Improving Health
Improving Lives

The End of Programme Report of the
African Youth Alliance

2007

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Acknowledgments

The African Youth Alliance — a partnership of the United Nations Population Fund, PATH, and Pathfinder International — was a five-year programme funded by The Bill and Melinda Gates Foundation. AYA aimed to improve HIV/AIDS prevention and sexual and reproductive health among young people ages 10-24 — with emphasis on 10-19 year olds — in Botswana, Ghana, Tanzania and Uganda.

This report is a compilation of the AYA End of Programme country reports written by Judith Senderowitz, an independent consultant with nearly 40 years' experience in population and family planning, women's health and international development. She serves as an advisor on adolescent sexual and reproductive health programming for various organizations, and has written extensively on this subject.

Ugochi Daniels, Deputy Programme Manager, conceptualized AYA's End of Programme reports, provided technical guidance and contributed to the content based on her in-depth knowledge and experience with AYA.

Irit Houvras, an independent consultant with substantial experience in adolescent sexual and reproductive health, contributed to the final versions of the AYA End of Programme reports.

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Acronyms

ASRH	Adolecent Sexual & Reproductive Health
CBO	Community-Based Organization
FBO	Faith-Based Organization
IP	Implementing Partner
JSI	John Snow, Inc.
LPS	Life Planning Skills
MIS	Management Information Systems
MOE	Ministry of Education
MOH	Ministry Of Health
NGO	Non-Governmental Organization
OCA	Organizational Capacity Assessment
PI	Pathfinder International
PLA	Participatory Learning and Action
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TOT	Training of Trainers
UNFPA	United Nations Population Fund

OVERVIEW

The African Youth Alliance — a partnership of the United Nations Population Fund, PATH, and Pathfinder International — sought to improve adolescent sexual and reproductive health, including the prevention of HIV/AIDS, among young people ages 10-24. The AYA programme was implemented in four countries — Botswana, Ghana, Tanzania and Uganda — in partnership with their governments, non-governmental organizations, community-based organizations, and key stakeholders including youth, parents, religious leaders, the media and policy makers.

To accomplish AYA's goal, six programme components were developed using evidence-based strategies —

Policy and Advocacy

Responsible Technical Partner: UNFPA

Foster a supportive environment for adolescent sexual and reproductive health

Behaviour Change Communication

Responsible Technical Partner: PATH

Improve knowledge, skills and attitudes to adopt safer sexual practices

Youth Friendly Services

Responsible Technical Partner: Pathfinder

Increase the use of quality, youth-friendly reproductive health services

Livelihood Programmes

Responsible Technical Partner: PATH

Integrate ASRH into existing livelihood programmes

Institutional Capacity Building

Responsible Technical Partner: Pathfinder

Strengthen ability of organizations to sustain ASRH programmes and results

OVERVIEW

Coordination and Dissemination

Responsible Technical Partner: UNFPA

Improve coordination and dissemination mechanisms to strengthen ASRH partnerships

AYA also mainstreamed "crosscutting" objectives in each component[1] —

Partnerships

Establish internal and external partnerships for effective and integrated programme design and implementation

Youth Participation

Maintain active participation of youth in programme design and implementation

Gender

Design all AYA activities to reflect and address issues of gender equity and rights

Community Involvement

Increase involvement of communities to define response to ASRH issues and encourage ownership of interventions

Sustainability

Improve sustainability of ASRH programmes

Scaling Up

Increase number of youth reached in a broader geographic area by institutionalizing effective programmes

In each AYA country, programme components and crosscutting objectives were adapted to meet the specific needs and context. AYA developed a results framework that guided programme planning, implementation, monitoring and evaluation. Using various country-specific approaches, youth were involved and played a significant role in all stages of the AYA programme.

The AYA model was designed as a comprehensive range of integrated interventions, implemented concurrently and at scale using a multi-sectoral approach. Funded for five years with US$56.7 million from the Bill and Melinda Gates Foundation as "venture capital", AYA offered an unprecedented innovation to build the capacity required for governments and other development agencies to sustain and scale up SRH and HIV prevention interventions for young people. AYA created a legacy of both behaviour change in the young people reached directly by the programme, and development of the enabling and sustainable programme environment that continues to support ASRH programming in the four AYA countries.

1 During the design phase, five crosscutting objectives were identified. The sixth, Community Involvement, was added during programme implementation given its emphasis in all aspects of programming and its contribution to programme objectives.

AYA RESULTS FRAMEWORK

Policy & Advocacy
Developed an enabling and supportive environment for ASRH.

Behaviour Change Communication
Improved knowledge, skills, norms and positive attitudes regarding adoption of safer sexual practices.

Youth Friendly Services
Increased use of quality, youth-friendly adolescent sexual and reproductive health services.

Livelihood Programmes
Integrated ASRH into livelihood programs.

Institutional Capacity Building
Strengthened organizational capacity to sustain ASRH outcomes.

Coordination & Dissemination
Established and strengthened mechanisms for improved ASRH partnerships.

Partnerships
Established internal and external partnerships for effective and integrated programme design and implementation.

Youth Participation
Ensured active participation of youth in programme design and implementation.

Gender
Designed programmes to reflect and address issues of gender equity and sexuality, including ASRH rights.

Community Involvement
Increased involvement of communities in defining responses to ASRH issues and supporting interventions.

Sustainability
Enhanced and strengthened sustainability of ASRH programs.

Scaling Up
Increased number of youth reached in a broader geographic area by institutionalizing effective programmes.

Visit **www.ayaonline.org** for frameworks on each programme objective.

ASRH in the AYA Countries

In each AYA country, young people represent approximately one-third of the population — a segment of the population whose overall status of sexual and reproductive health indicates a need for ASRH programmes. National level data, as shown in Table One, reveal that young people are sexually active; and the percentage of the population ages 15-24 with HIV/AIDS in these countries is high, most significantly in Botswana (26.8%). AYA baseline findings similarly indicated the need to address ASRH issues. Young people generally had low levels of knowledge, high perceptions of ability, and low perceptions of risk, as reflected in the summary of responses from AYA baseline data seen in Table Two.

Table One

Demographic Data for AYA Countries	Botswana	Ghana	Tanzania	Uganda
Population mid-2006[2]	1,800,000	22,600,000	37,900,000	27,700,000
Population of youth ages 10-24, 2006[3]	37%	33%	34%	34%
Enrolled in secondary school latest year 2000/2004, female/male[3]	75/70%	38/47%	5/6%	18/22%
Ever married ages 15-19, female/male[3]	5/2%	14/1%	24/2%	32/7%
Women giving birth by age 18[3]	—[4]	15%	26%	42%
Unmarried teens ages 15-19 who have had sex, female/male[3]	—/—	31/19%	37/56%	32/34%
Single, sexually active women using modern contraception, ages 15-19/ages 20-24[3]	—/—	36/30%[5]	19/46%	48/50%[5]
Married women using modern contraception ages 15-19/ages 20-24[3]	—/—	7/17%	7/19%	12/19%
Women ages 15-24 with comprehensive knowledge of HIV/AIDS (2000-2003)[3]	40%	38%	44%	28%
HIV/AIDS among adult population, ages 15-49, 2003[2]	24%	2.3%	6.6%	6.8%
Population ages 15-24 with HIV/AIDS, 2001[6]	26.8%	2.2%	5.8%	3.3%
Population ages 15-24 with HIV/AIDS, 2005, female/male[7]	15.3/5.7%	1.3/0.2%	3.8/2.8%	5.0/2.3%
Young people ages 15-24 with comprehensive HIV and AIDS knowledge (2001-2005), female/male[8]	40/33%	38/44%	44/49%	—/—
Young people ages 15-24 reporting the use of a condom the last time they had sex with a non-regular partner (2001-2005), female/male[8]	75/88%	33/52%	42/47%	53/55%

In response to the SRH status and needs of young people, governments of all four AYA countries positively addressed ASRH issues in national policies, including specific youth policies or strategies, as well as issue-specific policies such as those addressing HIV/AIDS.

Rolling out the AYA Model

In order to prepare for rolling out the AYA model at the country level, initial emphasis was placed on strengthening the AYA partnership and defining the modalities by which the partnership would function effectively. Forming an effective partnership initially proved to be a challenging and time consuming process. At the level of the Partners Council[9], whose role was to address strategic programmatic issues, it became clear that operational and management issues required definition and negotiation. The CEO Group[10] was instrumental in reaching consensus on how best to move the partnership forward.

