1. Background.

The Sexual and Reproductive Health for Adolescents and Youth (ASRH) Project underway since early 1999 aims to address vulnerability to sexual and reproductive health (SRH) problems among both in and out-of-school youth 10-24 years old in six districts of Zambezia Province and urban Maputo. Its holistic approach to meeting youth needs with information, skills and services is implemented through a multi-sectorial structure involving government youth, health and education sectors and NGOs under the coordination of the National Directorate of Youth Affairs (DNAJ) of the Ministry of Youth and Sports. Project objectives include:

a) increasing access and use of youth-friendly SRH services;
b) increasing access to information on sexuality, sexual and reproductive rights and adoption of safe practices;
c) building technical and management capacity of implementing agencies;
d) supporting AYSRH policy and strategy development; and,
e) ensuring intersectoral coordination among implementing agencies at central level and their affiliated activities in Zambezia Province.

The current project strategy has as a reference point several policy and programme initiatives already underway, not the least of which is the UNAIDS Programme. A major UNAIDS focus at this stage of the epidemic is capacity-building and support at the national level, with a focus on support to local and community responses through development of community-based approaches. It also aims to increase protection and support to *vulnerable* populations, especially youth, with a focus on strengthening access and coverage of prevention and care.

Under the ***National Strategic Plan to Combat HIV/AIDS*** in Mozambique, different ministries are responsible for coordinating the responses to the needs of different *vulnerable groups*. The Ministry of Youth and Sport has been tasked with addressing the needs of out-of-school youth, the Ministry of Education responds to needs of in-school youth, and the Ministry of Health coordinates responses to the needs of people with STDs and HIV/AIDS. For the purposes of this project, ***outreach*** is defined as any approach that attempts to go beyond the health facility to provide information, life skills or clinical services to these vulnerable groups of young people.

Vulnerability, according to Jonathan Mann (*AIDS in the World I & II*), can be seen on a continuum from personal to programmatic to societal vulnerability. At the personal level – e.g., for an adolescent girl or boy, it is gauged in terms of the youth's capacities and personal resources, as well as in terms of his/her social support networks and access to programme interventions. Within the context of this project, all youth are considered vulnerable in these terms by nature of their developmental stage, and they are catered for in the project strategy, first through provision of youth-friendly services, and then through outreach to in-school youth through peer education activities. Both of these components are underway.

However, within this transitional stage from 10 to 24 years, age, gender and education determine the degree of vulnerability. It is clearly greater for the younger cohort, e.g. 10-14 years, who tend to be unprepared because of lack of exposure to life-saving information and skills. It is also greater for girls than for boys, in terms of the gender roles they are called on to play under an unequal sexual and socio-economic power dynamic. And, finally it is greatest for those whose education has been limited, who are out of school, and/or who are unemployed. This out-of-school, unemployed status not only increases the impact of the other two determinants (age and gender), but it is often both caused by and contributes to the youth's deprivation of a cohesive, economically and socially secure environment (including school) within which life skills can be reinforced and safe sex can be exercised.

Clearly, these out-of-school, unemployed youth are the most vulnerable to SRH problems. They are rendered all the more vulnerable in that programmes find them hard to reach with life-saving interventions of any kind. Therefore, in addition to services and outreach through school programmes, the Project strategy places a major emphasis on outreach to out-of-school youth in the communities where they live. This out-of-school, hard-to-reach aspect of the outreach component is the focus of the present document.

2. The Context.

In a recent review of SADC youth programmes, the author indicates that "although it is important to recognise that adolescence is an 'inherent developmental phase between childhood dependency and adult autonomy' (Mensch et al., 1998) in all cultures, it is equally important to recognise that the period of adolescence and ASRH behaviour vary greatly depending upon *social, economic and cultural contexts*. These variations have important program and policy implications; adolescents cannot be treated as a homogeneous group with a universally shared set of needs." (FOCUS, 2000b) The context within which these youth live defines their *vulnerability* and points to ways to address it. Contextual dimensions are, epidemiological, socio-economic, socio-demographic, socio-cultural, political, and spiritual. The scope and reach of current programme interventions also moderates their vulnerability by defining access. *Annex 2.* provides a concise, universal summary of the main influences on youth's SRH.

2.1 Epidemiological Context.

Increasing numbers of young people are migrating to the major transport corridors for economic livelihood opportunities, where, not surprisingly, Mozambique experiences its highest HIV prevalence rates. STDs can increase HIV transmission. The 1996-97 prevalence rate for STDs among sexually active Mozambicans 15-49 was 12.6%. Of all cases reported to the NACP, 45% were in Zambezia, making it the most affected part of the country. At the end of 1999, the estimated HIV prevalence in young Mozambican females 15-24 years ranged from 13.36% to 16.11%, and among males the same age it ranged from 4.49% to 8.97%. (UNAIDS, 2000) Of the estimated 700 new cases of HIV infection in the country per day, 300 *or 42.8%* are among adolescents and youth. (*NACP*, 1999) This indicates the extremely young age at which young people, especially girls, are becoming infected.

> "I go about telling people of my status. Some will actually believe me, but some will feel pity, or they accuse me of being promiscuous. But this sexual act that left me HIV positive was only my second."
> *- Young man in Mozambique*

Teen pregnancy continues to be a serious problem, with an estimated 10% of adolescent females 15-19 years old experiencing their first pregnancy, and 30% already mothers. (DHS, 1997) 44% of admissions to Maputo Central Hospital for complications of abortion are adolescents. (HCM, 1994)

2.2 Socio-Demographic Context.

Mozambique's estimated 1999 population is close to 17 million, with 45% under the age of 15. Zambezia Province has an estimated 3.1 million residents. The population estimates in Table 1. assist in depicting the project sites, and providing a framework for target setting. Roughly half are females (52%) and half are males (48%).

Table 1. Demographics of Project Sites, RH for Adolescents and Youth

Project Site	Population Estimates D=district C=city T=town	Adolescents 10-14 yrs & [% School Enrolment]	Adolescents 15-19 yrs & [% School Enrolment]	Youth 20-24 yrs & [School Enrolment]	Total Youth Population 10-24 [School Enrolment]	Project Targets (Reach/ Coverage) by end 2002*
Maputo City	996,837					
Quelimane City	150,116					
Gurué District	D197,179 C 99,335					
Alta Molocué District	D T					
Mocuba District	D C					
Ile District	D T					
Milange District	D T					
Morrumbala District	D 310,000 T 21,000					
Namacurra District	D T					

* for Out-of-School Youth

In the project areas, x% live in urban areas, y% live in rural areas where infrastructure is extremely poor. An estimated 70% of the Mozambican population is without access to health services.

Access to education is THE key protective factor for sexual and reproductive health, since the relationships between increased schooling and reduction of the risk factors for sexual and reproductive health problems hold for all socio-economic classes and in all regions of the world. While there is a general positive trend in *Southern* Africa toward decreasing discrimination against girls for secondary school attendance, still only 5% of [eligible] girls in Mozambique are enrolled in secondary education (as opposed to South Africa, which is close to universal coverage). For boys… Poor infrastructure is a major factor in this. . For example, Morrumbala District has no secondary school, and only one school for EP1, one for EP2.

This contributes to an estimated 60% of youth 10-24 years old in Maputo who cannot be reached through the formal school system. In Quelimane City, this figure reaches 83% of youth 10-24 years old. And, in the six rural districts of Zambezia Province participating in the project, these "hard-to-reach" rates are even higher. *(Break down by 10-19 years for primary and secondary.) For 19-24 year olds, what proportion are unemployed?*

Language and literacy rates… Only 16% of women in Zambezia are able to speak Portuguese.?? CHECK WITH INE – LEO MORRIS.

Main transport corridors run through x, y, z towns of project areas. These corridors are receiving influxes of migrants from other parts of rural Zambezia, as residents, especially youth look for income-generation possibilities.
In Zambezia, X% of youth 10-24 are married, with marriages as early as , and most beginning within the 15-19 year cohort.

In Mozambique, age of marriage (using PRB classifications) averages , in contrast with 18-19 in all other SADC countries, except for Mauritius and South Africa. In Mozambique, 65% of women had given birth by age 20, while most SADC countries averaged between 52% and 63%.

Most residents of Zambezia live by subsistence agriculture, and it is said that by the time a young man has enough money to buy a bicycle and a radio

(about $100), he is expected to obtain land from the community leader, build his own hut, start farming and get married. Girls usually leave school to help at home before age 12. (CHECK THIS)

2.3 Socio-economic Context.

Extreme poverty (increasingly occasioned by abandonment or orphanhood) is a central risk factor for sexual and reproductive health, resulting, among other things, in young people being pressured to have sex in exchange for money, favours, or goods. Conversely, increasing socio-economic status (SES) and living standards, access to quality comprehensive health services, and educational attainment are all *protective factors* identified in the sexual and reproductive health literature. To the extent that sexual and reproductive health programs are able to link with such programs or incorporate such activities, they will greatly increase their impact. Unfortunately, many of these *protective factors* linked with SES are declining in Mozambique.

Clearly, HIV/AIDS is the most significant factor shaping the socio-economic context in which Mozambican youth live, learn, develop and make decisions that affect the rest of their young lives. Its effects are particularly felt among those already most vulnerable, e.g. those out-of-school. It is estimated that in 1998-1999, some 30,000-60,000 Mozambican families were affected by HIV/AIDS, resulting in changes in resource and income distribution, consumption patterns, decreased savings, family breakdown, disruption of traditional family and community structures, and the erosion of social capital. The burden of AIDS-related illnesses on caregivers (usually wives, mothers, daughters and grandmothers) compromises their ability to carry out domestic tasks, childcare and supervision, food and economic productivity, and daily subsistence activities. This will increase the vulnerability of young people.

Special sub-groups such as refugees, commercial sex workers, youth orphaned by AIDS, and street children suffer from the almost complete absence of protective factors in their social context, and consequently show higher rates of most or all SRH problems, including HIV/AIDS. Programs to address their needs need to identify substitutes for these protective factors.

2.4 Socio-Cultural Context.

Within Mozambique, the Project assumes considerable diversity in cultural groups, variations in levels of poverty, and striking urban/rural differences. These contexts will have to be explored within each district. These social factors can operate either to reduce health risks, or to protect young people's health. Two common socio-cultural values across the SADC region have great relevance to this Sexual and Reproductive Health Project for Adolescents and Youth.

- First, most cultures in the region attach great importance to *fertility*. This has important implications for strategies with youth, whose future fertility is often impaired by exposure to STIs and by unsafe abortions.
- Another common value system, which may not apply to all of the traditional cultures, is a double standard, which disapproves of the *sexual activity* of single women (virginity and faithfulness are highly prized), while encouraging the sexual activity of men (losing virginity and having multiple partners are strongly valued). Hence, girls receive heavy social pressure, on the one hand, to stay a virgin, while in relationships with boys who are pressured by their peers to be heroes by having sex.

In this context, high prevalence of non-consensual sex is probable, and the Project must place a high priority on preventing sexual coercion, violence, abuse and incest among youth of all ages. Prevention efforts must include working toward gender equity, working intensively with young men on masculine sexual norms that condone sexual violence, and with young women on female norms that mandate passivity. The social norms of virginity and passivity for girls can be prevent girls who need contraception or STD prevention/treatment from getting services or initiating condom use as these are clear admissions of sexual knowledge and activity. Cultural norms of masculinity encourage risk-taking, making men less open to safer sex practices. Expectations that men should start having sexual intercourse early and have multiple partners heightens sexual health risks both for them and for their partners. In the Project areas, it will be critical to assess the local cultural norms of masculinity to determine which of these pose threats to well-being and health, and which could be emphasized to promote health.

The most significant source of these gender-based norms is *the family*, especially in "early adolescence" (10-14). The breadth of the family support network varies widely among different ethnic groups, and from rural to

urban areas. The once common tradition of family members other than the parents, serving as mentors and confidantes in matters related to reproduction, sexuality and family formation has diminished, both during the long war, and in the process of rural to urban migration. Now studies document discomfort of parents and other family members with transmitting SRH information and messages to their children. (FOCUS, 2000a) The family can also be a source of oppression, depending on the status of women within the family, the level of violence within the family, and whether the family has repressive attitudes towards young people's sexual and emotional expression. A significant proportion of sexual acts are unwanted by adolescents and not pleasurable.

In rural areas where *age of marriage/union* tends to be earlier, girls carry different health burdens from their urban counterparts. Greater burdens of physical labour, earlier and more frequent child-bearing, lower education levels, greater maternal and infant mortality and morbidity, less access to clean water, health services, and sanitation. The prevalence of sexually transmitted infections, however, may not be that different between rural and urban areas, depending on migration patterns of male workers.

Multi-lingualism poses a real challenge for the educational system; those ethnic groups whose languages are not taught in the school system, and/or have little or no written usage, are at a disadvantage in schools and in a society where innovations are vehicled by communication. In Zambezia… Community-based outreach approaches to education and communication must meet the challenge of differing levels of literacy and fluency in the language(s) among those they serve.

Finally, *health services* are perceived to cater mostly for females. Hence, utilization of (and access to) health services among boys and men is very low and or/delayed. There is need for "male-friendly" services.

