanding its youth focus throughout its broad network of Family Planning Associations across China. Its initial programme focus on industrialized and urban areas will gradually expand to cover rural and less-developed provinces in China.

Programme development and institutionalization

This requires that programmes analyse the systems within multiple sectors, primarily ministries of health and education. This process presents a number of challenges in the current climate of reform, particularly

in identifying institutional structures, gaining political commitment for youth reproductive health and AIDS education in schools, and training service providers in adopting positive attitudes towards young people and to the provision of services for them. Furthermore, assessments of administrative and training needs and costs are required.

Building on existing institutions and infrastructure

A key challenge to scaling-up (for example in sexuality education) is identifying the appropriate age at which students should be introduced to particular topics; and identifying appropriate teachers, structures and courses in which to introduce the curriculum.

Catalyzing other organizations, technically and financially

In this case, an organization provides technical and/or financial support to other organizations with the same mandate, in the same or other sectors. For example, in Thailand, PATH is working with the Thai NGO Coalition on AIDS, AIDSNET and the Northern Thai Network of AIDS NGOs to introduce strategies, approaches and resources that focus on youth.

Diffusion

The spread of new ideas or innovations through systems is referred to as diffusion. This process is achieved through active communication, dissemination of programme approaches, and community mobilization. Youth programmes may build on natural trends and existing mechanisms of diffusion (such as commercial television and radio music channels, the internet, and other media) to change norms or ideas about a particular issue.

Influencing policy

As described above, developing support for the institutionalization of sexuality education and services, and fostering multisectoral collaboration requires systems analysis and engagement with policy-makers at various levels. NGOs often engage in media advocacy approaches, policy debates and community rallies or fora to influence policy-makers on particular issues. Young people in particular may serve as agents of change in bringing about support from policy-makers. Where a policy climate is supportive of programmes for youth, attention then needs to be given to ensuring a constituency of support for effective approaches, and identifying plans and mechanisms through which to implement policies.

Identifying committed leaders to support, guide and sponsor the scaling-up process

A key aspect of achieving policy support is identifying (and gaining support from) individuals holding existing positions of leadership at governmental levels, and in communities. In many settings there is a great need to build leadership in the field in order to lay a foundation for longer term implementation and ongoing support.

Mainstreaming in development

This process, like that of building multisectoral support described above, requires that the issues of youth health be integrally linked to social and economic development goals across sectors. Political mobilization is required to bring this process about, and there are few examples globally of this being done to address the needs of youth specifically.

Fostering a participatory and flexible process for scaling-up

Under health and education reform, facilities and schools will have increased autonomy to make decisions relating to the use of curricula. Therefore, it is increasingly important to provide evidence of the effectiveness of different approaches, and to understand local decision-making processes in order to influence the adoption of appropriate curricula and approaches.

Use of data, research, and monitoring and evaluation systems to scale-up effective programmes

There remains limited formal evidence on the implementing of youth programmes in different settings and on their impact. However, where data are available, they can be used to make a compelling case for future investments in programmes and expansion of reach. Data also help to monitor the scaling-up

process, to identify strengths and weaknesses within the system, and to ensure that implementation is conducted according to targets.

3.3 Systems and capacity to carry out interventions at scale

Regardless of whether it is government ministries, communities, private-sector health-service providers, or nongovernmental organizations that are scaling-up programmes, four key components are required to effectively carry out the stated goals or objectives[7]:

- strategic planning that aims for appropriate targeting and equity in distribution of care and services
- structures and systems through which to implement interventions and deliver youth programmes
- technical and managerial skills that build upon and enhance human resources
- financial support and other resources to carry out and sustain effective youth interventions.

The stated objective of many donors is:

not just to improve health status or individual behaviour during a project's lifetime, but to ensure that local entities – organizations, groups and even health systems – can maintain these improvements over time, independent of external support.

(Brown, LaFond and MacIntyre, 2001)

To move towards this goal, building capacity and strengthening institutions is critical. Capacity can be measured in terms of intermediate outcomes in a system – existence of strategies; organizational performance; responsiveness in planning; and skills and competencies – as well as in the changes in community norms and practices that contribute to health. Capacity may be considered as having been established when:

- communities and constituents (youth, families) set priorities, identify and contribute to developing solutions, and establish networks for diffusing solutions
- management, procurement, production, quality assurance, and monitoring systems are in place and operational
- personnel – including health-service providers, educators, and managers – have adequate knowledge and skills to carry out youth interventions[8].

The capacity of a health or education system is often reflected in the design of structures and policies that guide delivery; coordination of organizations; and allocation of resources (Brown, LaFond and MacIntyre, 2001). Effective youth programmes extend beyond the health system to other ministries – including education, youth, sports and culture, and finance – and to communities and other social and cultural institutions whose norms and practices influence health behaviours and access to health services. Building structures may be most appropriately based on self-assessments that address:

- decision-making processes, authority, and supervisory systems
- inter-agency collaboration and coordination
- monitoring systems, quality, and performance
- community involvement and investment in resources and practices that affect health.