OVERVIEW

A key focus of AYA's strategic planning activities was development of an overall programme that ensured—

- state of the art adolescent reproductive health service delivery
- the ability to document effectiveness in changing behavioural outcomes
- increased consensus in the ASRH field about effective solutions
- a model for increased effectiveness of programmes and enhanced donor commitment

Table Two

Summary Findings from AYA Baseline Data

All numbers express percentages of males (m) and females (f) ages 15-19	Botswana		Ghana		Tanzania		Uganda	
	M	F	M	F	M	F	M	F
Young people responding "yes" to "ever had sex"	33.1	19.1	31.4	26.1	33.1	19.1	50.1	41.6
Young people responding "yes" to "ever been coerced to have sex"	4.5	6.8	29.9	47.5	N/A	6.8	1.5	4.2
Young peple responding "yes" to "perceived risk of catching HIV"	19.7	17.8	43.9	47.0	19.7	17.3	30.1	30.7
Young people responding "definitely yes" to "confidence or ability to insist on condom use"	56.7	54.8	70.8	68.5	61.2	54.8	50.6	46.2
Young people responding "definitely yes" to "confidence or ability to refuse sex if partner will not use condom"	54.1	56.8	66.5	71.3	58.9	56.8	47.4	44.1
Young people responding "definitely yes" to "confidence or ability to avoid sex when not interested or in need"	67.9	71.9	N/A	N/A	72.5	71.9	64.5	60.0

AYA conducted a state of the art review of programming evidence and identified best practices and appropriate strategies for each AYA programme component. Strategy papers then guided the development of programme component objectives and key strategies, which in turn guided the development of a comprehensive Monitoring and Evaluation Plan.[11]

Each AYA country was selected to participate in the programme based on existing positive ASRH policies and commitment to expand programmes to improve ASRH status. Officially launched in April 2000, AYA signed Memoranda of Understanding with each government, establishing the basic partnership and principles. The AYA programme-wide model was then contextualized: a country-level operating structure was created, partnerships formed, staff recruited, offices established, and operational guidelines developed.

Selection of districts and implementing partners (IP) to carry out AYA activities was accomplished through a highly consultative process with the government, other key stakeholders, and advisors based on agreed criteria. For identification of districts, each country used relevant ASRH indicators and factors that would affect programme implementation: balancing need, strategic importance, and the opportunity to make an impact. Implementing partners represented government, media, religious institutions, NGOs and CBOs, with selection based on criteria reflecting experience and commitment, refined by the needs of each AYA lead technical partner to conduct component activities. In working with IPs, AYA placed significant emphasis on coordination, integration, coverage and sustainability.

2 PRB DataFinder: PRB 2006 World Population Data Sheet

3 PRB The World's Youth 2006 Data Sheet

4 Data are unavailable or inapplicable

5 Fewer than 100 cases; may not be representative

6 PRB DataFinder: UNFPA Population and Reproductive Health Country Profiles, 2003

7 UNAIDS 2006 Report on the Global AIDS Epidemic, Annex 2: HIV and AIDS Estimates and Data, 2005 and 2003

8 UNAIDS 2006 Report on the Global AIDS Epidemic, Annex 3: Country Progress Indicators. Data sources: DHS (2001-2005), AIDS Indicator Survey and AIDS Impact Survey

9 With representation of each international AYA partner, the Partner's Council managed the AYA programme, addressing both programmatic and organizational management issues. In order to maximise technical resources and manage workloads effectively, the Partners' Council formed sub-committees, including Budget, Communication, and Operations Committees.

10 The CEO Group included the three chief executives of the international partnership (PATH, Pathfinder, UNFPA) and acted as the Board of Directors for AYA, providing strategic leadership, personnel management and conflict resolution.

11 The AYA Monitoring and Evaluation plan is available online at www.ayaonline.org.

AYA Programme Coverage 2002-2005[12]					
Policy And Advocacy	**Botswana**	**Ghana**	**Tanzania**	**Uganda**	**Total**
Media campaign contacts	—	7,000,000	16,558,400	12,000,000	**35,558,400**
Young people, community members and stakeholders reached through advocacy activities (networking, workshops, campaigns, student essay competitions and debates)	111,535	163,071	8309	46,853	**329,768**
Advocacy materials distributed (reports on review of ASRH laws, policies and practices; advocacy strategy; newsletters; brochures; booklets; fact sheets; flyers; posters; etc.)	78,765	51,958	363,000	58,000	**551,723**
Condoms distributed during advocacy campaigns	260,251	—	—	—	**260,251**
Policies created, changed and/or harmonized	Yes, by religious council	Yes, by government	Yes, by government	Yes, by kingdoms & religious groups	
Behaviour Change Communication	**Botswana**	**Ghana**	**Tanzania**	**Uganda**	**Total**
Young people reached in-school with LPS	24,147	39,668	114,111	112,828	**290,754**
Young people reached out-of-school with LPS	—	31,150	23,803	35,101	**90,054**
Young people reached by peer educators (individually and through group activities)	14,412	61,641	103,541	Data not available	**179,594**
Young people reached through enter-educate activities (debates, jam sessions, drama, festivals, sport events)	64,346	142,012	149,558	210,518	**566,434**
BCC materials distributed (LPS manuals, LPS workbooks, brochures, posters, pull-outs	128,000	250,000	500,000	272,248	**1,150,248**
Teachers trained in LPS (does not include supervisors, education officers, trainers)	279	202	357	475	**1313**
Peer educators trained in LPS	2007	80	2612	730	**5429**
LPS curriculum institutionalized by government	Yes, in all secondary schools	Yes	Yes, in all vocational institutions in Zanzibar	No	
Youth Friendly Services	**Botswana**	**Ghana**	**Tanzania**	**Uganda**	**Total**
Facilities established as youth friendly	20	65	58	76	**219**
Visits by young people to YFS facilities	24,325	281,296	216,719	209,571	**731,911**
Outreach visits with young people (by peer educators, peer service providers, nontraditional condom distributors)	10,629	1,150,915	96,547	588,078	**1,846,169**
Condoms distributed (male and female, through clinic and outreach)	41,881	1,954,194	1,108,764	1,574,510	**4,679,349**
Visits by young people to VCT (clinic and outreach)	329	2775	92,910	14,921	**110,935**
Trainers, service providers, and supervisors trained in ASRH and YFS	224	871	649	285	**2,029**
Peer providers trained in ASRH/YFS	25	497	529	647	**1,698**
ASRH/YFS curriculum institutionalized in MOH in-service training (*AYA/PI curriculum)	*Yes	N/A[13]	*Yes	Yes	
ASRH/YFS integrated into pre-service training (*institutionalized)	Yes, by Institute of Health Sciences, University of Botswana	*Yes, by NMCG[A] (course and licensure exam for all nurses and midwives)	Yes, by College of Health Sciences, Zanzibar	*Yes, by Makerere Medical School	
Integrating ASRH into Livelihood Programmes	**Botswana**	**Ghana**	**Tanzania**	**Uganda**	**TOTAL**
Vocational institution instructors trained in LPS	79	60	73	34	**246**
Institutional Capacity Building	**Botswana**	**Ghana**	**Tanzania**	**Uganda**	**TOTAL**
IPs that received general technical assistance	10	12	24	24	**70**
IPs that also received intensive technical assistance	0	0	7	6	**13**
Coordination and Dissemination	**Botswana**	**Ghana**	**Tanzania**	**Uganda**	**TOTAL**
Proportion of AYA districts where IP work plans were shared, and districts integrated ASRH into plan/budgets	7/8	20/20	10/10	6/13	**43/51**

Please see end of programme reports for full reference citations at **www.ayaonline.org**

OVERVIEW

Programme-wide, district entry was a highly participatory process, designed to inform and involve the private and public sectors, and foster linkages for partnership activities. Engagement with the community was further enhanced by participatory learning and action (PLA) activities, which took place in each country in 2002. The PLA activities, complementing baseline data, led to increased understanding of ASRH issues by the community, improved communication between adults and young people, and an informed commitment to designing programme interventions responsive to young people's needs.

AYA prioritized monitoring of the progress of programme implementation and assessment of programme effects. To roll out the AYA model in each country, baseline and PLA were vital start-up activities.

In 2003, at mid-term, two assessments were conducted —

- a programme review funded by AYA and conducted by the Institute for Health Sector Development to assess progress and potential for successfully achieving programme outcomes and impact

- a management and finance assessment funded by The Bill and Melinda Gates Foundation and conducted by KPMG, LLP.

Both assessments concluded that AYA had developed a strong foundation and the programme was well positioned for achieving its objectives. AYA's efforts to build capacity and establish partnerships received special recognition. Recommendations from the assessments informed continued programming.

12 Time periods for activity implementation vary and in some cases are as short as 1.5 years; in addition, not all programme sites (e.g. schools, clinics, group events) reported consistently or completely. Results should be viewed for a general sense of scope rather than as specific numerical achievements under standardized conditions.

13 The government of Ghana had already developed and adopted an in-service training curriculum on adolescent health prior to AYA.