2.5 Spiritual Context.

X% of residents of Zambezia Province and Y% of Maputo City profess a religion (belong to a church). During the time just after independence, with the efforts to achieve a Marxist-Leninist state, much of the church infrastructure was destroyed and it became politically unacceptable to profess a religion. While spirituality is said to have remained very much

alive, the protracted war also had quite a devastating effect on this critical aspect of society. The moral authority of the church in people's lives suffered, social cohesion and "family values" declined (particularly due to the war), and both only began to be rebuilt in the last five years after the war.

Some adults feel that this period of deprivation of open moral and spiritual guidance has particularly affected the young people. They are lacking role models, a sense of purpose and dignity, and a sense of community solidarity. One church-affiliated NGO feels it has actually been easier to establish this spiritual direction and solidarity in rural communities where there were never any churches (and thus no one witnessed them being destroyed). It is also important to note the continued appeal of the traditional healers for Mozambicans of all ages for STD/HIV/AIDS and other sexual and reproductive health problems which have a significant emotive aspect. Their holistic approach offers something that the allopathic medical system has not yet assimilated.

Efforts to regain this moral course and social cohesion have resulted in several significant associations of church leaders such as the Christian Council of Mozambique (CCM), the Catholic Bishops Conference (this is a guess???), Scripture Union, the Nucleo of Church Associations, and Islamic??, as well as the Association of Traditional Medical Healers. World Vision notes that their Church Relations Programme has already been an effective conduit for HIV/AIDS-related life-saving information and skills to pastors and church members. Traditional practices and some church teachings that health workers have observed to result in e.g. non-protective sexual behaviour or delays in obtaining effective treatment of STDs, must be addressed through sensitively formulated messages to young people and partnerships with church leaders and traditional healers that do not undermine, but rather strengthen their positive spiritual influence.

2.6 Political Context.

In addition to the increasingly enabling policy environment described in *Section 1*, it is important to note that the Government of Mozambique recognizes the destruction of social capital and the negative changes in the socio-economic well-being of families and communities, the President having recently declared HIV/AIDS a national disaster requiring attention by all sectors. It truly views youth, especially the younger cohort of 10-14, as the

"window of hope for the future". It has not only publicly committed itself to improving quality and expanding coverage of essential services through its NSP to Combat HIV/AIDS, with a significant focus on prevention among young people. It has also placed overall coordination of HIV/AIDS programmes under the Presidency in the body of the National AIDS Council. The then-governor of the Province of Zambezia supported preparation of the Provincial Operational Plan for HIV/AIDS in 1999, and it is hoped that the current governor will commit to support/spearhead its activities.

In its recognition of the magnitude of resources needed in this fight, the GOM is also increasingly recognizing and supporting the positive contributions of NGOs and civil society in this fight. It has endorsed the coordination of NGO, church groups and self-help group efforts through MONASO in collaboration with Kundlimuka Association of PLWHA at national level, and through FUNGOZA and Esperança in Zambezia Province. The active participation of these groups at district level will be crucial to implementation of this outreach approach.

2.7 Programmatic Context.

2.7.1 The RH for Adolescents and Youth Project.

In the first year and a half of implementation, the Project has provided the training and equipment, to complement other inputs from other donors, for the establishment of youth-friendly services in four sites in Maputo and four sites in Quelimane City. While two clinics in Maputo are self-standing, dedicated to youth only (Adolescent Clinic adjacent to the Central Hospital and at the Mozarte Craft Centre), the others are integrated into comprehensive services at the health centre (Maxiquene) and clinic (Romao) level. Another self-standing, youth-dedicated facility will soon be established in Maputo under the NGO AMODEFA. A similar setup is planned for Quelimane City to augment the services offered through the current integrated facilities there. It is sobering to note however, that for all RH services in Zambezia Province, coverage is currently estimated at only 27%.

In addition to establishment of youth-friendly services, five youth counseling centres have been established at or nearby five Maputo schools under AMODEFA, and at an additional school in Maxaquene *bairro* under the Youth Association, Nucleo de Mavalane. While AMODEFA has staffed the five centres with a rotating psychologist, the Nucleo counseling centre is

staffed by two trained peer counselors. All of these counseling centres receive support and referrals from peer educators in the participating schools. Across the six school locations, there are now x trained peer educators operating. These peer educators address mostly their in-school peers, using a variety of techniques – drama, one-to-one counseling, public debates, and group educational sessions.

In Zambezia, these counseling services… Among the schools, x trained peer educators are operating, using techniques similar to those used by peer educators in Maputo.

2.7.2 Existing Communication Strategies.

At Pequenos Libombos in May 1999, a multi-sectoral group developed *National IEC Strategic Options for Integrated Sexual and Reproductive Health* including actions to address unwanted pregnancy, maternal morbidity and mortality and STD/HIV/AIDS. Options for action on these fronts were proposed with regard to youth in different contexts. The document reflects consensus on the contextual factors associated with behaviour change including behavioural, institutional, socio-cultural, political and environmental factors, as well as their implications for communication approaches and strategic objectives and quantifiable indicators. Major thrusts of the *IEC Strategic Options* are in keeping with the *National Integrated RH Plan* and the *National Strategic Plan to Combat HIV/AIDS,* and they provide the following guidance to the development of outreach approaches for out-of-school youth:

> "[Focus on] interventions that feature dialogue, self-expression, participation and interpersonal communication. In this respect, innovative interventions for Integrated Sexual and Reproductive Health should include the following actions:
>
> - ✓ Reinforce skills in interpersonal communication and counseling of those who influence [youth], particularly [youth themselves], service providers and community agents.
> - ✓ Promote double protection.
> - ✓ Promote youth-friendly services to increase utilization.
> - ✓ Develop the channels of dialogue and support, such as "Circles of Friends" in the community.
> - ✓ Develop youth-to-youth communication by training peer educators to promote SRH among their age-mates in and out-of-school.

A principle of the Strategy that will guide this Outreach component is the use of complementary communication channels - interpersonal, mass and small media, print/audiovisual materials – for transmission of a set of coherent messages.

Annex . contains amplifications of these recommendations for reference as the "how to?" of these channels is further concretized in the field.
The Project has also drafted elements of a *Project Communication Strategy,* this time with a specific focus on a popular communication approach to support the project's specific scope and coverage as a "youth-identified" project. The approach consists of dissemination and popularization of a communication concept *"The Active Generation"* through phased preparation of interpersonal channels as well as associated materials and media. A sustained interpersonal approach will be punctuated by periodic mass media-supported campaigns.

2.7.3 The National Strategic Plan to Combat HIV/AIDS.

Essential services for priority vulnerable groups under the National Strategic Plan include: youth-to-youth education, STD diagnosis and treatment, confidential counseling and voluntary testing, treatment of opportunistic infections, and concentration on the geographic areas of the central, northern and southern economic corridors. As a focal point for out-of-school youth under the NSP, the Ministry of Youth and Sport has designated this UNFPA-supported SRH for Adolescents and Youth Project as a potential catalytic or *animating project* from which lessons will be derived for scaling up throughout the country, beginning with Zambezia. One of the integrated activities of the Ministry of Youth and Sport under the NSP is support to communication campaigns. This will include the World AIDS Campaign 2000 for which the major theme is *Male Involvement.* This male focus can be used to the best advantage of the Project in its efforts to attract young men to services and encourage responsible sexual behaviour, including paternity, shared sexual health decision-making and overall improved gender relations.

Zambezia's Provincial Strategic Plan for HIV/AIDS, 2000-2002 focuses on…

2.7.4 Existing Partnerships.

Joint UN Support to the Provincial HIV/AIDS Operational Plan of Zambezia Province supported by UNFIP is due to start August 2000. Under that Project, the UN system will build on several current programmes and structures to implement a project geared toward expanding the quality and coverage of HIV prevention efforts among young people and community-level mitigation of HIV/AIDS impact in Zambezia Province. The RH for Adolescents and Youth Project will utilize this support to expand its activities in six districts of Zambezia in YFS (6 facilities), in-school and out-of-school peer education and complementary outreach approaches suggested in this document. Ongoing projects and initiatives proposed under UNFIP support for other ***collaborating partners*** will complement the AYSRH Project interventions. These include:

- Other UNFPA projects (RH, Gender Mainstreaming, and support to ICS for social communication through Community Radio)
- UNICEF (YFS (additional 6 facilities) and in-school peer education through UNFIP support, implementation of a community capacity-building strategy, support for the Stepping Stones process through ActionAid and Save The Children/UK in Zambezia, "Jovial" youth communication intiative)
- UNDP (improving access to gender-sensitive income generation and micro-finance services), and
- UNESCO (vocational and literacy training, and recreational programmes through establishment and support of a multi-purpose youth centre in Morrumbala District. A memo of understanding supports UNFPA establishment of YFS and peer education programmes at this facility).

Implementing partners in the AYSRH Project with the National Directorate of Youth Affairs (DNAJ) of the Ministry of Youth and Sports are both governmental and NGO, representing a multi-sectoral approach. These include National Health and Education Departments (SEA and DSC of MISAU), Maputo and Quelimane City Youth, Health and Education offices, AMODEFA, ARO Juvenil, and Youth Associations. **MONASO, FUNGOZA???**

2.7.5 Other Relevant Existing Partnerships and Related Activities.

Project Staff in Zambezia are currently identifying alliances, networks, and coalitions at provincial, district and community levels. At least 30 youth associations are operating in Quelimane City alone, 10 of them of

considerable "weight". A group of young musicians living with HIV/AIDS in Quelimane is operating under the auspices of the local MONASO affiliate Esperança, as association of PLWHA. **MONASO, FUNGOZA???**

Other Related Activities are being conducted by NGOs such as Action Aid and Save The Children/UK (intensive piloting of the Stepping Stones approach in four semi-urban district capitals, one of which, Morrumbala, is also a zone of intervention for this DNAJ project. ActionAid activities on Stepping Stones are also expected to start up soon in another Project district, Ile. World Vision is conducting a variety of community-based activities for integrated rural development, including STD/HIV/AIDS. Many of these partnerships are described in more detail under *Section 7* and *Annexes…* as they offer opportunities for building effective, sustainable outreach approaches.

3. Conceptual Framework/Guiding Principles.

This outreach component is guided by certain principles set out by the Project from its inception, respect of which is considered critical to the Project's success. The framework is one of promoting the full enjoyment of sexual and reproductive health and rights of young people, within a positive view of human sexuality, and a desire to reduce risks and problems associated with it. Other important guiding principles include commitments to gender equity, to respect for cultural diversity, and to full citizenship for youth. These principles are amplified below.

3.1 Multi-sectoral Approach.

In keeping with the holistic approach to youth health development, the Project is coordinated and implemented through a multi-sectoral approach to address the health, educational, recreational, cultural and other needs of young people in an integrated manner. This multi-sectoriality is sought at all levels as implementation proceeds, and promises to be easier to achieve at the more decentralized levels. At the Central and Provincial levels, it is reflected in the existing partnerships which the Project aims to render more interactive, rather than simply a series of vertical interactions between a given sector and the Project activities. At community level, it implies that health centres, schools, youth and vocational centres all serve as easy access and referral points for vulnerable youth.

3.2 Youth as Partners and a Decentralized Approach.

Experience in the region and indeed, throughout the world indicates that young people and youth organisations are not obstacles, but invaluable resources for development. The Project aims to ensure its continuous relevance to youth concerns and issues by ensuring their involvement at all stages. Male and female youth experience adolescence very differently and require different, but related, messages and interventions. Hence, project processes will be carried out in such a way as to ensure gender equity in voicing of concerns and shaping appropriately tailored programmes. "Youth as partners" also implies that the Project will foster male-female dialogue.

Only *decentralized* youth programme approaches are compatible with encouraging *real*, rather than token participation of young people in programmes. Maputo is unique as the capital city. And, Quelimane is different from the rest of Zambezia. The districts of Zambezia are linguistically and culturally diverse, with inadequate infrastructure for transport and a large percentage of the population living in poverty. If rural and urban low-income, out-of-school youth are to be incorporated meaningfully into programmes, then the Project must decentralise authority for at least some aspects of planning, design, implementation and evaluation of programs at the district, locality, village and neighbourhood levels. Then, a quota for youth participation (female and male) must be applied in existing coordinating and programming committees or those to be set up.

Various agencies have experimented successfully with *decentralised* youth-driven approaches to appraisals and needs assessments for youth programs. This includes the Narrative Research Method used by the Adolescent Health Programme of WHO, and the Participatory Learning and Action (PLA) used by FOCUS on Young Adults in Cambodia, Zambia, and other settings (See *Section 8. Tools*). Project staff and implementers at district, locality and municipal levels (committees, youth associations…) must be trained in these techniques.

Decentralized approaches also have major implications for coordination and management roles and mechanisms at central and provincial levels. These are discussed in *Section 10.*

3.3 Definitions and Parameters of Sexual and Reproductive Health and Rights.

Health and rights are inseparable. When young people's sexual and reproductive rights are violated, their health suffers. The Project is guided by the definitions of reproductive and sexual health and rights as defined in ICPD Programme of Action. (Annex .) Both the Convention on the Rights of the Child, and the Cairo and Beijing agreements, recognise the primacy of the child's interests and, therefore, young people's right to sexuality education and health services, and to privacy and confidentiality in those programmes." (HERA) They also take a positive approach to sexuality as an integral part of human life, and respect youth by recognising their human right to be sexually active, so long as they cause no harm to others. This includes the right to choose not to be sexually active.