7 "Capacity" in public health systems has been defined as "the ability to carry out a stated objective" (Goodman, Speers and McLeroy, 1a998).

8 Modified from *Guiding Principles for Achieving and Assessing Programmatic Impact* (Program for Appropriate Technology in Health, 2002).

For communities and local organizations, self-assessment tools can be used to analyze the potential of organizations to address specific health challenges to communities; and to generate engagement and participation in developing solutions to those challenges.[9]

Systems are often assessed by organizational performance, which is composed of:

- strategic planning
- financial management
- information management
- logistics systems
- communication networks
- human-resources development and management.

(Brown, LaFond and MacIntyre, 2001)

Within countries, broader systems of resource allocation, and the degree of centralization or decentralization of authority and planning, will also influence the opportunities available to foster multisectoral collaboration and implementation.

"Community capacity" can be defined in different ways: legitimacy and recognition; governance and leadership; systems of accountability; identity and vision; resource mobilization; communication systems and organizational learning; relationships, linkages and collaboration; and ability to identify and prioritize problems, acquire and adapt new practices, implement activities, and apply policies and advocate for local interests (Gubbels and Koss, 2000).

Community capacity is often developed to further enable community members to identify and respond to health challenges; to demand services and programmes that address health needs; to generate other social responses; and to invest in solutions to health challenges. In many settings, this form of community action has been correlated with increased utilization of health programmes and services and improvements in health outcomes.

Human-resource capacity (capacity of professionals) is at the core of consistent and ongoing delivery and performance of ASRH programmes. Health and education professionals require specific technical skills in order to provide quality programmes and services. They also require an awareness of youth perspectives and health-seeking behaviours. Many organizations approach the capacity-building of health and education professionals by developing quality standards and guidelines, conducting training to introduce those standards and guidelines, and assessing performance and competence.

Managerial skills, systems and policies are also needed in order to enable technically skilled professionals to perform. Human-resource management can be assessed according to recruitment, selection, training, supervision, problem solving, and communication skills. Institutionalizing human-resource capacity requires a training system that:

reliably anticipates and responds to, and interacts with, the service system in order for the service system to carry out its functions.

(INTRAH, 1992)

Table 4 summarizes the core skills and competencies required of managers working in ASRH programmes.

9 Suggested tools are listed in Annex I.

Table 4: Core Skills and Competencies for Managers in ASRH

Programme Element	Core Skills and Competencies
Analysing key issues and trends	• Understanding of youth sexual and reproductive health issues • Ability to assess trends and data • Application of relevance to organizational mandate
Understanding of context	• Define issue or problem • Select and define issues/variables relevant to problem • If relevant, determine appropriate methods of data collection • Use qualitative and quantitative research designs and methods • Make relevant inferences from data • Assess and define youth health status, determinants of health and illness, factors contributing to health, and factors influencing use of services
Programme strategy and design	• Identify and access current relevant scientific evidence • Collect, summarize and interpret information relevant to issue • Articulate policy/programme options, benefits and implications • Develop plan with goals, outcome and process objectives and implementation steps • Translate programme design into operational plans, structures and activities • Develop monitoring system, and evaluate programme for effectiveness, efficiency, and quality
Understanding, involving, and interacting with youth	• Clarify values about youth and sexuality • Communicate and facilitate in an open, nonjudgemental manner • Involve youth and engage them in all aspects of programme • Identify and recognize assets contributed by youth • Understand the concerns, needs and opinions expressed by youth
Advocacy	• Communicate effectively with multiple audiences • Advocate for programmes and resources • Lead and participate in groups to address specific issues, including deflecting resistance • Use the media, technologies, and community networks to communicate information • Make accurate and effective presentations to multiple audiences
Building partnerships and networks	• Facilitate collaboration with internal and external groups to ensure participation of key stakeholders • Maintain linkages with key stakeholders • Collaborate with community partners • Mobilize organizations and networks that operate within the community • Use leadership, team building, negotiation and conflict-resolution skills to build partnerships • Identify community assets and available resources
Managing change	• Identify internal and external issues that may impact programme implementation or service delivery
Programme implementation exchange	• Identify key issues related to strategy • Discuss and address implementation constraints • Facilitate and exchange experiences and solutions

Key questions in scaling-up programmes[10]

What levels of resources are available to youth programmes? What are the trends in resource mobilization and allocation?

In what ways might a programme be able to achieve economies of scale by increasing service coverage but maintaining the overall cost?

What scope and coverage will be achieved once a programme operates at scale?

What evidence, if any, exists that the programme to be scaled-up has been effective?

Which elements of the programme are key to its effectiveness and which of these elements is included in the scaled-up programme?

In what ways might scaling-up reduce a programme's effectiveness?

What monitoring system is in place to determine whether scaling-up is causing a reduction in effectiveness?

What capacity and resources are required to manage the scaling-up process?

What level of interest and ownership is needed to successfully scale-up a programme?

What will be the effects of scaling-up a programme on the general operations of the organization?

What efforts are needed to involve youth in the plan to scale-up? What about the involvement of community members and programme staff?