A Nurses & Midwives' Council of Ghana

SUMMARY OF AYA RESULTS

Guided by the Monitoring and Evaluation Plan, programme objective indicators, and intermediate results, five of the six AYA components were evaluated in 2005-06.[14] Crosscutting objectives were also assessed. In 2006, The Bill and Melinda Gates Foundation funded an independent impact evaluation, conducted by John Snow, Inc (JSI), the preliminary results of which are reported in the following pages.[15]

AYA's Impact on Behaviour

JSI was engaged to determine whether exposure to AYA programmes resulted in improved ASRH behavioural outcomes among youth ages 17-22 in areas where AYA worked in Ghana, Tanzania, and Uganda.[16] The essential research question:

Among sexually active 17-to-22-year-olds, are those who report exposure to AYA more likely than those not exposed to AYA to —

- use condoms?
- have fewer sexual partners?
- use modern contraceptives?
- abstain from sex or delay first intercourse?[17]

The evaluation was post-test only, and combined case-control and self-reported exposure design. Data was collected from early March through the beginning of June 2006 by local research organizations, using a one-stage (Tanzania) or two-stage (Ghana, Uganda) cluster sampling: cases and controls (purposive), random selection of segments, and random selection (or census) of households within segments. Household, individual and community questionnaires were applied. Case-control design data was analyzed using Propensity Score Matching, and the Self-Reported Exposure design data was analyzed using PSM and Instrumental Variable (two-stage regression).

- Indicates strong significant impact of AYA in the expected direction
- Indicates significant impact of AYA in the expected direction
- Indicates strong significant impact in the opposite direction
- No significant impact

Sexual Behaviour	Females			Males		
	Ghana	Tanzania	Uganda	Ghana	Tanzania	Uganda
Delay of sexual onset						
Abstains from sex[18]						
Fewer than two sex partners during past 12 months						
Condom use at first sex						
Condom use at last sex						
Ever used condom with current partner						
Always use condom with current partner						
Modern contraceptive used at first sex						
Modern contraceptive used at last sex						

SUMMARY OF AYA RESULTS

Preliminary results of the impact evaluation indicate evidence of a significant positive AYA effect on sexual knowledge, attitudes, and behaviours. Across the AYA countries evaluated, more effects were reported for females; among sexually active females, AYA achieved a significant positive effect on condom used at first sex, consistent condom use with current partner, and modern contraceptive use at first and most recent sex.

These preliminary results further substantiate component evaluation results, and JSI concluded that the research suggests a comprehensive, multi-component approach such as AYA's can be effective in improving some key ASRH variables.

Component Results

Policy and Advocacy (P&A)

AYA's P&A component was designed to improve the legal and policy environment by assuring implementation of supportive ASRH policies in order to successfully carry out AYA interventions. The longer-term objective: to create a sustainable, enabling environment for ongoing work in ASRH. In each country, AYA and its partners developed a National Advocacy Strategy and strengthened existing coalitions and networks. Where necessary, AYA created new advocacy structures to conduct community advocacy and mobilization campaigns.

> *An evaluation of the P&A component showed that significant progress was made, including — improved knowledge and supportive attitudes of young people and stakeholders, increased commitments and actions supportive of ASRH by stakeholders, increased resource allocation for ASRH.*

Botswana — Leaders of 36 religious denominations all agreed to develop and implement ASRH policy guidelines. In 2005, the Government of Botswana provided $700,000 to support sustained youth HIV prevention information and services in 10 districts. And in two districts, Ghanzi and Maun, the District Multi-Sectoral AIDS Committees generated the equivalent of $400,000 and $500,000 respectively, as a result of AYA support on proposal development and resource mobilization.

Ghana — Through advocacy training, community-based paralegals publicized and implemented gender-related ASRH policy, while young people stimulated media debate on various ASRH policy issues, raising commitment among policymakers through radio, as well as direct lobbying and negotiations with ministers of state. AYA advocacy activities in Ghana led to the revision and adoption of the national HIV and AIDS policy, and contributed to the review and revision of the School Health Policy and Action Plan.

Tanzania —AYA advocacy activities led to changes in key laws and policies, increased allocation of resources; and at the national and the district level, the government began to include ASRH in plans and budgets.

Uganda — As a result of advocacy through the P&A and YFS components, ASRH activities were incorporated into district health, education and community budgets in seven of 13 districts. Toro and Busoga Kingdoms secured grants for HIV/AIDS activities ($39,000 and $12,000 respectively), while the Inter-Religious Council mobilized over $2 million, including a $700,000 grant from the

14 The Integration of ASRH into Livelihood Programmes component was not evaluated.

15 Basic information on the component evaluation methodology is provided, however details and limitations can be found in the respective evaluation report documents.

16 The impact evaluation was not conducted in Botswana due to financial constraints.

17 See the full JSI reports for additional information on the design, methodology and results: JSI Research & Training Institute. Arlington VA, 2007. *Results of an Evaluation of the African Youth Alliance program in Ghana: Impact on Youth People's Sexual and Reproductive Health; Results of an Evaluation of the African Youth Alliance program in Tanzania: Impact on Youth People's Sexual and Reproductive Health; Results of an Evaluation of the African Youth Alliance program in Uganda: Impact on Youth People's Sexual and Reproductive Health.*

18 The group studied for the impact evaluation, young people ages 17-22, were not targeted by AYA for abstinence messages or delay of sexual debut.

US Agency for International Development, the President's Emergency Plan for AIDS Relief, and resources from the Global Fund for HIV/AIDS interventions among young people. The Dioceses of the Church of Uganda raised $38,000 to continue ASRH advocacy programmes.

Behaviour Change Communication (BCC)

AYA's BCC strategy aimed to enable and sustain healthy behaviour adoption by building the necessary skills of young people. The implementation of Life Planning Skills (LPS) training with both in- and out-of-school young people was a cornerstone of the component, supported by numerous other activities including enter-educate activities such as drama, debates, and interaction at festivals, sports events; peer education; youth clubs; and parent-child communication sessions with parents.

> *Evaluations and process data from this component demonstrated improvements in ASRH knowledge, perceptions, attitudes and behaviours among students who received LPS training.*

Botswana — Results of an evaluation conducted for the in-school LPS intervention included increased knowledge about HIV transmission, increased risk reduction behaviours among those who perceived themselves at risk (eg, getting an HIV test, reducing partners, condom use and abstinence), increased intention to use condoms, and increased use of condoms. In 2004, the Ministry of Education adopted the AYA LPS manual for nationwide use in secondary schools.

Ghana — An evaluation of the in-school LPS intervention showed a large increase in the percentage of students confident they could refuse undesired sex and negotiate condom use, a positive change in students' intentions to use condoms, and increased awareness of HIV transmission risks. AYA contributed to the sustainability and scaling up of LPS in Ghana by facilitating government institutionalization of the LPS curriculum.

Tanzania — Pre- and post-test scores (monitoring data) showed that young people's ASRH knowledge increased an average of 20% after receiving LPS training education. Debates and discussions in the community and the media led to an increased openness on ASRH topics.

Uganda — A post-intervention assessment in schools with extracurricular ASRH activities showed an increase in the percentage of participants who could articulate their personal values, talk to a parent, obtain youth-friendly clinical services, and resist pressure to have sex. AYA was also able to introduce a sensitive cultural topic – female genital cutting – into LPS sessions, resulting in the rejection of FGC by trained participants.

Youth Friendly Services (YFS)

AYA designed a strategy to make SRH services youth-friendly and available to young people — and set the stage for scaling up — working with public health facilities, NGOs and faith-based organizations to improve the quality of services for young people in both static clinic facilities[19] and outreach. In each country, innovative approaches were undertaken: working with both faith-based health providers and nontraditional condom distributors in Ghana; working with public health facilities in Tanzania; outreach with commercial sex workers and other marginalized youth conducted by former peers in Uganda.

19 Facility assessments — which included evaluation of 25 elements of the clinic, personnel, policies, offerings — were conducted through review of clinic records; observation; interviews with managers, staff and clients; and review of polices and procedures.

Component evaluations, including facility reassessments on a representative sample, determined that the availability of YFS broadened, the quality of and client satisfaction with YFS improved, and utilization of YFS increased. In all AYA countries, ASRH/YFS was integrated into pre-service training for medical professionals.

Botswana — Twelve of the 18 clinics sampled for reassessment improved, with a majority of the YFS elements strengthened across all facilities, including assured privacy, respect for youth, emphasis on dual protection/condoms, and provision of a comfortable setting. AYA saw an upward trend in numbers of young people visiting public sector facilities from 2003 to 2004; not surprisingly, more females than males visited the clinics, and particularly those between 20 and 24 years of age. The *AYA Botswana ASRH Training Manual for Service Providers* was adapted by the Ministry of Health and adopted as the official national curriculum for in-service training.

Ghana — Four of the five clinics sampled for reassessment improved, with increases in visits for services. Clients reached at facilities and in the community expressed high satisfaction with service quality. In an important action to foster sustainability and scaling up, a two-credit course on ASRH was incorporated into the pre-service training curriculum as well as the licensure examination for nurses and midwives.