This Project aims to promote programmes that go beyond preventing pregnancy and curing STIs and reproductive tract infections. They will deal with issues integrally related to SRH, with both male and female youth, including:

- respect within sexual relationships, with no coercion or violence
- gender roles, gender equity and power-sharing within family and sexual relationships, and abuses of power, including sexual harassment, and sexual abuse of children
- respect for diversity in sexual practices that do not conform to traditional sexual norms
- any physical or emotional condition that poses an obstacle to a safe and satisfying sex life
- alcohol and drug abuse
- harmful traditional practices as well as positive aspects of traditional practices, such as mentoring by adults other than the parents
- self-esteem and assertiveness, and skills to resist pressures to be sexually active (B. Shephard, 2000)

Finally, the Project takes its cue from Rajani's perception that "**investing in young people's assets and 'protective factors' is far more effective than focusing on young people's myriad problems**. Seeing adolescents as collections of discrete problems leads to fragmented, vertical responses — separate projects on AIDS, drugs, literacy for instance, that fail to see how problems are interrelated and reinforce one another. Problems that are more visible or scandalous tend to garner more attention and resources, while other more important but less sexy areas are neglected. The problem-based approach is antithetical to the crucial lesson that development is the key to enhancing adolescent potentials and achieving positive outcomes.

There is now a considerable body of research that shows that problems have common antecedents, and that *investing in strengthening a common set of protective factors is more likely to both have a deeper, lasting impact and help address multiple problems at the same time."* (Rajani, 2000,1)

3.4 "Sexual and Reproductive Health *Competence*".

Under the UNAIDS Local Response Initiative, the notion of "AIDS *competence*" is coming into currency as a more concrete means of highlighting what individuals, communities, institutions, and development sectors must do to effectively address AIDS. An individual has developed AIDS competence when she/he has done the following:

- accurately assessed the impact of HIV/AIDS on her/his own life;
- accurately assessed the factors that put her/him at risk of HIV infection; and,
- developed and used the necessary skills to reduce those risks and cope with the impact.

This notion of *competence* can similarly be applied to adolescent sexual and reproductive health (SRH), and serve as the reference point for all project interventions. Rajani's focus on *assets* and *protective factors* further enhances this notion.

***Competence* in sexual and reproductive health (SRH)**
A [young] person is "*SRH competent*" when she/he: ➢ accurately assesses his/her personal *assets* and the *impact* of early and unwanted pregnancy, STDs, HIV/AIDS on those assets; ➢ assesses the factors that put her/him at risk of these problems as well as protective factors; and, ➢ acquires and uses the knowledge and skills to reduce his/her risks and strengthen his/her protective factors.

Fostering this *competence* is our aim at individual, community, and sector levels, as well as within the institutional partners of this Project. To develop AIDS or SRH competence, an individual, community, or sector requires a favourable socio-political environment, as well as the availability of and access to a range of services. Hence, the multi-pronged approach of this project entailing services, information and life skills development for youth, as well as community-level advocacy and capacity-building.

3.5 Theoretical Underpinnings and A Model for Implementation of Youth-centred Local Responses.

It is said that *social theory without action is a daydream, and action without social theory is a nightmare*. (Roy Anderson, Durban AIDS Conference 2000) To guide the implementation of this Outreach component, two models or theories are highlighted: 1) the *Theory of Diffusion of Innovations*, and 2) the *UNAIDS Partnership Model for Local Responses.*

3.5.1 ***Theory of Diffusion of Innovations***.

The ultimate aim of the Outreach component will be to scale up successful innovations in rural project areas and amongst hard-to-reach groups that from most standpoints, have been quite isolated and slow to change. The Project decision to work first in and around the cities and district capitals, then along the transport corridors, does not merely rest on a logistical justification, albeit a practical and perhaps sufficient one. It is also based on decades of development experience that highlight the usefulness of the ***Theory of Diffusion of Innovations***.

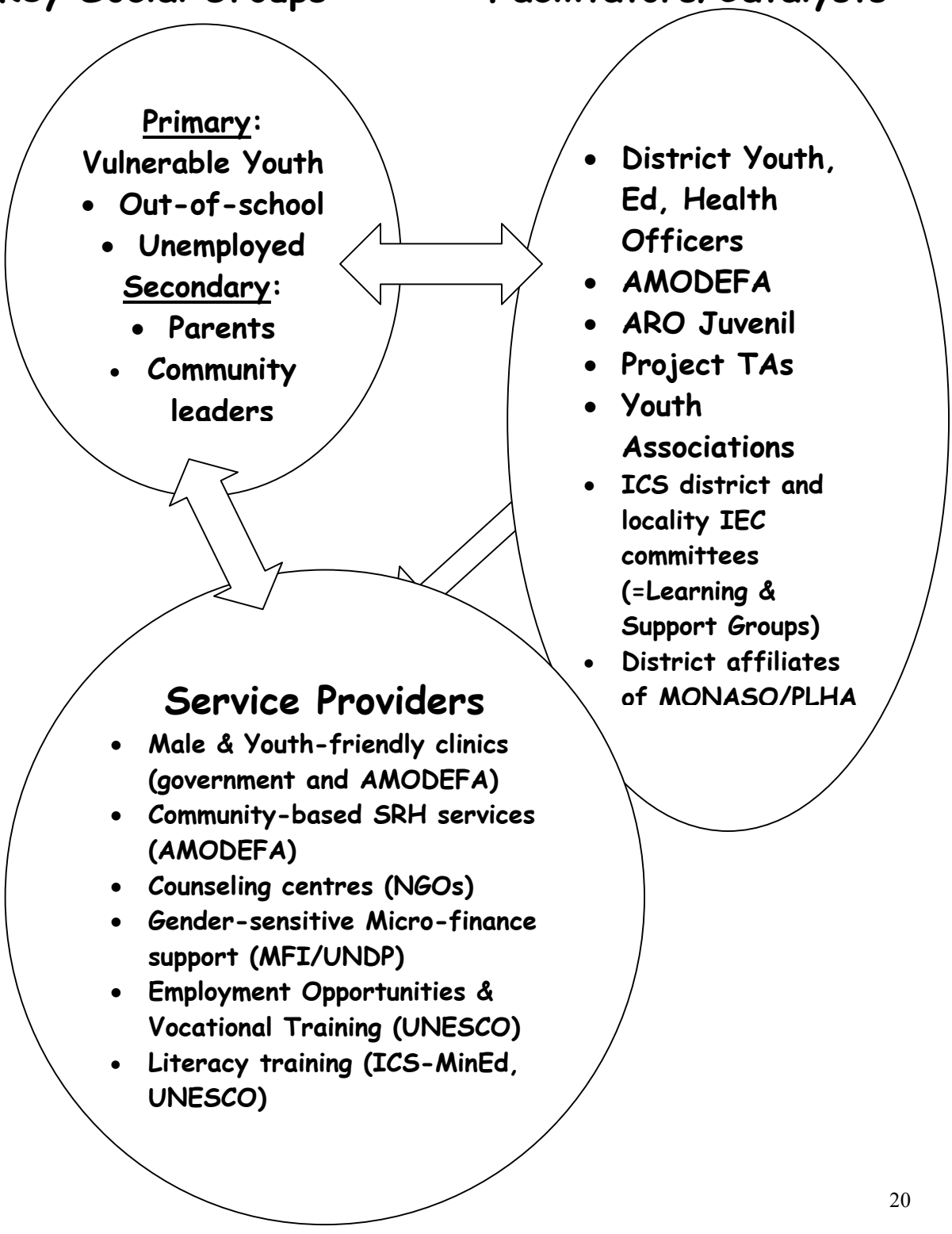
This theory depicts a communication process whereby new ideas, products or behaviours are introduced and supported first among proven innovators, e.g. those who have moved to a city, town or transport corridor, who have attained a certain level of education, who use health services, or who have adopted new technologies. The *innovations*, that is, the ideas, products or behaviours are then diffused - most often through the innovators themselves – to those around them who were undecided. The uptake of the new ideas by the innovators and early adopters has been seen to render change easier amongst others who were either slow (held back by many factors) or resistant to change. Application of this theory to the phasing of the project is further discussed in *Section 9*.

3.4.2 ***UNAIDS Partnership Model for Local Responses*** applies to the partnerships and linkages necessary for sustainable local action on AYSRH issues. The model is *people-driven* and identifies the roles and linkages between *Key Social Groups*, *Service Providers*, and *Facilitators/Catalysts*. Illustrated in *Figure 1*, *key social groups* are the groups whose members have a particularly important role to play in SRH prevention and care activities at the local level. Either they are particularly at risk of SRH problems or they

have been more affected than others – both of which are true in the case of out-of-school, unemployed youth. The concept also assists to break down the out-of-school, unemployed youth into segmented groups of actors/programme participants: adolescent girls and young women are generally more at risk and worse affected by SRH problems than their male cohort, and thus require special attention. Parents and Community Leaders are also *key social groups* in light of the critical role they play in creating a favourable environment for youth development of *SRH competence*.

Also illustrated in *Figure 1*, *Service Providers* are government bodies, NGOs, community-based organizations (CBOs), religious or other groups that provide essential information, resources and services, in this case in the health, social, education and labour/credit sectors.

Figure 1. ***The Partnership Model for Local Responses to SRH Problems among Hard-to-reach Youth in Zambezia Province***



Facilitators/Catalysts are groups or individuals, such as the District Health, Education and Youth Officers or the Locality IEC Committees, who make easier the interaction between the various partners in the local response to ASRH problems. *Facilitators* help Service Providers and Key Social Groups to gain SRH competence through information, training and skill development. And, they facilitate the links between the two, especially moving Key Social Groups toward greater use of Services, and ensuring information exchange, coordination and referrals of youth between the different Services according to their developmental or SRH needs. Facilitators help partners to attract greater resources, as well as to clearly articulate their views and their mandates. In their facilitation of the local responses to youth and adolescent SRH problems under this project, they will be expected to perform the following tasks: *participatory needs assessment and planning, resource mobilization, implementation, monitoring and documenting results and lessons learned, sharing with partners*. Specific facilitator tasks are described under *Section 9.2.*

The aim of these partnerships is not only to achieve synergistic, holistic results, but also to exchange learning to enable scaling up. Hence, the Model also suggests the establishment of multi-sectoral Learning and Support Groups who document and share learning for more effective diffusion of innovations. In Zambezia Province, the appropriate level and composition of these groups might be the District IEC Committees, with regular input from the Locality Committees for IEC/Health/Community Development, depending on the district.

4. *Key Social Groups* and Specific SRH Competency-Based Objectives.

Primary Key Social Groups are those most affected by SRH problems, while Secondary Key Social Groups are those who can influence them or the level of societal/environmental vulnerability.

4.1 Primary Key Social Group: Out-of-School, Hard-to-Reach Youth.

4.1.1 Characteristics.

Different out-of-school youth experience different levels of vulnerability according to how they are affected by the factors – socio-economic, socio-

cultural, etc. – discussed in Section 2. The most important distinguishing variables for segmentation of this very large and certainly not homogeneous social group, are sex, residence in rural versus urban/peri-urban settings, age, sexual activity and marital status. For the sake of assisting Local Response Facilitators with targeting of interventions, basic assumptions are made below. The limitations of this segmentation are discussed at the end of this section.

- First, male and female youth experience adolescence very differently and require different, but related, messages and interventions. They also need to dialogue with each other.
- Rural-urban differences will be critical in terms of short vs. long premarital sexual exposure.
- Most ***girls and boys 10-14 years*** who are out of school can be found with and must be reached through parents/elders (as the main, but not only channel). This will probably be the case relatively more often in rural areas than urban, because of relative access to places where other youth congregate. Girls will be harder to reach than boys because of parents' expectations that they will do domestic work, and that they must not be exposed to risky elements outside the home.

  To influence this group, the facilitators must continuously take cognizance of the need to recruit parents as partners and develop their SRH competence. It is also assumed that girls and boys in this age group are (mostly) unmarried and not yet sexually active. (Most of the cases of sexual activity in this cohort are expected to be between young girls and older boys/men, and be coerced, abusive or forced for exchange of money/goods for the family.) They are assumed to need the information, life skills and counseling to delay their first sexual encounter, and, when they have it, to prevent it from being a risky one.

- Most ***girls and boys 15-19 years*** who are out of school will not as readily be found with parents/elders, but rather must be reached through various community channels. Parents will be relatively less important as partners, and community leaders more important in their influence of the community environment.
  The DHS 1997 indicated that 74% of girls 15-19 years had already had sexual intercourse, with an estimated 10% experiencing their first

pregnancy, and 30% already mothers. DATA ON BOYS?? So, first sexual relations (most of which are unprotected at this stage) are assumed to be closely followed either by pregnancy, STD infection, HIV infection and/or marriage. This Outreach strategy thus assumes sexual activity amongst rural and urban girls and boys from age 15 onward, and the urgent need to make preventive services (contraception, STD, VCT) accessible as early as possible to this cohort. Antenatal care and post-abortion care will be important for pregnant teens/youth, as will special services for teen/young mothers.