3.4 Sustaining youth programmes

The sustainability of programmes is a major concern for international donors. Over recent years, several definitions of sustainability have emerged:

The capacity of a programme to continue to achieve programme objectives and to adapt and respond to change over time.

(Smith and Colvin, 2000)

The capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to underserved populations while decreasing dependence on external aid.

(SEATS, 2000)

The probability that an organization's programme activities and services will continue to produce benefits of sufficient value to their clients that they will generate local resources to support them at a steady or growing level.

(Sclafani, undated)

Since the field of ASRH in developing countries is young, there is scant experience about the ways in which programmes have been successfully sustained; for how long and at what levels. The primary concerns of ASRH programmes continue to relate to programme effectiveness, outreach to vulnerable

10 Drawn from worksheets in Smith and Colvin, 2000.

populations, involvement of young people, and gaining political and institutional support – all of which are necessary requirements for sustained programming. There are numerous examples, however, of programmes that have not been sustained beyond the project lifetime, and others that have evolved into a different type of programme in response to the dynamic needs of youth and the changing contexts of programming. Thus, a more flexible definition of sustainability may be required in assessing programmes for young people.

3.4(a): Elements of sustained programmes

Since there is no single definition or perspective on how to sustain programmes, it may be more useful to consider possible elements that contribute to the sustained delivery of programme benefits and impact in the target populations. SEATS (SEATS, 2000) have developed a list of elements of sustainability for reproductive-health services that were integrated into early programme planning. These cover elements relating to the external environment, institutional capacity and operations, and financial viability, and include:

- Contextual considerations
- Donor objectives and policies
- Host government policies and priorities
- The competitive environment
- Economic conditions and determinants of demand for services.

These elements are relevant to youth programming at any phase. However, even when a programme has demonstrated its effectiveness, and has had some success in being institutionalized, without political and financial support its sustainability will be called into question. Furthermore, changes in the external environment, policies, and programmes may undermine efforts at sustainability.

Institutional components include:

- Procurement and management system
- Quality of care/quality improvement
- Effectiveness of annual planning and evaluation cycle
- Marketing capabilities
- Diversification of services and service integration
- Strategic planning capabilities
- Human resources/training capabilities
- Level of community involvement
- "Leveraging" and coordination with other institutions and programmes
- Degree of internal policy commitment.

The majority of these elements have been discussed above when considering the implementation of programmes. When institutional capacity is strengthened, programmes will more likely continue to function and be operational after the initial start-up period, assuming they receive continued support. At the same time, programmes that demonstrate that they function well are more likely to be able to leverage further support.

The sustainability of human-resource capacity presents another challenge for youth programmes. Professional health workers, teachers and NGO workers trained to provide "youth-friendly services" and sexuality education are often transferred out of their posts or move onto other assignments. Young people who participate in peer or other programmes have high turnover rates. However, in a few settings (for example in Zambia) peer educators have demonstrated an ability to generate income to support their own activities, facilitated by supervisors who were willing to let them take the initiative (Newton, 2000). It is clear that the elements listed above must work in tandem in order to increase the likelihood that programme activities continue or evolve to meet the needs of young people.

Financial elements include:

- Financial plan
- Presence of functioning user-fee system
- Revenue-generation sources other than fee-for-service/user fees
- Financial planning, allocation, budgeting and management capabilities
- Cost structure, use of analysis, containment and efficiency measures.

One of the key components of financial sustainability is the ability of a programme or service to generate revenue (in addition to effectively managing existing resources). ASRH programmes face particular challenges in this area given that many young people are limited in their ability to pay for services (Newton, 2000) and (because of their age) do not represent a political constituency that can easily influence policies and resource priorities. These constraints, once again, highlight the need for family, community and other stakeholder support in advocating for youth programmes and in calling for continued investment in sectors where youth are beneficiaries.

The elements described in the SEATS framework above refer mainly to the "supply" side of public and private organizations delivering programmes. An alternative approach to sustainability focuses on the organization as a "social enterprise" that combines elements of a mission to contribute to some common good, with programmes that operate based on business practices (Sclafani, undated). In this case, organizations are driven by entrepreneurship based on perceived market, or client demands that are then matched with its own capabilities. Many of the programme innovations generated by youth programmes follow this model; however, there is limited evidence as to how they are sustained or evolve in a changing environment.

Key questions in sustaining youth programmes[11]

Is the project leadership committed to achieving sustainability?

Do managers think strategically about sustainability?

Is there an accounting and management system in place to support operations?

Is there a programme-management system in place to support operations?

Is there a plan to assess client needs and satisfaction?

Are personnel-management systems in place?

Do managers promote community involvement and participation?

Is reliance on donor support decreasing over time?

Is there a diversification of donor base?

Are less-restrictive donor funds sought?

Are other sources of income increasing proportionately to donor funds?

Are other sources of funds able to increasingly cover operations costs?

Are opportunities to leverage funds and support being pursued?

Are operations run efficiently?

11 Drawn from worksheets in SEATS (2000).

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Annex I
Research Tools and Programme Resources

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