Tanzania — All 16 of the clinics sampled for reassessment showed improvements, with the greatest successes in availability of separate space for youth services, emphasis on dual protection, young adolescents served, competence of staff, and privacy. Outreach data showed that nearly as many males as females were reached, making the outreach approach an effective way to reach male clients. Ninety-one percent of young people were satisfied with the peer providers, liking their friendliness, emphasis on HIV testing, and instruction on how to protect against HIV/AIDS and use a condom. AYA's ASRH/YFS curriculum was institutionalized for in-service training.

Uganda — All five of the clinics sampled for reassessment saw overall improvements in quality from baseline to endline in each of the five elements, with "peer provider/counselors available," "privacy ensured," and "publicity for YFS" showing the greatest increases. The evaluation of outreach activities showed that peer providers performed well and responsively. Seven of 13 AYA districts were funded to continue AYA activities to increase use and availability of YFS. With AYA assistance, an ASRH/YFS curriculum was institutionalized for in-service training.

Integrating ASRH into Livelihood Programmes

AYA's livelihood interventions strategy called for the integration of ASRH activities into existing livelihood programmes for young people, and advocated for increased recognition and funding for livelihood programming. AYA carried out an effective set of activities, selecting vocational education as the existing structure with the greatest reach and most potential to institutionalize such integration due to the large attendance of young people at vocational education centres — centres which had not traditionally received support for ASRH programming.

In each country, AYA worked with public and/or private vocational institutions to train instructors in LPS and integrate ASRH into their curriculum. LPS was institutionalized in Zanzibar, Tanzania, where the Zanzibar Vocational Education Policy incorporated language stating that all vocational institutions, public and private, must include LPS training, guidance and counselling in their programmes.

Institutional Capacity Building (ICB)

Seeking to ensure overall sustainability, AYA provided technical or material assistance to strengthen one or more elements of organizational effectiveness: governance, management, financial resources, service delivery, external relations, and sustainability. AYA IPs were provided intensive technical assistance or general training, with training covering such topics as financial management, management information systems, data management and analysis, report writing, proposal development, resource mobilization, strategic management and youth leadership.

Evaluated to assess the extent to which the interventions achieved their objectives of increased capacity and sustainability, ICB improvements were noted by IPs in each country, particularly in MIS. Several IPs secured funding to sustain ASRH programming post-AYA, including the notable example of UYANET, a coalition formed by AYA IPs in Uganda.

Coordination and Dissemination (C&D)

AYA designed a coordination approach to effectively integrate programme components both within AYA and within government and other important programmes, and assisted government structures to ultimately assume this coordination task. Other important activities included programme planning and evaluation, and dissemination of materials and findings. AYA prioritized coordination work among its own partners and at the district level.

An evaluation of the C&D component, conducted to assess the extent to which activities contributed to improved coordination and dissemination mechanisms to strengthen ASRH partnership, showed improvements were made in each country: IP work plans were shared, networking and collaboration among implementing partners and district coordination offices occurred at all levels through various channels, and youth participation increased.

Crosscutting Objectives

Partnerships

AYA established a number of key, influential internal and external partnerships with government, media, cultural institutions, religious groups, and youth-led organizations, which facilitated the implementation of AYA's programme, significantly increased its coverage, and ensured achievement of objectives including the sustainability of ASRH programming.

Botswana — Partnering with religious institutions to address ASRH, AYA supported the Botswana Christian Council, formed by three of the country's major religious denominations, improving the understanding of ASRH issues and assisting church leadership to educate and counsel congregants on sexual health and HIV issues. Religious leaders welcomed the broader discussion of ASRH as an entry point to discuss the more sensitive issue of HIV/AIDS. Leaders of 36 religious denominations developed guidelines, established action plans and endorsed ASRH programmes as a major strategy for addressing HIV/AIDS. The Council supported the need for ASRH policies and laws, and encouraged community and political support for ASRH services and resources.

Ghana — Religious health centres became committed and exemplary providers of YFS, demonstrated by the Christian Health Association of Ghana (CHAG). Consisting of many religious

denominations engaged in health services, CHAG provides 35-40% of Ghana's health care through its network of health facilities. In a partnership with AYA, CHAG's three-year Window of Hope project introduced the rationale for youth-friendly services and upgraded its technical ability to deliver these services. YFS were established in 10 CHAG facilities that were well-equipped, have highly motivated staff, and were well accepted and respected. One Presbyterian Hospital Youth Centre was designated a "centre of excellence," with all facilities in the region being asked by the Regional Health Directorate to replicate the lessons learned there.

Tanzania — AYA forged a close and meaningful partnership with the Government of Tanzania, enabling coordination of AYA implementation with on-going government reforms, providing the ability to operate within existing government structures to spearhead ownership and sustainability, and promoting public-private partnerships (a strategy in the government reforms programme). Early in 2001, AYA signed a Memorandum of Understanding with the government of Tanzania, creating a strong foundation for AYA at both national and district levels. During the mid-term programme assessment, a Tanzanian government representative said, "AYA has full government cooperation and commitment. AYA is part of government and government is part of AYA." This partnership during the life of the programme significantly facilitated implementation, but more importantly led to the AYA model being the basis for the National Adolescent Health and Development Strategy 2004-2008, ensuring sustainability of ASRH/HIV prevention programming for young people.

Uganda — Kingdoms are cultural institutions in Uganda that have significant influence over traditions and social norms, and on the formulation and implementation of laws and policies. AYA's partnerships with four Kingdoms, covering 50% of the Ugandan population, furthered HIV/AIDS prevention among young people. ASRH and HIV/AIDS prevention initiatives were institutionalized as critical concerns within the Kingdoms' development agendas, for which Toro and Busoga Kingdoms have secured funding. The Busoga Kingdom set up a bylaw prescribing 18 as the earliest age of marriage — a measure later adopted by all other Kingdoms, leading to harmonization with the national age of consent in Uganda. Some government departments and development partners are now channeling funds to Kingdoms for projects, including HIV/AIDS campaigns funded by the World Bank through the Uganda AIDS Commission. In addition, AYA's partnership with Christian and Muslim denominations in Uganda resulted in policy change related to age of marriage, contraceptive use and school continuation —

- ASRH issues were incorporated into religious groups' pronouncements and sermons, and into their organized educational activities for young people.
- The Anglican Church signed a declaration supporting ASRH and revised prenuptial counseling guidelines to include VCT.
- His Eminence the Mufti of Uganda announced that Muslim couples should use condoms in marriage to prevent HIV/AIDS and other STIs.
- Both Christian and Muslim institutions committed to enforcing the legal age of marriage (18), and young women are now required to produce birth certificates as proof of age.
- Christian religious institutions have incorporated ASRH into their seminary schools.

Youth Participation

Youth participated in all programme components — planning, implementing and evaluating programme activities — and secured representation on national, district and community level decision-making committees. Capacity building among youth resulted in youth-led organizations securing new funding and sustaining ASRH programming, and led youth to found new organizations and networks.

Botswana — At the district level, Botswana National Youth Council (BNYC) supported the AYA-established District ASRH Committees (DASRHs), comprised of the district officer, AYA IPs and other implementers and stakeholders. In the AYA districts, 75% of DASRH members were young people, and DASRH members influenced the District Multi-Sectoral AIDS Committees. As a result, ASRH was integrated into district AIDS plans and budgets, funding ASRH activities. Through BNYC, young people continue to be effectively engaged in policy dialogue at the National level on HIV/AIDS policy, the Youth Development Policy, and harmonization of ASRH laws.

Ghana — The Youth Empowerment and Participation Study examined the role of the Youth Empowerment Index (YEI) in measuring the progress in youth capacities and competencies related to behaviours, attitudes, skills and knowledge, and assessing the extent to which youth were meaningfully involved in AYA and the level of support they were provided. The YEI was used by youth involved with AYA IPs as a self-assessment tool in collaboration with their coaches. When reapplied after participation in AYA (one year later), the scores showed significant positive shifts in all capacity areas, with particular improvement in the areas of commitment, self-management and emotional maturity, teamwork, and analytical thinking. Modest improvements were made in knowledge, experience, skills training, and communication. The use of the YEI process was considered by youth to be motivational, helping them to set and work toward goals, and teaching them how to assess core and functional competencies and knowledge, skills and behaviours. The process enabled targeted planning for programme managers, identified capacity needs for trainers, and served to facilitate communication and consensus building between young people and their coaches. Youth reported that training programmes provided them with the ability to successfully advocate on ASRH issues, and specifically mentioned enhanced skill in —

- speaking confidently on ASRH issues with peers, parents, traditional leaders, and others
- successfully lobbying for support and mobilizing funds for ASRH programmes
- addressing press conferences
- developing advocacy plans

Founded in 1996 by a group of young people, Children and Youth in Broadcasting – Curious Minds (CYIB-CM) is a youth-led and youth-run media advocacy group. Before AYA, the group advocated for child rights, but had little or no knowledge of ASRH issues. Once members participated in AYA trainings on ASRH issues, advocacy and media broadcasting, the group began to advocate for SRH rights — they have since become a 'hub of youth ASRH experts'. Through involvement with AYA, the group gained access to policy makers, raised issues and demanded accountability for youth. They have played a key role in keeping youth issues and perspectives on the media agenda. CYIB-CM airs four live one-hour radio shows with national coverage, produced, presented and directed by young people. The programmes serve as an advocacy tool for

the rights of young people, with a minimum of five minutes per show dedicated to the discussion of SRH issues. Thanks to AYA, members are part of the Media Communication and Advocacy Network and have sustained a relationship with UNFPA.