The Project also assumes that *in rural areas*, where marriages are early, teens will usually assume adult livelihood responsibilities between the ages of 15-19. It is expected that from age 15 years onward, an ever-increasing number of young people will be married (officially or in common law), living and farming on their own or adjacent to their parents. Addressing married youth of this age will differ considerably from addressing unmarried sexually active girls and boys who are exposed to multiple partners over a longer period of time before they marry. Most of the latter are probably in urban and semi-urban areas.

- Finally, the Project makes some assumptions regarding ***youth 20-24 years***. The DHS 1997 indicated that 98% of girls 20-24 years had already had sexual intercourse, and at least half would already have had at least one child. Data on boys the same age are assumed to be similar. Hence, the Project will assume this cohort to be sexually active, and in the rural areas, mostly married/in union. In the urban areas, most of this group will be starting to marry, though many young women will already have a child.

Transport corridors – a special case?

Assumptions concerning the different cohorts of out-of-school youth who have migrated to the transport corridors must be made on further consultation of the existing studies as well as direct observation of the dynamics in those areas. The Project will effect small studies to obtain these insights, as necessary. Certainly, these youth will have different, more fragile social networks from those in their original rural areas, probably including exchanges with mobile groups such as truck drivers, migrant workers. The effects of community leaders on environmental cohesion would probably be much less, and those of parents, practically nil.

4.1.2 Behavioural Objectives.
Developing *"SRH competency"* in these youth will entail strengthening the following capacities:

- Increasing knowledge about reproductive and sexual health, and prevention of unwanted pregnancy and disease;
- Identifying harmful aspects of traditional gender roles (violence, domination, discrimination) and effective ways for working towards gender equity in relationships;
- Increasing life skills, such as assertiveness, and communications and negotiation skills on sexual and reproductive health issues between parents and children, teachers and students, girlfriends and boyfriends, and partners.
- Talking about sexuality and reproduction. This is taboo in many cultures, but when young people can converse about these topics, they are empowered.
- Increasing decision-making skills, which include moral and situational analysis skills;
- Increasing ability to resist pressures to have unwanted sex, whether from peers or from potential sexual partners;
- Increasing ability to insist on safer sex practice with sexual partners;
- Increasing ability to resist pressures to engage in risky and unhealthy practices, such as drinking alcohol and taking drugs; and,
- Increasing young adults' ability to exercise leadership in programs for their benefit, specifically learning to assess problems, design responses, organise and manage programs, and evaluate them.

4.1.3 Limitations/ Caveats of Segmentation. It is clear that membership in this *key social group* defined as "out-of-school" is cross-cut by membership in other key social groups, such as orphans, youth/children affected by AIDS, substance abusers, and that these multiple vulnerabilities imply other competency-based objectives, mainly related to acquisition of coping skills.

It is also clear that out-of-school youth socialize with in-school youth, younger socialize with older, unemployed socialize with employed youth. So, it is not expected that the Project will always be able to or in many cases, even want to channel interventions exclusively to an isolated group. Rather,

these associations simply present opportunities for more rapid diffusion of innovations.

4.2 Secondary: Other Key Social Groups (Influencing Youth).
Parents and ***community leaders*** play a pivotal role in determining whether a young person grows up in an environment surrounded by protective factors or fraught with risks. (Ref. Annex . The main influences on youth's sexual and reproductive health, either as protective (+) or risk (-) factors)
The Project recognises that the impact of HIV/AIDS on many already struggling Mozambican communities has affected the composition of families. **"Parents"** may not be intact couples, they may not be coping well under the daily strains of families extended by orphans or children affected by AIDS. Hence, their capacities to provide a supportive environment may be compromised, or they may even be directly destabilising the youth's environment, e.g. by pressuring a girl to have sex to bring home money or pulling a boy out of school to work in the fields. This is in addition to the already difficult parent-child communication that characterises most families in societies where talk about sexuality is taboo. **Community leaders**, including administrative, religious, traditional and opinion leaders, may be having difficulty coping and setting a proper course for young people. In urban areas and the transport corridors, this is more likely to be the case.

The Project approach will be to strengthen the capacity of parents and community leaders to *provide adolescents and youth with safe supportive environments.* They will be solicited as partners in the following principle tasks:

- Identifying sources of lack of safety in lives of young adults, and areas in which support is missing.

Some situations — that of street children, displaced children, and AIDS orphans — are extreme cases of lack of the necessary safety and support for youth development.

- Opening up discussion of sexual and reproductive health issues in the social networks of out-of-school youth.
- Finding substitutes for traditional sources of SRH information and various types of support in rural villages — including but not limited to the extended family —which are missing in urban areas.
- Advocating the transformation of norms of masculinity that promote physical violence among young men, and physical and sexual violence against women.

5. Outreach Component Aims and Objectives.

The WHO/UNICEF/UNFPA *Framework for Country Programming for Adolescent Health* suggests that the central aim of a sexual and reproductive health strategy should be young people's development, that is:

- meeting their basic physical, emotional and social needs;
- building their competencies;
- preventing and responding to their SRH and related problems;
- increasing their access to opportunities; and,
- providing them with safe, supportive environments.

In keeping with this aim, the Project will target its Outreach Component in Zambezia and Maputo toward the following aim and objectives.

5.1 Aim: Develop *competence* in Sexual and Reproductive Health, especially STD/HIV/AIDS, at the individual and community level, particularly among hard-to-reach youth and their social networks in Zambezia Province and Maputo.

5.2 Impact Objectives.

This Project's timeframe for attainment of impact on ASRH is harmonized with the three-year duration of the UNFIP Joint UN Project in Zambezia, given that expansion of Project initiatives is made possible through the UNFIP grant.

By the end of 2003, in the areas of project intervention:

- Reduce the incidence of pregnancy among 10-19 year olds.
  Indicator: 15-19 year olds – from _% to _%.
- Reduce the incidence of unsafe abortion among youth 10-24 years.
  Indicator: incidence of hospital admissions associated with abortion complications among youth 10-24 years.
- Reduce the incidence of STDs among adolescents and youth 10-24 years.
  Indicator: from 29% (Maputo) to __%, and from __% to __% in Zambezia.
- Reduce the estimated prevalence of HIV among youth 10-24 years.
  Indicators: from the endpoint of the range for 15-24 year olds - males from 8.97% to __%; females from 16.11% to __%)

5.3 Strategic Objectives and Indicators of the Outreach Component.

The outreach component for hard-to-reach, out-of-school youth will contribute to the attainment of these broader aims by achieving the following key objectives *in the project areas, by the end of 2003:*

5.3.1 To link vulnerable out-of-school youth to youth-friendly, gender-sensitive health and social services, particularly for counseling, contraception, prevention and treatment of STIs, and livelihood improvement.

- Increased number of out-of-school youth 15-24 years (by sex) using RH and VCCT services (where they exist) by 50%.
- Increased proportion of pregnant out-of-school youth 10-24 years making at least 2 ANC visits from __ to __.
- Increased proportion of out-of-school youth 10-24 who use counseling services.
- [Increased] proportion of out-of-school youth using services to improve their livelihood (credit from Micro Finance Initiative, literacy or vocational skills training).

NSP to combat AIDS target:

By the end of 2002, 417,000 young people (in and out-of-school) aged 10-24 years in Maputo and Quelimane Cities will have been reached by the following essential activities: education for RH, treatment of STD and gynaecological problems, counseling and information about health services.

5.3.2 To empower out-of-school youth with life-saving information and skills related to the development and protection of their sexual and reproductive health.

- *50% increase in proportion of out-of-school youth (by sex) aged 10-14 participating in life skill interventions ??*
- *25%* of out-of-school adolescents (by sex) aged 10-14 aged 10-14, able to demonstrate at least two life skills (sexual negotiation and seeking health/counseling services), and with knowledge of HIV/AIDS transmission and prevention;
- 25% of out-of-school adolescents (by sex) aged 15-19, able to demonstrate at least life skills (sexual negotiation and seeking health/counseling services), knowledge of HIV/AIDS transmission and prevention, and safer sexual practices (for sexually active) and maintenance of existing behaviours (for non-sexually active).

NSP to combat AIDS target:
By the end of 2002, 1 million young people (students and out-of-school) will have been reached by the following essential activities: peer education and promotion of condom use.

5.3.3 To create a supportive, cohesive social environment for behavioural development and change among out-of-school youth and their social networks.

- Qualitatively greater openness among key social groups in discussing sexual and reproductive health issues, including STD/HIV/AIDS, and visibility of Project communication materials in project areas.
- 25% increase in number (by sex) of people attending VCCT services (where they exist).
- Number and nature of community-initiated and supported, youth-centred actions, and proportion that are youth-initiated and supported.
- Composition of locality, district and other planning and coordination structures for SRH, incl. HIV/AIDS issues inclusive of out-of-school youth (by sex).
- Number of youth associations, locality and neighborhood committees trained in participatory learning and action, including vulnerability mapping, as well as basic planning and monitoring skills.
- Number of local intersectorial partnerships formed and mobilised.
- **Indicators of change in Gender norms??**

NSP to combat AIDS target:
By the end of 2000, two specialised centres for youth will be functioning in Maputo and Quelimane.

5.3.4 To strengthen the capacities of government, NGOs and other facilitators and service providers to implement decentralised, youth-centred programmes to reach hard-to-reach populations.

- Formulation of clear terms of reference for the Coordination structures, Key Facilitators, Service Providers and linkages amongst them.
- Formulation of clear lines and protocols of referral to and amongst services.

- Number of government and NGOs facilitators trained in participatory learning and action, including vulnerability mapping, as well as basic planning and monitoring skills.
- Number of government and NGOs facilitators trained in building partnerships.
- Number of Learning and Support Groups operating, and number of local initiatives documented and shared.

Reference should be made to the full list of core indicators to be measured during planned monitoring and evaluation (e.g. through Young Adult Survey). *(Section 11)*

6. Project Scope and Coverage.

The project is focussing its efforts on the rural, semi-rural and semi-urban communities of six districts of Zambezia Province, as well as on urban and peri-urban Maputo. In development terms, a *community* is generally defined as a group of people with common interests and networks of personal interaction. Identification of these communities, especially in rural Zambezia, requires considerable and sustained grassroots investigation which will be undertaken as local partnerships are formed and activated. However, for the purposes of this phase of the project, a *community* is the zone of project intervention. A community consists of an area with at least one school (where in-school peer education is/will be established), a health facility (where youth-friendly services are/will be offered), and an identifiable leadership structure (traditional or administrative) through which interventions can be conceived, planned, implemented, coordinated, and monitored.

Within the context of urban Maputo and Zambezia's Provincial capital Quelimane, this **community** can be defined within the limits of a neighborhood (*bairro)* populated by 3000-7000 people or a neighborhood sub-division which can be populated by a more manageable 1000-1500 people, *half of whom are presumed to be between the ages of 10-24 years*. The same applies in the six district capitals in the provincial project zones, which qualify more as semi-urban towns than cities, although the populations and concentration of schools and health facilities is lower. *See Section 2.1 The Demographic Context.*

In the rural areas outside the district capitals, the definition of community becomes problematic due to the lack of agglomeration and the scarcity of schools and health facilities. Hence, the most peripheral target of our interventions in the expansion phase of the project is the *locality*, which is under the administrative post, which in turn is under the district capital. It is at the locality level, for example, that ICS is establishing IEC Committees to catalyse social communication activities in the rural areas.

7. Strategic Framework and Options for Outreach.

The National Strategic Plan for HIV/AIDS notes that only four projects throughout the entire country focus their activities on out-of-school youth: two are ADPP and the Biblical Union. Otherwise, this project supports the work of CIADAJ nationally, and the SRH project in Zambezia. (NSP, p. 18) Without a doubt, this is because of the inherent challenge of implementing community-based interventions in such a way as to achieve coverage and maintain contact with these hard-to-reach groups sufficiently long enough to achieve impact on behaviours and on the social environment that must support them. Indeed, WHO indicates that while "innovation in intervention delivery is a common feature" of these community-based interventions addressing adolescent needs, "coverage is frequently limited and sustainability uncertain". (WHO, p. 257)

Research as well as general consensus indicates that a combination of interventions in multiple settings where risk factors converge is more likely to influence adolescent health. From a sound communication perspective, these interventions must be directed at reducing *the range* of contextual factors that increase adolescent and youth vulnerability, and reinforcing those factors that protect (or could support) healthy youth development and adoption and maintenance of life-saving SRH practices.

The interventions must also be built on the recognition that out-of-school youth are not a homogeneous population for whom a single message-channel approach is appropriate. On the contrary, it must utilize a combination of communication approaches – mass and small media, group and one-to-one interpersonal communication, and be carried out in the different places where these various segments of the out-of-school population congregate.

To enhance the relevance and sustainability of these interventions and the possibility of scaling up, youth involvement and community participation will be at the core of the strategies. People drive the success of interventions at the district/community level. Hence, partnerships will be key. The Project's ability or inability to establish and maintain partnerships will be key to its success or its downfall.

Main Lines of Action for Reaching Out-of-school Youth

Under the three programmatic objectives, strategic elements and lines of approach to out-of-school youth have been identified as follows.