Tanzania — In collaboration with the youth-based organizations including Youth for United Nations Association (YUNA) and the Tanzanian Youth Alliance (TAYOA), a youth involvement and participation framework for ASRH interventions was developed which became the basis for planning, implementing, and monitoring youth involvement activities by both AYA and the IPs. The programme, Youth Involvement and Participation (YIP), was designed to engage young people at the district level through the establishment of Youth Implementation Committees. YIP's focused on ASRH advocacy, with activities that included surveying and meeting with district stakeholders to mobilize support; sensitizing young people about positive policies and laws; training young people in each AYA site to spearhead advocacy activities; promoting positive behaviours; providing information about, and referral for, services; and mobilizing Mock Youth Parliaments to foster awareness and action on ASRH policy initiatives. In addition, the AYA Tanzania office engaged three young interns to advise on the main programme activity areas. Beyond the tangible achievements of increasing youth involvement and community participation, youth participation demonstrated to a broad array of leaders and the public that young people are capable of identifying their needs and acting effectively on behalf of them. Because of the work of YUNA, TAYOA and other youth activities, youth participation became an accepted and critical element of ASRH programming in Tanzania, which has led to the inclusion of youth representatives on Ward Development Committees.

Uganda — The youth-based organization Ma-PLAY (Making Positive Living Attractive to Youth) focused on improving ASRH behaviours by promoting and organizing young people to become role models for successful lives – and still have fun. While Ma-PLAY was youth-led, a major strategy was to engage adult stakeholders (parents, teachers and others) — a youth-adult partnership that implemented after-school youth clubs to help students develop a group culture supporting positive behaviours. Young people also became involved in enter-education activities, using drama, talk shows and other entertaining formats to reach a wider audience. In addition to significant changes in participating students' attitudes, behaviours and intentions, the project influenced adults' commitment to ASRH issues in school and beyond, positively affecting the community environment. The project also achieved expansion and sustainability: the activity grew from five to 11 districts, and obtained a diversified funding base. Ma-PLAY demonstrated that a youth-led and staffed organization can effectively carry out behaviour change interventions.

Gender

Gender issues were incorporated into every aspect of AYA's work: gender equity was addressed in programme opportunities and leadership, and a focus on gender awareness and gender rights was stressed in educational and behaviour change messages. Advocacy for gender-related issues resulted in national policy changes across AYA.

Botswana — AYA's IP Women Against Rape was specifically supported to focus on gender-based violence in its own activities, and to help other IPs address gender issues, including advocacy for gender equity and equality. Working in schools and communities, where they formed clubs to focus on gender-based violence, Women Against Rape addressed the policy environment and helped to mitigate the effects of sexual violence by giving support to survivors of sexual abuse. AYA also specifically targeted young men, as in BOFWA's Male-Only Hour — tailored to enhance young men's comfort in the clinic setting. While acknowledging the difficulty in changing

the perception that services are only for females, the initiative recognized that programmes can make a difference by reaching males in schools and recreational settings, offering effective incentives, and collaborating with other programmes that involve males.

Ghana — Working with AYA, the International Federation of Women Lawyers developed a creative project to train community people as paralegals in order to increase understanding, awareness and support for ASRH policy, laws and rights, with priority placed on gender issues and rights. Traditional and religious leaders, teachers, health providers, district assembly members, parents and young people were trained on ASRH content and in such skill areas as communication, counseling, mediation, legal ethics, arbitration, advocacy and management. Paralegals sensitizes their communities on gender issues and provided legal aid to victims of domestic violence, rape and abuse. In addition, the paralegals resolved cases related to adolescents and their parents, and made referrals to other services when necessary. Leaders were enabled to identify the cases more appropriate for out-of-court settlement, and those which needed to be referred to the authorities, such as incest and sexual assault. Many cases were resolved by counseling and arbitration, placing protection of adolescent rights in the hands of an informed community. Paralegals also made recommendations to the District Assembly to take on specific issues, and associations of paralegals, comprising over 850 members, were established in all 20 AYA districts. Given that village elders and religious leaders were included as entry points, paralegals successfully encouraged change while respecting cultural values.

Tanzania — Gender-related policies, such as age of marriage and sexual abuse, were emphasized in AYA's Policy and Advocacy programming, fostering public discussion and awareness. Specific issue and policy campaigns highlighted gender issues, such as the successful effort to change the Spinsters, Widows and Divorcees Protection Act in Zanzibar to remove the mandatory imprisonment of unmarried pregnant girls and women. Another success was the issuance of a standing order to allow girls under 18 years old to continue their education after childbirth, reversing the practice of expelling these girls from school. Gender was also mainstreamed in all programme components and AYA IPs implemented activities focused on promoting gender equity. AYA IP CHAWAKUA, for example, established sports teams for girls, while also working with boys' teams and fostering parental support for this gender-equity approach.

Uganda — AYA emphasized gender issues through support to *Straight Talk* and *Young Talk*, strengthening the ASRH content of these publications designed to reach youth with age-appropriate information about adolescent development, relationships and sexuality, and the prevention of early pregnancy and HIV/STD infection. Key gender issues covered by the publications included gender roles, sexual harassment, domestic violence, statutory rape, forced/early marriage and male/female friendships. Working in policy environments, AYA also joined with faith-based and cultural groups to address such gender issues as preventing early marriage, and with the Family Planning Association of Uganda, ending the practice of female genital cutting.

Community Involvement

AYA identified and sensitized local stakeholders such as government, religious and traditional leaders, media, parents and youth — engaging them in defining the ASRH response and encouraging community involvement and ownership of interventions. Community involvement played a significant role in policy change, implementation and enforcement.

SUMMARY OF AYA RESULTS

Botswana — Ghetto Artists Productions (GAP) helped foster community awareness and positive community change. Founded, led, managed, and composed almost entirely of youth, GAP members are inspired by artistic interests and a desire to help their community, and use drama, dance and music — along with life skills education — to promote behavioural change. GAP's efforts have been widely acknowledged by awards and acclaim, and AYA was the first supporter to provide this group a multi-year grant, helping them to expand and improve their formats and reach, and strengthen their capacity and sustainability as an organization. In the process, GAP was able to have a positive effect beyond their primary youth audience, improving attitudes about ASRH issues and receiving enormous support and praise from government and traditional leaders, religious leaders and religious communities, school headmasters, teachers and parents — as well as donors and NGOs.

Ghana — Identifying young shopkeepers as good condom distributors, AYA developed a creative and successful activity for involving the community, and gaining its support for condom distribution to young people. The Planned Parenthood Association of Ghana, CHAG, and the National Youth Council collaborated to engage non-traditional condom distributors (NTCDs) — young barbers, tailors, artisans and shopkeepers — whose businesses are frequented by young people. Once trained, and after the community had been introduced to the programme, these business owners provided confidential SRH information and condoms in their shops, in a convenient and private environment. Results showed that NTCDs were effective in condom distribution, even more effective than traditional Peer Service Providers. Together, NTCDs and peer service providers contributed to creating more positive views in the community toward ASRH information and service provision. Young people reported that they valued the privacy afforded by these outlets, and the shopkeepers reported a positive impact on their businesses.

Tanzania — Through its media partnership programme, AYA reached millions and supported community-level policy dialogue, introducing and engaging the public —particularly policy makers and young people — on ASRH issues. Five media partners, representing a mix of government-owned and private stations, were selected: Africa Media Group, Television Zanzibar, Radio Tanzania Dar es Salaam, Sauti ya Tanzania Zanzibar, and Clouds FM; and a network of journalists who served both the print and electronic media was established. Following ASRH and advocacy training, key issues and messages were identified and implementation planned, focusing on talk shows and debates for TV programming, and for radio: youth variety shows, including mini-dramas, music, interviews and youth testimonials. Programmes were often recorded at AYA activity sites to sensitize the community and its leadership, and reinforce policy efforts by raising key issues for public discussion while policy debates were underway. The significant airing of identified issues resulted in increased awareness of ASRH, increased leadership support for ASRH issues, more openness in public discussions on sexuality and condoms, and increased youth participation in activities. The approach supported public engagement and dialogue on a number of current policy debates, and led to broad consultations on the National Youth Policy (2004); conception of the Zanzibar Youth Policy; amendment of the Zanzibar Spinsters, Widows, and Female Divorcee Protection Act; legal consultations on the 1971 Marriage Act, and popularization of the National Policy Guidelines on Reproductive and Child Health (2003).