- **Reorienting existing interventions, staff and programme resources to the outreach task.**

- *This includes the design of youth-friendly services. Design factors influence whether or not young people decide to use RH services and if they "reach the door" of a health facility. These characteristics may vary greatly from one setting to the next, and even within one community, youth may have different perceptions about what makes services appealing and accessible to them.* ***It will be essential to expressly include out-of-school youth in the design of/feedback on YFS.***

- *Peer education and counseling programmes in schools,*

> *To gain parental acceptance of girls' participation in youth clubs, groups, centres etc., Malawi BLM is associating these with respected older members of the community. This is particularly critical for the girls 10-14 years for whom parents are still the key gatekeepers.*

- *Where resources are scarce, especially in rural communities, TBAs, extension workers, and village health workers can be trained, but the training must address cultural barriers to providing sexually active unmarried adolescents –especially young women -- with sexual and reproductive health information and services.*

- **Reaching youth where they congregate**

- *In Maputo, Quelimane, and district capitals Discos, markets, periphery of schools and workplaces,*
- *In churches/ church youth groups*
- Where recreational centres have a long history of acceptance in the community, they can begin to offer S&RH information.
- Other venues include sports events and (for young men), gaming rooms, markets, community events, workplaces, etc.

➢ Using livelihood opportunities and credit as an entry point

A pilot programme in Zambia is experimenting with facilitating livelihoods and combining with sexual and reproductive health information and access to services. In Kenya, Population Council is targeting associations of adolescent girls from slum areas with micro-credit opportunities. Repayment results so far are promising.

Experts suggest that to have a sustainable impact, programmes should help young people develop skills and talents that offer them opportunities for economic viability and develop their sense of having a potentially successful adulthood. Such opportunities, combined with reproductive health information and services, can help motivate youth to [prevent unwanted pregnancy] by helping them understand the long-range impact of their decisions and the importance of planning their futures. (RHO)

A Population Council study suggests that parents are more amenable to adolescents using centres for purposes such as library and career services than for recreation.

- **Reconstructing traditional mechanisms of education of adolescents in SRH matters**
  - *Where there is a tradition of having relatives aside from the parents or traditional initiators provide such information, reconstruct this with volunteer trusted adults. The FPA of Kenya is experimenting with this approach in Nyeri, and it has been accepted by this largely Catholic community*

  - Assessments from Malawi and other countries show that as traditional initiation rites are abandoned, there is a vacuum in young people's sexuality education. More young people are receiving information from their peers.

  - Adolescents in Mozambique, and many other places, recommend reviving initiation rites, adapted to modern needs, without genital cutting, and with counselling and referrals to enable adolescents to avoid unwanted pregnancies and disease.

> *Parents are often reluctant to permit their girls to participate in community youth activities, especially those that mix boys and girls. It has proven important to associate respected older people with activities.*

  - *Initiation counselors, traditional advisers*

- **Supporting innovative approaches developed through local initiatives with associated inputs.**

"Stepping Stones" Community Transformation Approach

Action Aid and Save The Children/UK are currently funded by UNICEF to pilot this intergenerational community training approach to combat HIV/AIDS in Zambezia Province. Evidence from the pilot and from other country experiences in the region suggests that as a personal and community development approach, SS strengthens the links between youth and elders, transforms gender relations as it brings men into active participation in SRH concerns, and brings women into greater participation in household and public decision-making. In Zambezia, the health services (and UNFPA TA/RH –Zambezia) have noticed that there is a marked increase in health service use in the areas where Stepping Stones has been implemented. Development workers (and UNFPA TA/DNAJ–Zambezia) note that the techniques are particularly appropriate for low-literate participants, such as out-of-school youth.

As a result of this process, the Project can build on the following resources in Zambezia:

- 6 trainers (3 women, 3 men) of Stepping Stones facilitators in Quelimane City – 2 of whom work directly with the project through ARO Juvenil and the Provincial Directorate of Youth and Sport
- 10 Stepping Stones facilitators in Morrumbala and 5 in Quelimane City
- 80 trained community members per *bairro* of Morrumbala Town (approximately 20 women, 20 men, 20 male youth, 20 female youth) in each of the 12 *bairros*, resulting in 960 community members by mid-2001 – approximately half youth, half parents or community leaders

Opportunities for the ASRH Project: Build on the heightened self-efficacy, motivation, relationship skills and AIDS competence by: requesting trained community members (youth, parents, leaders) to be focal points, a sounding board, designers, mobilizers and monitors for outreach initiatives; Facilitate learning and sharing by these SS groups, especially on approaches to vulnerable youth, by funding small inter-bairro, inter-district forums on community initiatives; link the SS group agendas for community action to the service providers (YFS/youth centres) to be accessed in the project. In particular, these groups could serve as a good reference or even as members of a District Learning and Support Group under the proposed Partnership Model for Local Responses.

Considerations:

- Requires follow-up, supervision, various inputs and/or development of linkages to act on the planned community response to HIV/AIDS. E.g. inputs for rehabilitation or construction of a youth centre, availability and accessibility of YFS, micro-financing, income-generating activities… Hence, the very strong need to build partnerships with all sectors, all development partners.
- Costs are approximately $700-800 per group of 80 community members trained and including a year of follow-up meetings to monitor resultant community actions and sustain group cohesion. (Based on a facilitator payment of US$5/facilitator/session or meeting.)
- Enlisting of the SS group members may raise expectations of incentives. ActionAid feels these are generally modest, and that perhaps participation in inter-district forums to share experiences would be highly appreciated as an incentive. Linking to micro-finance or other opportunities could also be considered, however caution should be exercised not to create divisions in the community.

These lines of approach can be achieved in different ways, with different out-of-school cohorts, and in urban/town versus rural – depending on the programme and local resources and other contextual dimensions operating in the targeted community/district (ref. *Section 2)*. These "different ways" constitute a menu of approaches, some of which are detailed in the boxes in this section, others in Annex . Project Management and the Facilitators, with a given community (including youth), will choose from the menu of approaches based on local assessment of the following factors:

- the local characteristics of the out-of-school youth and their social networks (relative to the identification of key social groups in *Section 4*);
- their strengths and gaps in SRH competency (relative to competencies outlined in *Sections 3 & 4*);
- local analysis of the causes for those gaps (relative to the contexts presented in *Section 2*);
- analysis of the roles and capacities of facilitators and partners they will work with to mobilize action for and among out-of-school youth.

The steps to identify these factors are discussed in the next Section (8).

Outreach Programme objective 1. To link vulnerable out-of-school youth to youth-friendly, gender-sensitive health and social services, particularly for counseling, contraception, prevention and treatment of STIs, and livelihood improvement.

Strategic elements

- Linking teen girls and boys to counseling and education services before they are sexually active.
- Linking sexually active male and female adolescents and youth to male and youth-sensitive STD, contraceptive and VCCT (where available) services.
- Linking pregnant teens to youth-friendly antenatal, STD, and contraceptive services.
- Linking low-literate, low-income youth with literacy, vocational and livelihood skills training.

Strategic Action 1. Reorienting existing interventions and programme resources to the outreach task, focus: quality and coverage.

This will be achieved by:

- reorienting in-school peer educators and counselors to reach out-of-school youth;

- training staff and volunteers in other existing community-based programmes to provide out-of-school youth with SRH information and referrals;
- linking out-of-school youth with in-school programmes by using contexts they are comfortable with – drama and music competitions, traditional dance, soccer – and in places where they can be reached;
- using the media (community radio) based on existing data on listenership of specific programmes by out-of-school youth

8. Implementation Steps

See M.B. and CCS and Ogba

Strategic Issues:

- How to target the 10-14 year cohort out-of-school in rural areas the only that are likely to be uniformly unmarried? Mainly markets and discos – but aren't these in the towns?? With what? By whom? The interlocuter must be acceptable to parents and elders.
- The concerns of the rural 15-19 year old out-of-school will be getting a husband, a wife, a bike, a radio, livelihood, farming.
- How to maximize exposure to the out-of-school youth to facilitate life skills development?

The "How?"

The following steps should be followed by the partnership identified to fill the role of catalyst/facilitator (Gov't – NGO - Youth Association – IEC/Health/Development Committee at the Locality level.

Step One.

1. Set a functional definition of "community" within which it is feasible to work. In an urban area, this could be a *bairro* or a division of a *bairro*. In a rural area, this could be an area within a certain radius of the health centre/clinic or the school or the place where market days are held. It should be sufficiently manageable to allow regular follow-up and monitoring of activities by a core group of two-five people.
2. Identify the key social sub-groups (Who are most vulnerable?) and where they can be found, where do they congregate? If possible, identify key focal points/spokespersons/informants within the groups. Within out-of-school youth, there
3. Menu of options: How to decide on "the how" of reaching youth?

a) Map the "community" in terms of where young people of different categories/ages by sex congregate at different times of the day and on different days of the week? Of those places where is the proportion of out-of-school youth is highest? For each age cohort by sex or other category (e.g. street kids, drug users), map the areas/times/days of greatest SRH risk and see how they overlap with the areas where people gather. Where is there less/no adult supervision? Where do sugar daddies/mamas wait? Where do boys and girls meet to decide to go off together? Where do kids get drugs/abuse drugs? Where are the discos/nightlife areas? To start peer ed - Does the community have secondary or primary schools (EP2) where peer ed is already being done? Are there existing youth associations? Drama groups? Sales agents? Who in the community has the longest sustained contact with the different cohorts? Whose sustained interaction with them, e.g. 10-14 year olds would be acceptable? These are the possible providers of life skills education?

Step Two.

9. Tools for Implementation.

Tools to facilitate implementation of local responses built on the above strategic options consist of training curricula, guides for working with communities and building partnerships, and SRH-related IEC materials for wide dissemination.

9.1 <u>Curricula</u>

Recent research among out-of-school youth in Maputo *(PSI)* underscores their greater vulnerability to unequal gender/power dynamics, relative to in-school youth, and the extreme importance of influencing these dynamics through gender-transformative life skills education. Curricula currently being used in peer education and other related training will be reviewed for relevance to out-of-school youth and the other key social groups who are partners and participants in this outreach component. These and other materials for the Project will respect a life cycle approach to phases in physical, emotional, social, and cognitive development: pre-puberty (under 10), early adolescence (10-14), middle adolescence (15-19), and late adolescence/young adulthood (20-24). (These ages may differ somewhat depending on the cultural and socio-economic context, but the biological determinants of physical and sexual maturation are fairly universal.) Training

materials listed below are resources for improving the existing curricula and, as needed, developing other *appropriate* training, i.e. training that uses interactive, participatory methods; facilitates local analysis of gender dynamics, and challenges gender-based norms with the aim of transforming them; builds life skills such as decision-making assertiveness, negotiation; and, yields follow-up action for personal and community development.

- ✓ **Training of Training Manual for Education and Counseling in Sexual and Reproductive Health and Rights for Adolescents and Youth** (existing Project peer educator curriculum), MISAU, MINED, MCJD, AMODEFA, ARO Juvenil, February 1999.
- ✓ ***Stepping Stones*** Manual (Mozambican adaptation)- ActionAid
- ✓ ***Stepping Stones*** Curriculum for Training Facilitators
- ✓ **My Future My Choice** curriculum for 15-17 year olds, **Namibia**
- ✓ **Gender, Adolescents and Reproductive Health: *Skills-Building Workshop*** *with a special emphasis on Violence, HIV/AIDS and other RH issues* [3-part curriculum], Ipas/Chapel Hill – WHO, June 2000.
- ✓ **Reducing the Risk: *Building Skills to Prevent Pregnancy STD & HIV*,** [endorsed by US Centers for Disease Control], R. Barth, ETR Associates, Santa Cruz, CA, 1989.

9.2 Guides to working with youth and community and building partnerships

The "how to" of working with NGOs, with youth, and with communities, and of building and sustaining effective partnerships at district and local level is not self-evident. But the wheel has been invented by NGOs and others with vast grassroots experience, which has yielded relevant tools to facilitate implementation of this outreach component. For example, "Participatory Learning and Action" has proved a useful tool for involving youth in assessing their situation, their needs, and then participating in design of a SRH programme. (See *Annex* for a full description of such a process in Zambia.) Useful tools include, among others:

- ✓ ***Pathways to Partnership*** Toolkit- Int'l HIV/AIDS Alliance
- ✓ ***Advocates Guide*** – ICASO
- ✓ ***Networking Guide*** - ICASO
- ✓ **Integrating Gender and HIV/AIDS into NGO Activities: *A Guide for NGOs*** (simple gender analysis frameworks) by ActionAid, ACORD & Save The Children

- ✓ Gender analysis frameworks by UNFPA/Moz Gender Mainstreaming Project
- ✓ **Listening to Young Voices*: Facilitating Participatory Appraisals on Reproductive Health with Adolescents: FOCUS Tool Series 1,*** FOCUS on Young Adults, Care International/Zambia, June 1999.
- ✓ **Participatory Learning and Action** [a booklet], PPAZ/GRZ CBD Project, Zambia, 1999.
- ✓ **Using Stories, Drama and Pictures in Group Activities** [a booklet], PPAZ/GRZ CBD Project, Zambia, 1999.
- ✓ **Narrative Research Method** used by WHO Adolescent Health Programme
- ✓ ***Visualization in Participatory Programmes*** (VIPP), UNICEF/Bangladesh.
- ✓ ***Men As Partners*** *(MAP)* guidelines & materials – AVSC/PPASA

9.3 IEC Materials

The Project is very concerned that funds not be wasted on materials that will not be understood by out-of-school youth whose literacy skills are generally minimal. Hence, existing materials whose messages are accurate and epidemiologically and socio-culturally sound, and whose attractiveness and appeal to youth have been substantiated will be tested specifically with the out-of-school youth to ascertain whether they are sufficiently low-literate to suit the majority of the out-of-school population in each project zone. *Print Materials for Low-literate Audiences* by Program for Appropriate Technology for Health (PATH) will provide the guidelines for this testing. Furthermore, if deemed useful, the materials will be translated into the four major languages of Zambezia – Chuabo, Lomwe, Chinhanja or Zena, as appropriate to the project zone. Any new materials will emphasize pictorial presentation – illustrations, photos, and possibly simple diagrams.

To the extent possible, these IEC materials will be used in conjunction with and for the purpose of reinforcing interpersonal communication, e.g. during life skills training, after drama presentations, as a support for youth-to-youth communication… Print materials will also serve as a useful reinforcement of messages conveyed by the Community Radios, particularly in the radio listening groups.

- ✓ **Updated inventory** of quality STD/HIV/AIDS materials for Mozambique, MONASO, 2000: 10 materials retained for use including …flipchart, *Soul City*, *75 Ways to Say I Love You*…

- ✓ ***How to Use a Condom*** leaflet, PSI or National AIDS Council
- ✓ ***ARO News,*** ARO Juvenil (current production is 3000 per number; increased circulation should be provided for to cover project areas)
- ✓ ***Voz Comunitaria*** (ICS)
- ✓ ***"Geraçao Biz"*** materials (print, radio spots, etc) to be produced under Project Communication Strategy. Explicit materials indicating the locations of services (YFS, counseling, vocational training, youth multi-purpose centres, micro-finance, condom depots…) will be critical to optimizing their use. Provisions should be made for regular updating of these materials. *ARO News* and *Voz Comunitaria* (ICS) can help in this.
- ✓ **Films and Videos** from *Africa Film & Video Catalogue*, Media for Development Trust/Harare or local distributor, e.g. *Cartao Amarelo, Mais Tempo…*
- ✓ **Literacy materials** produced through Associations working in the proposed UNESCO Youth Centre in Morrumbala, as well as through the proposed ICS-Ministry of Education Literacy Initiative should be reviewed for gender and influenced to support the ASRH educational efforts.

10. Phasing and Mechanisms for Scaling Up.

The main strategic stages of the *National Strategic Plan to Combat HIV/AIDS* entail provision of quality essential services for priority vulnerable groups, followed by an increase in their social and geographic coverage. To reach out-of-school youth and ensure an impact on their sexual and reproductive health, most strategies will have to entail actions to *improve the quality and increase the coverage* of current interventions. *Quality improvements* will require: (i) taking the context into account better in the content of messages and clearly defining for all actors what those messages are; (ii) increased focus of training on skills; (iii) the focus of communication beyond awareness; and (iv) shifts to more participatory, interactive techniques of communication. *Increased coverage* will mean taking the interventions to new segments of the population – e.g. from in-school to out-of-school youth, from one linguistic group to another, and to new geographic areas, e.g. from Quelimane City to the district capitals and rural areas.
See WHO pp. 169-187

The ultimate aim will be to scale up successful innovations in rural project areas that from most standpoints, have been quite isolated and slow to change. The Project decision to work first in and around the cities and district capitals does not merely rest on a logistical justification, albeit a practical and perhaps sufficient one. It is also based on decades of development experience that highlight the usefulness of the *Theory of Diffusion of Innovations*. In keeping with the theory – described in Section 3.5, development workers in the rural Provinces, it commonly observe that households in the rural areas (especially youth) look with great interest to the trends in their peri-urban district capitals. Those in the district capitals take the lead from those in the more urban Provincial capital, such as Quelimane City. And those in Quelimane are greatly influenced by the innovations in Maputo City. Consequently, it is premised that in the early phases of the Project it was most effective and efficient to introduce innovations such as YFS and in-school peer education in the peri-urban areas the work in the urban and peri-urban areas of Maputo, Quelimane and the district capitals. Innovations will then be channeled to the rural areas through creation of linkages, from innovators to those who look to them for guidance. As new partnerships and linkages are formed, the pathways open to diffuse innovations in the harder-to-reach rural areas.

- Planning for scaling up from the start:
- ✓ Financial resources – Turner funds, MOH to replicate successes in other districts
- ✓ Human resources/partnerships – how and where to scale up will determine whom to involve from the start

  Other Mechanisms
- ✓ Horizontal (cross-district/village) learning/sharing through regular monitoring and purposive communication: – Learning and Support Groups at district and locality levels, visits, regular meetings, use of ICS media channels
- ✓ Adaptable "menu" of approaches to reach out to and create competence in vulnerable youth and *secondary* key social groups
- ✓ Development of modalities for partners to relate to each other and make decisions
- ✓ Regular review and adaptation of TOR for linkages and all key actors
- ✓ Capacity-building in facilitators/catalysts (Gov't, AMODEFA, ICS…)
- ✓ Building and sustaining partnerships with assistance of MONASO et al…

- ✓ Phases and steps - TBD
- ✓ Planning for monitoring (process – inputs,outputs) and evaluation (effectiveness- outcomes, impact) before we start with a focus on learning, documenting, sharing and innovation for more effective and larger scale responses

  BAISAMO TO DESCRIBE APPROACH TAKEN IN START-UP TO ACTIVITIES IN QUELIMANE. THEN AMPLIFY.
  Ongoing process of identifying relevant community-based initiatives that require support to achieve quality and coverage. This will be the task of the Locality Committees.

11. Coordination and Management Mechanisms.

In decentralised approaches, the function of a central office is not to mandate to and manage local levels, but rather to facilitate intersectorial co-operation, and thus provide requested services, technical assistance, and resources to local programmes. A central office can also gather program-wide information for evaluation, raise funds, and serve as the channel for external funding. This decentralisation ideally would include mechanisms for community oversight of the administration of the program at the local level, removing this responsibility from the central level. Such oversight must include youth representatives. The structures to facilitate this oversight and coordination are discussed in 9.1 below. Effective coordination will be ensured by establishing clear terms of reference for each key player in this equation – the Facilitators, Service Providers, and Key Social Groups, as well as the linkages between them.

MARCOS & BAISAMO & RITA – CORRECT AND ADD TO THIS SECTION.

11.1 Structures.

To the extent possible, coordination and management of the outreach component of the AYSRH Project will be assured through existing functional structures. In Maputo city, the City Youth, Health, and Education Directors in the National Committee… -- a municipal committee?

In Quelimane City…

At provincial level in Zambezia, all UNFPA projects are coordinated through a Senior Coordination Committee chaired by the Director of Finance and Development Planning. Members are managers of the Provincial Offices of Health, Education, Youth and Sports, and Women and Social Action, Institute of Social Communication, as well as direct NGO project partners such as AMODEFA, ARO Juvenil and MONASO. The Technical and Management Committee pulls together the technical and programmatic expertise from each sector Youth, Sports and Culture, Health, Education, as well as from the key NGO partners, and the UNFPA Project technical advisers.

At the district as well as the locality level, coordination structures for project outreach activities will vary, depending on which structures have been rendered functional through prior experience in executing multi-sectoral activities. Pending verification at district level, the inter-sectoral District IEC Committees will ensure coordination. Even within a given district, allowance will be made for this coordination capacity to vary among the different localities, as it is said to do in Morrumbala. In that district, some localities structures headed by the president of the locality work most effectively, and in others the traditional leaders (*regulo)* are best asked to take the lead. For the project districts, the following *multi-sectoral* coordination structures are operating or planned to be initiated at district and locality level to address development issues. In the five districts where ICS operates, District IEC Committees have youth members, but they would have to be reoriented. ICS District Programming Committees currently have no youth members, so they would have to be introduced. These could be solicited to take on the Youth Agenda, and their capacity could be built through orientation, joint planning exercises and perhaps visits to other districts and localities.

Mocuba – District IEC Committee and Programming Committee (supported by ICS)
- membership: District Health, Education & Youth officers, and… four Youth Associations - Clube Recrétivo da Escola Secondaria, Clube Recrétivo da Escola da EP2 sede (both to be affiliates of ARO Juvenil), Jovens da Paroquia (church) and OJM - MARCOS, IS THIS AT THE LOCALIDADE LEVEL?

Locality IEC Committee (supported by ICS); Could include World Vision staff;

- ***Gurué*** - District IEC Committee and Programming Committee (supported by ICS*) – membership: District Health, Education & Youth officers, AMME, AMODEFA, Nosso Rosto Youth Association*
  Locality IEC Committee (to be set up and supported by ICS); Could include World Vision staff;

- ***Alta Molocué*** - District IEC Committee and Programming Committee (supported by ICS)
  Locality IEC Committee (to be set up and supported by ICS)
- ***Ile*** – District IEC Committee and Programming Committee (supported by ICS)
  Locality Health Committee (supported by Project Hope)
  Should include ActionAid staff;
- **Milange** – District IEC Committee and Programming Committee (supported by ICS)
  Locality Community Development Committee (CDC) (supported by Christian Council of Mozambique);
- **Morrumbala** – District ???
  Locality Committees chaired by the President of the Locality or Committees set up under the régulo
  (to be explored jointly with Save The Children/UK Provincial Coordinator and UNESCO volunteer)
- **Namacurra** – District ???
  Locality Committees
  (could be explored jointly with World Vision)

11.2 Terms of Reference for Key Facilitators and Service Providers.

At the Central Level:

In the Project Areas:

Specific Facilitator tasks include:

- Coordinate own constituencies to ensure active participation in all phases of project;
- Assist youth, youth associations and communities to mobilize resources, both technical and financial;
- Help youth and communities to use PLA to assess local needs, to map vulnerability to SRH problems and local resources for addressing them;
- Facilitate the referral links among service providers, and between youth/communities and the service providers;
- Help youth and communities to select and adapt appropriate outreach approaches from a menu of possible approaches, based on the needs and resource assessment, and devise feasible ways to carry them out;
- Facilitate testing of IEC support materials and provide ongoing feedback on effectiveness, needs for modification;
- Ensure adequate supplies of IEC materials at all times;
- Develop locally meaningful indicators of progress according to the approaches selected for implementation;
- Establish multi-sectoral District Learning and Support Groups (including youth), linked with locality levels, to facilitate participatory review and analysis of the processes and the results of local initiatives under the Project;
- Help these District Learning and Support Groups to document experiences of local actors;
- Set up regular forums for sharing between actors within districts, between Learning and Support Groups across districts, among provinces, and even between the provincial and national levels.

Integrated Project Senior Coordination Committee will undertake the following:

TA – DNAJ, TA- ICS, TA-

Integrated Project Technical and Management Committee will undertake the following:

TA

- Ensure input from Gender and RH projects.
- Ensure input from and cross-fertilization of other relevant initiatives described in Section . Implementation Options and Annexes, e.g. Action Aid and Save The Children *Stepping Stones* Initiatives could be used as a springboard for community mobilization around SRH problems of out-of-school youth; World Vision's scheduled workshops on Quality Assurance of Health Services in Zambezia could be requested to 1) include project staff and counterparts; and 2) focus on quality of YFS in the project areas as a priority.
- Ensure that organizations providing services (health, social, micro-financing…) have clear, written lines of referral and intake amongst themselves.

ICS Locality Level IEC Committees will undertake the following:

Youth Associations

12. Monitoring and Evaluation.

12.1 **Aims of Monitoring and Evaluation.** The **primary aim of monitoring** is to ensure that the processes of planning and implementing the project in partnership are being carried out as intended, with timely and quality inputs and outputs. The key focus should be to ensure that:

- the key actors are respecting their terms of reference, and making linkages where needed
- needs for capacity-building are identified and met among the facilitators, service providers and the key social groups

The **aim of evaluation** is measure quantitative achievements and to learn what works and how, what is feasible, and what can be scaled up. To adjust approaches to achieve intended results. The focus will be effectiveness – specifically, outcomes and impact of project outreach interventions and partnership processes. The beneficiaries of the

evaluation are the district and locality actors themselves, with the documented findings providing a basis for sharing across districts.

12.2 Participatory Approach. Participatory Program Evaluation *involving program stakeholders in the evaluation process* To achieve the above aims, the Project will support the establishment of District Learning and Support Groups, most times on the basis of the existing structures for coordination and management, e.g. the District IEC Committees. In the UNAIDS Model (Section 3), *Facilitators* will act as intermediaries between local and global learning. They will help people develop meaningful indicators of change, and document and exchange experiences. Lessons learned will be gathered on a quarterly basis from the Locality Committees by the District Learning and Support Groups, who will present them in brief technical notes or case studies during quarterly meetings of the Project Technical Committee at Provincial level. Who is learning and who is best placed to apply at community level? Participatory (and technically guided) development of meaningful indicators of change at local level – focus on learning, documenting, sharing and innovation for more effective and larger scale responses If community members articulate what the necessary/desired changes would look like, they are more likely to achieve them.