Uganda — Uganda Youth Development Link (UYDEL) served as an AYA partner in Uganda with the mission of promoting ASRH among vulnerable and marginalized groups of adolescent street children and young commercial sex workers (CSWs) in five divisions of Kampala district. Given the challenge of reaching target audiences, UYDEL conducted consultative meetings with community

leaders, brothel owners and managers of commercial places where CSWs were found. The trained Peer Service Providers who work with these populations were selected from among those young people formerly part of these groups (street children and CSWs), providing a link between UYDEL and its clients. Peer Providers mobilized young people through health talks, behaviour change sessions, film shows and debates, and provided peer counselling, distributed non-prescription contraceptives and educational materials, made referrals to UYDEL drop-in centres, and generally served as role models. Some even offered their meager lodgings as outreach posts in order to be closer to the group being served. These activities positively influenced vulnerable young peoples' SRH knowledge, attitudes and behaviours: attitudes towards health centers improved, which led to increased access and use of VCT, treatment for STIs and other SRH services; HIV/AIDS awareness, condom use, and reduction of the number of sexual partners also improved. The approach of using Peer Service Providers to mobilize and sensitize young people for health services worked well, mainly because the providers enjoyed good relationships with their young clients and gained recognition in their communities as role models.

Sustainability

Actions to foster sustainability included incorporation of ASRH activities into district plans and budgets, strengthening institutional capacity, government adoption of curricula and improved data collection systems and tools.

Botswana — AYA's specific focus on strengthening district-level coordination resulted in seven of eight AYA districts integrating ASRH into district plans and sharing reports with DMSACs. In turn, five DMSACs integrated ASRH into annual and five year plans and budgets, with resource allocation for ASRH. Of these DMSACs, Ghanzi and Maun districts mobilized $400,000 and $500,000 respectively, as a result of AYA support with proposal development. Youth participation was instrumental to these successes.

Ghana — An effective role was designed for youth advocacy at the district level in Ghana in the form of Youth Mock Assemblies that emulated the democratic process at the district level. Young people linked with District Assembly members, holding their own sessions with these members, and with Parliamentarians and opinion leaders, to discuss crucial issues affecting youth and to pass on their conclusions and recommendations to the District Assembly. These groups were credited with identifying actions and solutions on current issues under consideration by the District Assemblies. A unique AYA activity, mock assemblies continue, and have been expanded to non-AYA districts.

Tanzania — The government of Tanzania's close collaboration with AYA helped to institutionalize ASRH activities, increasing the potential for sustainability, creating an enabling environment and facilitating involvement of district authorities. Government District Planning Officers were appointed as AYA District Coordinators and served to coordinate AYA IPs and other ASRH stakeholders in the community. Through capacity building and resource allocation, public-private partnerships were strengthened, and all 10 districts recorded strong commitment toward improving adolescent health and sustaining AYA activities —

- ASRH was identified as a standing agenda to be addressed at all Council levels
- A network of NGOs and CBOs was planned to provide ASRH and strengthen links with youth.

- The Arusha Municipality Council's adoption of AYA activities and incorporation into the 2005/06 budget.

- ASRH was incorporated into the comprehensive Council Health Plan, which sustained youth dialogue with community leaders and policy makers.

- IPs have formed youth facility boards to ensure youth involvement in planning and implementation of ASRH activities.

- In Tarime District, the delivery of quality youth-friendly services was established through a strategic process including community mobilization, involvement of opinion leaders and young people, enabling health providers to serve young people, and increasing the accessibility of affordable services. The success of the initial work encouraged Tarime's District Council to include YFS activities in its existing operations and to mobilize funds for continuing services, an unprecedented development.

Uganda — Sustainability in Uganda was fostered by integrating ASRH activities into district government development plans and budgets. While having less significant networks than government, NGOs also benefited and advanced the overall ASRH goal by becoming sustainable entities through capacity building. Parents Concern, for example, was active in only part of one district before receiving technical assistance on strategic planning, leadership, and policy upgrading on personnel, administration and finances. Afterward, Parents Concern grew to operate in five districts while expanding and diversifying its funding. IPs in Uganda also identified ways to collaborate in order to foster sustainability for all participants, and the Inter-Religious Council — made up of four AYA-supported faith-based institutions — was awarded funding for HIV/AIDS interventions. During a sustainability workshop held by AYA in 2004, participants acknowledged that their institutional and technical capacities to implement ASRH programming had been built through AYA, noting that different organizations endowed with different potentials can work together to achieve greater success. Twelve organizations formed the Uganda Youth Alliance Network (UYANET) to synergize capacities and work towards the promotion and protection of rights for the realization of a healthy, skilled, knowledgeable, and self-reliant population of young people in Uganda. The group has outlined its organizational vision, mission, goals and objectives; registered as an NGO; established management and operational systems; and received funding from the World Bank for institutional capacity building. UYANET members see opportunities for the network to assist in operationalizing the National Adolescent Health Policy and improving coordination between ASRH stakeholders at all levels, and plans to continue to improve the collection, analysis, and dissemination of youth-oriented data and information.

Scaling Up

AYA expanded Life Planning Skills and YFS activities, and set the stage for scaling up through policy commitment, training, and government adoption of the LPS and YFS training curricula. From the beginning, scaling up stood as an AYA programme objective; AYA leaders soon recognized that full national scale-up was optimistic given time and resource constraints. A more realistic objective was formulated: expand tested models, test other models, and lay the foundation for eventual scaling up by securing enabling polices, building capacity and institutionalizing models and tools.

SUMMARY OF AYA RESULTS

Botswana — Modifying its scope early on in Botswana, AYA achieved the foundation for widespread scale-up and expansion into multiple districts, strengthening many key national institutions — such as the Botswana National Youth Council, responsible for coordinating NGO activities on ASRH in the country — and developing policies and materials which were adopted as standards throughout the country. The Botswana Ministry of Education adopted AYA's Life Planning Skills Curriculum for use in all secondary schools, and the Ministry of Health adopted the ASRH curriculum to train in-service health providers. Substantial programme activities were undertaken in eight districts, including the establishment of youth-friendly services in 20 health facilities.

Ghana — The collaboration between AYA and the Nurses and Midwives' Council of Ghana (NMCG) led to sustainability of YFS in Ghana through the integration of ASRH into the pre-service training curriculum of all nursing and midwifery institutions in Ghana. AYA identified the negative attitude of service providers toward young clients as a major reason for low patronage of existing health facilities by young people — existing service providers were often poorly informed and ill-prepared to address the health needs of adolescents. As in-service training can be costly and is often not sustainable because of staff attrition and transfer, ASRH topics were integrated into the curricula of the training institutions, offering a cost effective and sustainable way to improve the attitudes of service. As a result of this joint effort between AYA and NMCG, ASRH is now a two-credit hour examinable course for all five disciplines of nursing in Ghana: General Nursing, Public Health Nursing, Community Nursing, Mental Health Nursing, and Midwifery. The ASRH course is also part of the licensing examinations conducted by the NMCG. Cordiality, trust, and commitment of the partners involved were key to a successful partnership and the development of the curriculum. At the 2005 conference of the West Africa College of Nurses, AYA and NMCG were recognized as pioneers for their integration of ASRH into pre-service training. The project also strengthened the capacities of NMCG members and the experience engendered their collaboration with other organizations in similar projects.

Tanzania — As one of AYA's YFS IPs, the government's Infectious Disease Centre (IDC) was selected to ensure youth-friendly services and to strengthen data collection and analysis. IDC became a model facility for other councils: District Medical Officers from four other district councils visited IDC and subsequently provided technical assistance to each other and to other councils, resulting in increased technical capacity at the district level for integrating YFS, and showing that YFS can be integrated into public health facilities using technical resources that exist within the public sector. Following this, authorities in Dar es Salaam City committed their own resources, in addition to AYA resources, to scale-up integration of YFS in three additional public health facilities with IDC serving as a referral centre. Expansion within the public sector moved far beyond Dar es Salaam to include all AYA districts. IDC was the only public health facility with computerized MIS for SRH service provision in Tanzania, and provided information that was disseminated at the 2004 International AIDS Conference in Bangkok.

Uganda — Working closely with districts, YFS were established in 76 facilities, and in-service and pre-service training activities were established with standardized curricula. Many of AYA's YFS activities continue to be sustained —

- Six out of 13 AYA districts were funded to continue AYA activities to increase use and availability of YFS.

SUMMARY OF AYA RESULTS

- Kampala City Council and Makerere University received financial support from an anonymous donor through Pathfinder to continue YFS activities in five clinics in Kampala, and to provide non-clinical YFS through peer educators on campus.
- Reports from DDHS indicate increased commitment and resources to integrate and sustain ASRH activities within institutional frameworks and development plans.
- Strong peer networks comprised of peer educators and youth advocates sustained activities and continue to refer youth to health units.
- Some districts expanded YFS to more facilities with resources from the Global Fund.
- Trained service providers and health units oriented non-medical staff and newly enrolled medical staff on YFS, contributing to increases in clientele.

The AYA experience proved rich in experimentation, challenge and discovery.[20] The investment in infrastructure to support a large, complex partnership required more time and resources than anticipated, abbreviating the limited implementation timeframe. Similarly, more time than initially expected was needed to develop activities for scaling up. Soon after the programme began, the strategy to go to scale — with the expansion of interventions nationwide — was recognized as optimistic. AYA adapted, pursuing the more practical and successful strategy to institutionalize ASRH through policy change, integration of ASRH into existing programmes, and institutional capacity building to establish a strong foundation for scaling up. AYA implemented innovative approaches which proved to be successful and increased models for replication in the future. Given AYA's achievements and insights gained into designing and implementing a complex, multi-sectoral programme, many lessons learned were shared across all four AYA countries.[21]

Programme-Wide Lessons Learned

Programme Planning

Operational Structures

- To lay a firm foundation for a large, multi-sectoral programme, early key tasks include defining the structure, relationships, operating procedures and plan for integration. Roles, responsibilities, systems and procedures must be detailed, well understood and accepted; oversight and accountability for individual programme components must be established, along with strong coordinating mechanisms and networks.

- The extent to which common operational mechanisms — including administrative and financial reporting for IPs — are available early in the programme can significantly reduce transaction burdens on IPs and minimize delays in disbursement of funds and implementation.

- Adequate human resources and RH commodities, along with effective systems and infrastructure should be assured, or activities to address these issues should be arranged early in the programme.

- An alliance with the host government should be prioritized, especially in cases where the government will assume coordination responsibilities. Such an alliance can prove to be a key step toward sustainability of programme interventions.

Design and Implementation

- While attempting to be strategic and far-reaching, maintain focus. Ensure a solid understanding of realistic goals given financial, time, and human resource constraints. Expectations of coverage and objective targets need to be realistic to ensure impact — especially important given government and donor expectations of programmes.

- Although detailed, results-based planning is fundamental to effective programme operations, good interventions will evolve and change — flexibility to accommodate such changes is necessary.

- Do not underestimate the significant amount of time needed to deploy a multi-sectoral partnership in which multiple stakeholders are involved, ownership is encouraged, and capacities must be built before effective outcomes can be expected — especially if sustainability and scaling up are to be achieved.

20 These lessons learned and recommendations stem from designing and implementing the programme, and from the various AYA evaluations including KPMG and IHSD mid-term assessments, component evaluations, crosscutting objective assessments, and the JSI impact evaluation.

21 Country specific lessons learned can be found in the AYA End of Programme report for each country.

- Determine which components can be integrated from the start, recognizing not all components can be integrated before they are operational.

- In-service training should be a continuous process, with updates and refresher courses delivered as needed to ensure teachers and providers have support, maintain momentum, and are able to develop strategies to address challenges faced in their schools, clinics and communities. Supervisors' training should be conducted before in-service training for teachers/service providers' begins, so that the supervisors are provided with appropriate tools and resource materials needed to execute their jobs. Such additional training will empower supervisors to offer more informed support to teachers/service providers in implementing quality LPS and YFS. Sufficient time and funding should be allocated to supervision tasks, critical to effective delivery of LPS and YFS.

- The decision to conduct a cost analysis of a programme needs to take place during the planning stage, with systems put in place accordingly. Costing programme components, while difficult, will serve to add value: without costing data, it is more difficult to garner commitment to replicate, sustain and/or scale up as a lack of data limits the ability to plan.

- Scaling up programmes first requires establishing the capacity to support a large-scale programme before replication can follow. AYA found that many talented organizations were committed to implementing ASRH interventions; however, in order for the organizations to reach large numbers of youth, substantial capacity building was necessary.

Evaluation

- Plan and prepare at programme inception for good evaluation design as part of an overall results-based management strategy — assure adequate funding and human resources from the beginning.

- Implementation and reporting periods, and use of data collection forms, should be standardized with all IPs to guarantee consistent and comparable data, and to enable analysis.

- To enable attribution, address issues of message saturation and contamination in determining programme and evaluation design.

- Measuring the change of perceptions is contextual and analysis can be complex. Rather than focusing on the directionality of perception, the emphasis should be on measuring accurate perception of risk linked to positive attitudes and behaviours.

Sustainability

- Plan for the end at the beginning: sustainability should be considered as early as possible, including building programme activities into ongoing institutions, so that an effective transfer of programme responsibilities can occur when a time-funded programme is scheduled to terminate support.

- Ensure that the phasing out of the programme is well planned, effectively communicated, and participatory. Engage stakeholders and partners in strategic planning for a comprehensive exit strategy and for future efforts beyond the life of the programme.

Programme Components

From the beginning of AYA, each partner agency maintained responsibility for particular programme objectives and component areas. While these distinctions were useful for programme management, administration, accounting and funding, once implementation was well underway and interventions fully integrated, these distinctions proved artificial. A key advantage of a multisectoral approach is the synergy across components, joint programming, and the enhanced results produced. The following lessons learned, although organized by programme component, should be understood within this context.

Policy and Advocacy

- Religious institutions can be effective partners in ASRH if programmes are willing to invest the time, patience and flexibility required for working with faith-based groups on sensitive issues such as ASRH advocacy, condom distribution, and HIV stigma.

- Community involvement is essential in implementation and enforcement of policies at the community level. Community referral networks — such as advocacy teams, networks and peer outreach established through AYA — have a demonstrated positive effect on community acceptance of ASRH interventions.

Behaviour Change Communication

- ASRH interventions must be customized for distinct groups of adolescents. Evidence from all AYA evaluations consistently underscores the heterogeneity of youth: programme interventions affected segments of the target population differently. In-school evaluations of the LPS curriculum found that for young people in primary school, the most significant change was in condom knowledge, intent to use condoms, and HIV/AIDS awareness; for those in secondary school, the most significant change was in building healthy relationships, confidence to refuse sex and negotiating condom use. The JSI impact evaluations demonstrated more positive effects on outcomes for females.

- Given that initiation of sex is a normal part of adolescence, and that mixed results are obtained with abstinence programming, a range of risk reduction options should be provided.

- Integration is key to increasing programme impact. AYA improved health-seeking behaviour, with increased percentages of both males and females visiting health facilities to receive information and services in all countries. Integration of the P&A, BCC and YFS components improved knowledge, skills and attitudes of young people, as well as the availability and quality of health services. Advocacy work improved knowledge and attitudes of community members.

- An efficient process is equally important to coordinate BCC and YFS components and to ensure a continuous supply of BCC materials to adequately support YFS activities

Youth Friendly Services

- In AYA, condom messages effectively resulted in increased use (ever and at last sex) and intent to use. Given condoms' ease of use, identification as the method of preference by

adolescents, effectiveness for both pregnancy and HIV/STI prevention — and recognizing mixed results with abstinence messages — condoms should be a fundamental element of SRH services for young people. AYA's experience reaffirms this lesson consistently learned in ASRH programmes.

- Heterogeneity of young people is also evident in their preferences for service provision. Data across all countries showed that more females visited clinics for counseling, more males obtained condoms through outreach. Variation also exists among age groups. Increasing utilization of services requires multiple approaches to match diversity of youth.

- The enthusiasm and commitment of peer providers are challenging to sustain. Prompt provision of transportation allowances and/or stipends, supervision, and a sufficient supply of BCC materials and condoms help to keep them active. Adherence to selection criteria can minimize dropout rates of peer providers.

- Integration of ASRH into pre-service training for health care providers should be pursued, especially in ways that influence all training institutions. Pre-service training reduces the burden of in-service training, assuring a more efficient system of preparing personnel for this intervention, at a lower cost and with better coverage. This will also contribute to sustainability and scaling up of YFS.

- Health facility staff and management should be involved in quality improvement planning and implementation to assure better results, and facilities should routinely use mystery clients and client exit interviews to monitor the quality of services rendered. Place continued emphasis on the importance of collecting service statistics to monitor the impact of improvement efforts.

- Adequate supply of contraceptives, particularly condoms, proved to be a significant challenge. Programmes must assure a consistent supply able to meet increased demand for YFS.

- Increasing access to YFS was facilitated by improving youth-friendliness of public health facilities, partnering with FBOs to provide YFS, offering outreach services, and integrating ASRH into pre-service training for nursing and midwifery institutions. Seek opportunities to use innovative approaches to reach large numbers of young people.

- Quality data for trend analysis and evaluation remain difficult to obtain from clinic staff and outreach volunteers. Standardized collection instruments must be implemented and data collectors must be recruited and trained, as lack of dependable data can compromise use of data for planned expansion and scaling up.

Integrating ASRH into Livelihood Programmes

- Seek opportunities to integrate ASRH into existing livelihood programmes: income generating activities, micro-enterprise schemes, vocational training.