12.3 Monitoring and Evaluation Tools.

Tools will reflect what we need to know about the project interventions to gauge progress. The following four domains are the major areas of focus:

a) Youth and Community Involvement.

b) Linkage with Services. The youth registers filled on a daily basis for services delivered in the clinics will reflect the in or out-of-school status of the client. This register already provides essential information on utilization by key social groups, and the nature of the SRH problems experienced. Registers in the counseling for services provided to the

c) Empowerment with SRH Information and Skills. In 2001, A *Young Adult Survey* will be conducted by the National Institute of Statistics under the joint sponsorship of UNFPA, UNICEF and USAID. Zambezia Province will be one of the three provinces sampled. Quelimane, Gurue and Mocuba will be oversampled to represent the urban areas. Maputo

will also be sampled. Data will include knowledge, attitudes, and reported SRH behaviour among 15-24 year olds, and can be sorted by school status.

d) **Community capacity/favourable environment**.

12.4 Indicators.

Indicators mentioned under each strategic line of action will be measured at intervals during the Project in terms of the following

Activity Stage – Indicator Type	**Possible Core Indicators**
Baseline – Pre-intervention, Participatory exploratory research/situation analysis	• Existing attitudes and self-reported behaviours • Existing service utilization data • STD/HIV prevalence in a defined population • Teen pregnancy rate
Process – Training, participation, information distribution, service provision	• Number of people trained • Number of materials [re]produced/distributed • Number of education sessions held • Number of condoms distributed • Number/ % out-of-school youth reached by age • Number of local youth-centred initiatives launched

Intermediate = interaction between Project and out-of-school youth – short-term, post-activity	• Changes in knowledge and attitudes
	  • Number/ % targeted out-of-school youth exposed to/ aware of messages/intervention/ services provided (reach/coverage)
	  • % targeted out-of-school youth correctly comprehending intervention message(s)
	  • Number/% targeted out-of-school who discuss the message with others
	• Changes in social/peer norms
	  • % target group who advocate the key message

Intermediate Outcome (Knowledge/Attitude)	• % targeted out-of-school youth intending to use condoms at first/next intercourse • % targeted out-of-school youth knowing at least one source of SRH information or services • % target group knowing that HIV latency period exceeds five years (or that one can carry and transmit HIV without appearing to be sick) • % targeted out-of-school youth believing that peers [consistently] use condoms

Medium-term Behavioural/Skill Outcome (post-activity)	• Self-reported adoption of positive behaviours:
	  • age at first intercourse
	  • % condom use at first intercourse
	  • % condom use at last intercourse
	  • % abstaining from sex by age
	  • age of first sexual partner
	  • % adolescents who have experienced coercive sex
	  • number of non-regular sexual partners in last year
	• Increased service utilization

Long-term, sustained Impact	• Maintenance of positive self-reported behaviours • Prevented onset of risky self-reported behaviours • Reduced teen pregnancy rate • Changed social/peer norms

Adapted from ESARO/UNICEF Guide – D. Webb

In addition to the above indicators, the Project will assess the level of involvement of youth and effectiveness of local partnerships.

To effectively monitor the involvement of the out-of-school youth in the project interventions, it will be necessary to modify existing clinic registers for adolescents, indicating in vs. out-of-school status (even by a * next to the client number. This will be true for registers in all social and economic services youth are offered or linked under this Project. This will also require orientation of the service providers to prompt them to indicate the out-of-school status of the participant/client.

Under PLA, each community will identify situations they would like to change, and propose a set of actions to enact the change. They will need a set of meaningful indicators to inform them of their progress on youth development over time. These indicators should come from the community or Locality Committee, with guidance from the District Committees who constitute the Learning and Support Groups. They will supplement those the Project has selected for overall monitoring of the Project.

Under *Intensified District Learning/District Response Initiatives to Combat HIV/AIDS* in Tanzania, community leaders suggested some of the following **meaningful indicators** for tracking progress at the ward and village levels:

- Reduction in multiple marriages
- Reduction in STD cases
- Increase in numbers of condoms sold in shops
- Increase in numbers of people going to church
- Increase in availability of educational materials
- Decrease in people staying late in bars…

♦

Under the ActionAid *Stepping Stones* approach, communities have suggested "before-SS" vs. "after-SS" indicators, such as:

- [Young] people go the health centre to find out what is happening to them
- Night gatherings and discos have reduced
- People no longer mind sleeping in the same place with PLWHA…

12.5 Time frame.

See WHO, p. 202-213, FOCUS M&E

13. Resources/Budget Items.

13.1 Human Resources.

The scope of the outreach component is sufficiently broad and will require such continuous monitoring of inputs and outputs as to warrant a full-time coordinator at central level and one at provincial level. At the central level, the need to cross-fertilize and coordinate between the in-school and out-of-school components and link with the service component, in many cases using shared resources and relating to the same stakeholders, makes an overall outreach coordinator a necessity. This coordinator would oversee the broader strategy, while the existing in-school and out-of-school coordinators would focus on the day-to-day operations of their respective components. In Zambezia, the coordinator would oversee all three components under the supervision of the current Project coordinator. This would require frequent travel in the districts to link with District-level Facilitators and Service Providers, especially the Learning and Support Groups. (See Annex . TOR)

13.2 Travel.

Transportation. To function effectively in facilitating, mobilizing and monitoring, district and locality structures will have to be supported for transport, preferably through provision of 2-3 motorcycles per district and 2-3 bicycles per locality in which the project supports local/linked initiatives. Gender-sensitive selection of vehicle models should be respected to ensure equal access to women/girls, e.g. bikes should have bars and heights that suit the average-size woman.

Monitoring trips by Central to Provincial Level, from Provincial to District Level, and from District to Locality Level.

Inter-country study tours. Malawi – local IPPF affiliate, its youth clubs and CBD activities, NYC-sponsored Girl Power Clubs in Lilongwe, Ministry of Youth interactive drama activities by peer educators.
Cross-district study tours.

Periodic Technical Assistance by CST or external consultants.

13.3 Materials.

Training curricula, manuals and IEC materials described under Section 7, especially reproduction of existing or planned materials to increase distribution and coverage.

14. Draft Work Plan 2000-2002.

The existence of a centrally-agreed mandate to cooperate in a determined program model, and the impetus provided by a lead agency with a broad focus, are necessary to get such programs going. But this is only the first step. Without a sufficient plan of action or funding for making the plan function at lower levels, the program will not run.

Annex 1. References.

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Annex2. . Key excerpts from **Diretrizes E Opçoes Para Estratégias De Communicaçao Em Saudé Sexual E Reproductiva Integrada,** May 1999. Focus: amplifications of these recommendations for reference as the "how to?" of these channels is further concretized in the field. *(ref. Pp. 22-23)*

Annex 3. Main influences on youth's sexual and reproductive health, either as protective (+) or risk (-) factors. (Adapted by B. Shephard from draft paper, FOCUS on Young Adults, 2000b, p.16)

Communities & Local Institutions	Schooling and Employment
• + Community support for ARH programs • + Participation in sports, music, drama activities • - Access to media portraying violence, pornography • + Access to media on educational and vocational issues, reproductive health issues • + Mentoring from supportive adults available • + Religious beliefs and practices (except when so rigidly pro-abstinence that sexually active youth are marginalized) • - Breakdown of extended family and village support systems and traditional protective social norms • - Harmful traditional practices • + Institutional infrastructure (youth-friendly service organisations for primary health care, sexual and reproductive health, violence, sexual abuse, counselling, entertainment, etc.) • - Settings of armed conflict, violence, sexual violence, and extreme poverty	• + Access to employment/ vocational training, and other income-generating opportunities (often correlated with urban location) • + Access to primary, secondary and higher education, with no financial barriers for low-income youth • + Literacy, Educational attainment, & Educational aspirations • + School attendance • + Extracurricular activities • + Sexual and reproductive health education in schools • - Discrimination against girls either in schooling or in employment/income/vocational opportunities • - School leaving (including that due to pregnancy/marriage)
Families and households	**Policy Environment**
• + Family structure including more than one supportive adult • + Positive communications with parents (about reproductive health and other concerns) • + Family values educational attainment for both sexes • + Family promotes sexual and reproductive health • - Physical and/or sexual violence within the family	• + Institutional policies that promote sexual and reproductive rights of youth: + making resources available for ARH services + legalisation of contraception for youth +enforcement of laws affecting youth (rape, violence within home, sexual abuse, legal age of marriage) • - Policies that exclude young people from S&RH information, education and services because of age, marital status, gender, or other reasons.
Individual characteristics & behaviours	**Peers and partners**
• + Knowledge about sexual and reproductive health • + Knowledge of and ability to utilise sexual and reproductive health services • + Attitudes & intentions promoting sexual & reproductive health and reducing risks • - Risk-taking behaviour: non-use of condoms, multiple partners, dry sex • + Self-esteem and self-efficacy • + Attitudes favouring gender equity • - Adherence to traditional sexual double standard (multiple partners and domination for men, submission & lack of sexual desire/activity for women) • - Victim of sexual abuse, coercion or rape • - Exchange of sex for money or goods • - Drug and Alcohol Use • - Mental health problems (depression, suicidal tendencies)	• - Peer or partner pressure to engage in sexual activity • + Peer and partner attitudes favouring sexual and reproductive health, & gender equity • + Communication with peers about sexual and reproductive health • - Risk-taking behaviour by peers • - Age differences with partners • + Communications with partners (about reproductive health and other concerns) • - Partner(s) having multiple partners

Annex 4. Definition of Sexual and Reproductive Health and Rights.

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility… and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant .... [Reproductive health] also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." *ICPD Programme of Action, 7.2*

Annex 5. Participatory Learning and Action

Facilitating Participatory Appraisals on Reproductive Health with Adolescents

Participatory learning and action (PLA) is defined as a growing family of methods and approaches that enable local people to analyse, share, and enhance their knowledge of life and its conditions, and to plan, prioritise, act, monitor, and evaluate their behaviour based on this knowledge. The main elements of PLA that differentiate it from traditional needs assessment methods are: facilitation of data collection by outsiders, as opposed to domination of the process; partnership and sharing of information between insiders and outsiders; open questions considered in group interactions; predominantly visual methods (maps, models, and diagrams) to gather data; and comparing rather than measuring.

When applied to appraising the needs of youth, PLA helps young people build positive relationships with one another and with relevant adults through an open, group process. Through the simple qualitative research techniques, program leaders learn from and with young people. By applying the key principles below, practitioners can build a solid foundation for a successful program that actively involves youth and other members of the community. [1]

- **A reversal of learning** so that one can learn directly from the local community;
- **Learning rapidly and progressively**— with flexible use of methods, improvisation, and cross-checking;
- **Offsetting biases** by listening and probing at the pace of the group, not imposing agendas, and seeking out marginalized groups in the community
- **Optimising trade-offs** by not gathering or measuring more than absolutely necessary;
- **Triangulating results** by learning from several methods, disciplines, individuals, groups, locations; and/or types of information;
- **Seeking diversity** by enabling the expression and analysis of complex information and judgements, and looking for exceptions and dissenting views;
- **Handing over the stick** (or pen or chalk) so that local people analyse, present, and generate the outcomes of the information collected;
- **Self-critical awareness**—facilitators need to examine their behaviour and strive to improve, embracing error, correcting dominating behaviour, and noting what is under the surface;
- **Sharing** of ideas, information, and experiences.

Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents is the first in the FOCUS on Young Adults Research and Evaluation Tool Series. This guide provides step-by-step information on designing a participatory appraisal with adolescents to analyse their sexual and reproductive health-related concerns, and on using PLA tools for this analysis. Listening to Young Voices also illustrates a PLA process undertaken by the Partnership for Adolescent Sexual and Reproductive Health (PALS) project of CARE International in Zambia. *(Summary by B. Shephard)*

Annex 6. City and District Profiles: Existing Infrastructure and Resources for Outreach. (may end up being redundant with text…).

See chart done with Baisamo

Annex 7. Menu of Approaches to Outreach for Hard-to-reach Youth 10-24 Years Old: *Some Options*

Programmatic Objectives

- To link vulnerable out-of-school youth to youth-friendly, gender-sensitive health and social services, particularly for contraception, prevention and treatment of STIs, livelihood skills.
- To empower out-of-school youth with life-saving information and skills related to the development and protection of their sexual and reproductive health.

Possible Outreach Approaches to be Initiated by Facilitator/Catalysts to Achieve the Objectives:

Community-Based Communication Networks

- ***Re-orient existing in-school peer educators to reach out to non-school-going youth for the purpose of making referrals, providing information and building life skills.*** AMODEFA indicates that many out-of-school youth spend considerable time "hanging around" the primary and secondary schools where their friends are. In-school peer educators could access these youth on the periphery of school grounds with referrals to counseling centres on school grounds and interpersonal approaches supported by low-literate leaflets or comics or, flyers on locations of YFS. If the school staff were sensitized, a classroom or, if it exists, a counseling centre could be used for various activities These encounters could take place on primary school grounds (which most out-of-school youth would have frequented at least for a few years and would be familiar territory) or better yet in a church or community hall.
  Advantage: Very little additional training necessary.
  Disadvantages: Out-of-school youth are frequently jealous of in-school youth, who, as peer educators, would need to overcome a superior attitude and real differences in popular culture and socio-economic status. Many out-of-school youth do not have the same literacy skills as in school youth. And then, would they find the time to reach out beyond the schools?