- Link young people in ASRH programmes to livelihood opportunities. Partnerships will facilitate this process. Employment and economic status are fundamental challenges for young people: throughout the AYA programme, young people identified their financial/economic status as their key priority, over and above their generally poor SRH status and access to services.

Institutional Capacity Building

- Initiate capacity building for sustainability early in the life of the programme. Early training on proposal writing and resource mobilization benefits partners throughout implementation, and skills will be thoroughly developed and absorbed by the close of the programme.

- Capacity assessments should be used with partner organizations and agencies to foster their awareness of needed institutional changes and to identify areas of most essential upgrading.

- General institutional capacity building, as opposed to intensive support, can succeed when interventions are strategically focused on a few key organizational areas.

Coordination and Dissemination

- Focus must be maintained at the national level to ensure sustained commitment and support, and at the district/village level to ensure implementation. Promote national government structures that address ASRH at the district and community level to facilitate comprehensive and complementary approaches that districts and communities can sustain and own.

Crosscutting Objectives

Youth participation, sustainability, scaling up, partnerships, community involvement and gender sensitivity are typical principles of ASRH programmes. Success at achieving these requires operational modalities to ensure objectives are met, as well as measurement systems to assess their contribution to programme outcomes.

Partnerships, Youth Participation and Gender

- Success of official government adoption of curricula and other tools — which lays the groundwork for sustainability and scaling up and facilitates future programming efforts — was achieved through partnership with the governments of AYA countries. Establishing partnerships ensures ownership and investment in the product, facilitating sustainability and scale-up.

- Building the capacity of young people proved to be a sure way of enhancing their effective participation in the planning, implementation and evaluation of AYA's programme. For example, in addition to serving as BCC peer educators and YFS peer providers, young people played lead roles in successful negotiations with policy makers due to skills acquired through AYA trainings. By the end of AYA, youth were able to successfully conduct their own assessment of youth involvement in the programme.

- Continue to seek out the meaningful participation of youth in all areas of programming: design, management, implementation, evaluation, and governance, including involvement in decision-making processes. This is a challenge, and significant planning must be undertaken, with resources designated to assure their preparation. Realistic expectations must be

set and adults must be trained to work effectively with youth. At the start of the intervention, create operational modalities and build upon the existing capacity of young people to create strong, sustainable youth-led initiatives — fulfilling the fundamental rights of young people and creating a generation of informed, active advocates for ASRH.

- Gender inequity is an entrenched problem that requires a two-pronged approach: mainstreaming gender into programme design (e.g. assure equity in programme participation, address social norms that affect both males and females, check interventions for gender sensitivity); and creating interventions that specifically target early marriage, rape, equity in education, FGC, and inter-generational sex.

Community Involvement

- Community involvement should be prioritized both for introducing a new intervention and for longer-term ownership and sustainability.

- Engaging the community can work well with both broad-based mechanisms (such as district advisory committees) or more focused channels (a religious denomination, cultural institution or youth group); the former gets messages out generally and the latter ties the message to the stakeholders' area(s) of identity and allegiance.

- Communities can be engaged to support ASRH if key stakeholders are identified and oriented to the needs of young people using local data to depict ASRH realities. PLA was key to achieving involvement, understanding, support, and eventual ownership by communities.

Sustainability and Scaling Up

- Seek opportunities to integrate ASRH issues into ongoing initiatives and materials of donors, governments, academia, religious and cultural institutions, youth groups, and other sectors of civil society to facilitate sustainability through stakeholder buy-in and resource allocation and to contribute to scaling up of ASRH interventions.

- For scaling up to occur, intervention models must be developed and implemented with, and through, networks with the potential to reach significant numbers of the target audience.

- Scaling up efforts are more strategically developed if they start with a careful selection of the most promising sites for establishing a potentially expandable model. Attempting to establish too many YFS sites too quickly and without strong criteria can result in a lack of focus and resources.

- Scaling up requires that fundamentals be addressed before actual expansion occurs: identify effective models, form enabling policies, prepare a capable infrastructure and capacity to implement, and institutionalize tools and strategies. Be prepared to devote required resources to both achieve and sustain fundamentals.

Conclusions & Opportunities

AYA's legacy lies in both behaviour change in the young people reached directly by the programme, and in the enabling and sustainable programme environment that continues to support sexual and reproductive health programming for young people in the four AYA countries. Youth, as the identified beneficiaries, became partners and leaders in assertively advocating for their needs and rights, and AYA successfully demonstrated the viability of interventions to address young peoples' needs.

The AYA experience benefits the larger sexual and reproductive health field by —

- demonstrating the efficacy of the model for donors and programmers
- offering best practices that ASRH programmers can collectively address
- providing a tested methodology for evaluation
- affording specific lessons learned for both technical programme components and managing each stage of the programming process.

Scaling up the multi-sectoral approach within AYA countries and expanding to other countries both within and beyond the Africa region would include —

- replication of the model to improve determinants and achieve behaviour change, maintaining a strong gender focus on girls' empowerment and increasing emphasis on male responsibility and involvement
- further study of the context of and motivation for behaviour change among young people and particularly males
- including very young adolescents (ages 10-14) in evaluation surveys to study impact on abstinence, delay of sexual debut and negotiation skills
- continued support to national and district governments to improve institutional and technical capacity to deliver and sustain good quality programmes for young people
- ensuring advocacy to both national governments and district councils, as well as community-based advocacy to guarantee implementation of national policies at the district, local government and community level
- Dissemination and capacity building for ASRH programme staff to ensure integration of the approach and improve the quality and effectiveness of the programmes.

THE AYA LEGACY

AYA has expanded the evidence base of youth programming, and the investment in AYA has proved catalytic in demonstrating and expanding "state of the art" in ASRH service delivery; creating capacity building models for scaling up; documenting effectiveness in changing reproductive health behavioural outcomes; and enhancing commitment from donors, national governments and communities. The evident implications for programming, resource mobilization, national ownership and capacity building are significant and establish a strong foundation for future programmes.

AYA's contribution will continue to benefit the lives of young people in Africa for many years to come. As civil society and government work to eradicate poverty and hunger, improvements in the health of young people will remain a fundamental strategy for youth empowerment, well-being and overall development. The effort and experience of the African Youth Alliance will help to position ASRH as a key strategy in the achievement of Millennium Goals, the cornerstone of collective global development efforts.

Implementing Partners

Botswana

- Botswana Christian Council
- Botswana Family Welfare Association
- Botswana National Sports Council
- Botswana National Youth Council
- Ministry of Health/ Family Health Division
- Ghetto Artists Productions
- Ministry of Education
- Population Services International
- Women Against Rape
- Young Women's Christian Association

Ghana

- The Centre for the Development of People
- Christian Health Association of Ghana
- International Federation of Women Lawyers of Ghana
- Junior Graphic
- Ministry of Education/ Ghana Education Services
- Ministry of Health/ Ghana Health Services
- National Population Council
- National Youth Council
- Nurses and Midwives Council for Ghana
- Planned Parenthood Association of Ghana
- Population Impact Project of the University of Ghana
- Voluntary Service Overseas

Tanzania

- African Media Group
- Arusha Municipal Council
- Chama Cha Wanawake Kupambana Na Ukimwi Arusha
- Clouds FM
- Dar es Salaam City Council/Infectious Disease Centre
- Family Planning Association of Tanzania
- Ilala Municipal Council
- Karagwe District Council
- Kasulu District Council
- Kibondo District Council
- Kinondoni Municipal Council
- Marie Stopes Tanzania
- Ministry of Education (Zanzibar)
- Ministry of Health (Mainland and Zanzibar)
- Radio Tanzania Dar Es Salaam
- Radio Tanzania Zanzibar
- Somo Adolescent Youth Friendly Organization
- Tanzania Gender Networking Programme
- Tanzania Youth Aware Trust Fund
- Tarime District Council
- Television Zanzibar
- Temeke Municipal Council
- University of Dar Es Salaam
- Vocational Education Training Authority (Mainland)
- Vocational Educational Training Department (Zanzibar)
- Youth for United Nations Association
- Zanzibar Association of Children's Advancement
- Zanzibar Association for Information Against Drug Abuse and Alcohol

Uganda

- Buganda Kingdom
- Busoga Diocese
- Busoga Kingdom
- Bunyoro Kingdom
- Catholic Secretariat
- Church of Uganda
- Family Planning Association of Uganda
- Iganga District
- International Care & Relief Uganda
- Kabale District
- Kabarole District Administration
- Kaberamaido District
- Kampala City Council
- Kampala District
- Kamwenge District
- Kapchorwa District
- Kasese District
- Kyenjojo District
- Makerere Medical School
- Ma-PLAY
- Mayuge District
- Mbale District
- Muslim Supreme Council
- National Curriculum Development Center
- Ndere Troupe
- Orthodox Church
- Parents Concern for Young People
- Population Secretariat
- Sironko District
- Soroti District
- South Rwenzori Diocese
- Straight Talk Foundation
- Toro Kingdom
- Uganda Red Cross Society
- Uganda Youth Development Link

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