Considerations: Need to investigate the extent to which these peer educators currently possess life skills and techniques for developing these in others. Additional training could equip them.

- ***Anti-AIDS Club members as peer educators***. Project Hope has helped to establish these clubs in schools in Ile District. These club members may already be trained as peer educators, and now they could be trained to address out-of-school youth.

- ***"Older" Same-Sex Advisers.***
  - In Malawi, the *Nankungwi* , traditional advisers (female) who perform female initiation ceremonies, have been identified as an essential part of the community-based communication networks that could be useful in reaching younger girls with specific information on risk related to STD/HIV/AIDS, unwanted pregnancy and abortion. Their potential role is to strengthen currently unenforced social norms about abstaining from sexual behaviour before menstruation and initiation, and delaying initiation until *after* onset of menstruation. (In rural Malawian communities, the mean age of first intercourse was nearly the same as age of initiation [13.63 vs. 13.83], whereas the mean age of menstruation was older [14.50].) This change was estimated to result in a one-year delay in first intercourse for 69% of the girls.
  - In Zimbabwe*, Sahwiras* - aunt-like (could be uncle-like) community educators trained like peer educators to link youth with health services, who convey correct SRH information and build a limited range of life skills. Ref. ZNFPC/Rockefeller/Pop Council (see reports) Based on the traditional channels whereby the father's sister and the mother's brother were responsible for the sexual education of the child.

    Advantages: Parents and community leaders trust these change agents with their youth and will permit them to participate in activities. Could build on traditional support systems, contributing to social cohesion needed to develop healthy behaviours. With the *sahwira* approach, one can economize on training cost and time by training in youth approaches an existing community health worker (e.g. CBD or even TBA) or an older community member who has participated in the Stepping Stones Process. They manage well in providing

information, skills, condoms and other contraceptives, and linking youth with services.

Disadvantage: The Malawi *nankungwi* approach would require advocacy with traditional advisers, and training in concepts of transmission and risk that might seem foreign, and might lose in the translation to the young girls. At least initially, this would require close monitoring of messages. Attention would have to be paid to possible incongruencies between these new messages and those the advisers traditionally disseminate. The secrecy surrounding what transpires in these initiation ceremonies might be a barrier, and advisers' fears of potentially being replaced would have to be allayed. The ZNFPC project evaluation indicated that *sahwiras* are less effective than peer educators in assisting youth to personalize their risks of SRH problems, including HIV infection.

Possible Actions to mitigate disadvantages: Re: traditional advisers, use established dialogue with traditional healers and community elders as an entry point. Re: *sahwira* approach, join this approach with a "circle of friends" approach. The interpersonal communication among peers would be expected to strengthen personalization of risk. Provide aunties/uncles with the low-literate checklist materials to aid in self-assessment of risk.

- ***Social Marketing Sales Agents as Peer Educators*** *or at least as links with Health and Social Services.* PSI has trained these agents in all districts in the project areas, and World Vision has augmented this number in Gurué, Mocuba, Morrumbala and Namacurra. These agents could conduits for dissemination of Project IEC materials, and mobilizers for educational-entertainment activities. If provided with specific information about youth-friendly health and social services, and oriented briefly to referral criteria, they could link youth with services. They would need to map their areas of operation to identify where to find vulnerable youth.

- ***Youth Centres with activities and venue that appeal particularly to girls and to younger boys.*** Might require assisting the community with building a modest youth centre to house a library, take-away materials such as Aro Juvenil News, and activities appealing to both girls and boys,

especially 10-19). The link with the health and social services should be clear.

Consideration: **Community participation** in the construction and input into design are crucial for the upkeep of the building, the relevance of the services and ultimately, their use. Wherever vocational schools exist, construction and repairs of this community-owned structure should definitely be one of the practical applications of the trainees' skills – to be negotiated with vocational training school principals. ARO Juvenil has recent experience negotiating with businesses to lend the use of a room/hall on their premises, the purchase of a small number of T-shirts with the business' brand name, the provision of a soccer ball, etc. The business gets publicity and the youth get a place to congregate and modest equipment to use.
In Zimbabwe, youth centres have mostly been used by older boys who do not often frequent the attached health centre; girls and younger males are missed. In Malawi, girls expressed that club/youth centre activities are not appealing to them, and they prefer netball and crafts and….

- ***Radio listening groups***. Community Radio in Mocuba has provided 50+ manually cranked radios to start 50+ groups in that district. Their location needs to be verified. More are planned in Zambezia as new community radios are put up. These groups would be facilitated best by a peer or an auntie/uncle-type outreach worker. In some cases, the animators from the *aldeias*-level committees in the peri-urban areas play this role, but it does not seem uniform. Swaziland has considerable experience with transmission of health messages to and follow-up with such groups (study tour possibility).

- AJOBAF Youth Association to link unemployed youth with **7 vocational training centres** in Maputo, provide SRH information and life skills

- ***Youth-to-youth church activities***. *E.g. The Fish Group in Kenya. Implementation approach:* **Youth Associations** to identify meeting days for youth groups, mothers groups and fathers groups at all **churches** in catchments of youth-friendly services. Youth friendly **health workers** to approach church leaders and parents, peer educators to link youth with YFS.

- ***Circle of Friends approach*** to recruitment and support of youth by satisfied users of youth-friendly services, Zambia.

- ***Stepping Stones Training Programme.*** Action Aid and Save The Children/UK, Zambezia. Strengthens the links between youth and elders through an intergenerational approach. Considered successful in transforming gender relations as it brings men into active participation in SRH concerns. In Zambezia, the health services (and UNFPA TA) have noticed that there is a marked increase in health service use in the areas where Stepping Stones has been implemented. Techniques are particularly appropriate for low-literate participants.
  Consideration: Is there a multiplier effect?

- ***Girl Power Clubs***: The National Youth Council of Malawi is supporting these in the interest of promoting self-awareness, self-esteem, decision-making, assertiveness and negotiation skills, and overall self-efficacy.

- ***My Future is My Choice:*** Using a very interactive curriculum (CST brought it from Namibia on this mission), older teens (17-19 year old) who have left school facilitate extra-curricular sessions on school grounds with younger in-school teens 11-16 years to develop life skills. Values clarification and decision-making skills figure heavily and condoms, SRH, HIV/AIDS are a major content focus. This could be oriented toward out-of-school youth.
  Consideration: Who would be the best facilitators of this sort of programme? Could it be linked with vocational training school attenders?

- ***Theatre groups.*** Currently being used in Zambezia to convey SRH information and to link youth with YFS.
  Consideration: Reports to date indicate that they are not trained to be sufficiently interactive to facilitate personalization of risk, development of life skills, and ultimately behaviour change.

- ***Casa de Cultura*** (where drama and other associations can come to learn drama techniques and other arts, 70% youth) 1 per city, 1 per district in seat.
- ***Drama groups*** trained by Casa de Cultura

- ***Radio drama*** – Empowering with life skills on i) condom negiotiation (7 stages); ii) condoms for STD prevention (strategies - negotiating from contraception standpoint); iii) recognizing STD signs and symptoms; iv) relationships – normalizing male-female friendships without sex

- ***Mobile audiovisual units of ICS*** (w/PYO) – with film projector, video, loudspeaker, 1 mobile unit per province, 1 video cassette player/recorder per district.

- ***Association of Married Youth*** (addressing problems of housing, setting up household, making baby clothes, literacy…)

- ***Mozambican Youth Organization*** (OJM) – political

- ***Renamo Youth Organization*** – political

Existing peer educators should be responsible for canvassing all shop/boutique owners surrounding market places where young people "hang out". Peers could assess the interest of these owners in keeping boxes of condoms and flyers on YFS and "How to Use a Condom"

3.1.1 To create a supportive and cohesive social environment for sustained behavioural development and change among vulnerable youth by fostering "SRH competence", gender-sensitivity and sustainable partnerships among key social groups, service providers, and NGO facilitators/catalysts.

Materials Needs

- A simple checklist for self-assessment of risk for STD, HIV/AIDS, unwanted pregnancy. Must include actions to take to reduce risk, including a visit to the YFS, further counseling, and participation in Geraçao Biz discussion groups (e.g. on alternative Saturdays at x locations).
- Pictorial "How to Use a Condom" brochures – e.g. from PSI, MOH, AIDS Council, MONASO.
-

Annex 8. Possible Study Tours and Literature Reviews to Enhance the Outreach Component

Swaziland:
Malawi:
Zambia:
Zimbabwe:
South Africa:

3.1.2 Key Social Group: Hard-to-Reach Youth 10-24 years

District (M, Q, AM, G, Mi, I, Mo, Mor, N)	Key Potential Channel	Actual or Potential Contribution				
		Linking Youth with Services	Providing Information (& Materials)	Empowering Youth with Life Skills	Facilitating creation of support groups	Providing Contraceptives Condoms
M, Q, AM, G, Mi, I, Mo	Casa de Cultura		✓			PSI – both Social marketing AJ – free condoms
M, Q	Drama groups (Aro Juvenil, PSI)	✓ (in message & feedback from health centres through monthly meetings)	✓			
AM, G, Mi	Other drama groups	✓ (P)	✓ (most need training in key SRH messages)	✓	✓	✓ (P)
M, Q, AM, G, Mi, I, Mo (3 now, 3 later)	Radio drama (community radio)	✓	✓	✓	✓	

Key Social Group: Hard-to-Reach Youth 10-24 years

District (M, Q, AM, G, Mi, I, Mo)	Key Potential Channel	Actual or Potential Contribution			
		Linking Youth with Services	Providing Information (& Materials)	Empowering Youth with Life Skills	Providing Contraceptives/ Condoms
Zambezia Province, M --- M, Q, AM, G, Mi, I, Mo (1 VCR only)	Mobile audiovisual unit of ICS (w/PYO)	✓ (P)	✓ (incl. print)	✓ PYO – may need strengthening	✓
Q (3)	Catholic Youth Association		✓ (P – delaying sexual intercourse)	✓ (P-strategies for delaying, decision-making…)	
Q	Adventist Youth Association		✓ (P)	✓ (P)	
Q	Association of Married Youth	✓ (P)	✓ (P)	✓ (P)	✓ (P-contraception & condom)
Q	Musicians Youth Association	✓ (P)	✓ (P)		✓ (P)
Q (30 total), M (?), AM (~2), G (~2), Mi (~2), I (~2), Mo (~2)	Other Youth Associations	✓ (P)	✓ (P)	✓ (P)	✓ (P)

Key Social Group: Hard-to-Reach Youth 10-24 years

Location/District (M, Q, AM, G, Mi, I, Mo)	Key Potential Channel	Actual or Potential Contribution			
		Linking Youth with Services	Providing Information (& Materials)	Empowering Youth with Life Skills	Providing Contraceptives/ Condoms
Q, M, AM, G, Mi, I, Mo (1 branch per district)	Mozambican Youth Organization (OJM) & drama group	✓ (P)	✓ (already doing drama on HIV/AIDS)	✓ (P -limited)	✓ (P-condoms)
??	Renamo Youth Organization (P)	✓ (P)	✓ (P)	✓ (P-limited)	✓ (P-condoms)
Q (2 sec sch, 1 vocational training, 3 EP2), M, AM, G (some)	In-school peer educators to be re-oriented toward other youth	✓	✓	✓ (limited)	✓
Q, M, AM, G, Mi, I, Mo (1+ per district seat)	Peer educators in boarding student accomodation??? to be re-oriented toward other youth (P)	✓ (P)	✓ (P)	✓ (P)	✓ (P)
	Building simple youth centres (P)				

Key Social Group: Hard-to-Reach Youth 10-24 years

District (M, Q, AM, G, Mi, I, Mo)	Key Channel (Existing or Potential)	Actual or Potential Contribution				
		Linking Youth with Services	Providing Information (& Materials)	Empowering Youth with Life Skills	Providing Contraceptives/ Condoms	
Q, AM, G	Agente de Saude Communautaire (AMODEFA) – ASRH as part of CBRHS	✓ (written referrals)	✓	✓	✓	✓ both
	Elders/"Aunties/ Uncles" Educators (P)					
	Initiation Rites Counselors reoriented (P)					

Annex 9. Detailed TOR for Key Actors (Facilitators and Service Providers).

At Central Level:

DNAJ will undertake the following:

SEA/MISAU will undertake the following:

DSC/MISAU will undertake the following:

MinEd will undertake the following:

AMODEFA will undertake the following:

ARO Juvenil will undertake the following: ??

MONASO will undertake the following: ??

Project Outreach Coordinator will undertake the following:

ICS??

In the Project Areas:

DSCM/MISAU

DEC/MinEd

ICS District IEC Committees will undertake the following:

AMODEFA Provincial Staff will undertake the following:

ARO Juvenil Provincial Staff will undertake the following:

ICS Locality Level IEC Committees will undertake the following:

Youth Associations will undertake the following:

Provincial and District Affiliates of MONASO will undertake the following: