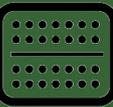




Family Planning and Youth:

Increasing youth access to family planning services using the pair-mentoring approach in the MAHEFA program areas



Madagascar Community-Based Integrated Health Program (CBIHP), locally known as MAHEFA, was a five-year (2011-2016), USAID-funded community health program that took place across six remote regions in north and north-west Madagascar (Menabe, SAVA, DIANA, Sofia, Melaky, and Boeny). The program was implemented by JSI Research & Training Institute, Inc. (JSI), with sub-recipients Transaid and The Manoff Group, and was carried out in close collaboration with the Ministry of Public Health, the Ministry of Water, Sanitation and Hygiene, and the Ministry of Youth and Sport. Over the course of the program, a total of 6,052 community health volunteers (CHVs) were trained, equipped, and supervised to provide basic health services in the areas of maternal, newborn, and child health; family planning and reproductive health, including sexually transmitted infections; water, sanitation, and hygiene; nutrition; and malaria treatment and prevention at the community level. The CHVs were selected by their own communities, supervised by heads of basic health centers, and provided services based on their scope of work as outlined in the National Community Health Policy. Their work and the work of other community actors involved with the MAHEFA program was entirely on a voluntary basis.

This brief is included in a series of fifteen MAHEFA technical briefs that share and highlight selected strategic approaches, innovations, results, and lessons learned from the program. Technical brief topics include *Behavior Change Empowerment, Community Radio Listening Groups, Community Score Card Approach, Chlorhexidine 7.1%/ Misoprostol, Champion Communes Approach, Community Health Volunteer Mobility, Emergency Transport Systems, Malaria, Community Health Volunteer Motivation, Family Planning & Youth, WASH, eBox, Community Health Financing Scheme, Information Systems for Community Health and NGO Capacity Building.*

Background

Access to contraception, reproductive health (RH) information and family planning (FP) services remains a global challenge. It is estimated that 225 million women in developing countries have an unmet need for contraception, meaning women who wish to stop or delay childbearing do not have access to and are unable to use any methods of contraception¹. The unmet need is highest in Africa (23.2 percent), compared with Asia (10.9 percent) and Latin America and the Caribbean (10.4 percent)². Additionally, the highest unmet need is amongst young people aged 10-24. Despite the need for FP services in many countries, RH and FP programs for young people remain limited in scope.

MAHEFA Context

Young people aged 10-24 account for 32 percent of the total population in Madagascar, with 17 percent between the ages of 15 to 24 years. The 2008/2009 Demographic and Health Survey (DHS)³ revealed that among youth aged 15-19, the unmet need for FP is 27 percent, and 26 percent had at least one child. Nearly 40 percent of young women aged 15 to 19 are or have been married compared with 14 percent for young men. For young women 15 to 24 years, over 17 percent had their first sexual intercourse before the age of 15 years.

Family planning has been adopted by the Government of Madagascar (GOM) as an important strategy to reduce maternal mortality. Attitudes and behaviors on family planning have changed significantly between 1992 and 2012 as evidenced by a contraceptive prevalence rate that has increased by 28.2 percent⁴ in the past two decades. Despite progress, contraceptive prevalence remains low among young Malagasy: only 14 percent of sexually active youth aged 15 to 19 years report having ever used a contraceptive method (traditional and modern methods, condoms included). The unmet need for contraception for the 15 to 19 years-old age group and the 20 to 24 year old age group are 25.7 percent and are 15.7 percent respectively⁵. In 2011, The Ministry of Health set up the "CSB youth-friendly" initiative to provide RH and FP services to adolescents and young people. In its 2012 National Policy for Reproductive Health, the GOM announced it would turn 50 percent of its CSBs "youth-friendly CSBs". More recently, the GOM stressed that RH and FP services for youth was an important focus area for the country's public health agenda. It renewed its commitment to the FP2020 initiative by declaring it would increase contraceptive prevalence to 50 percent and reduce the unmet need for family planning to nine percent by the year 2020.

The MAHEFA Approach

In the six remote regions where MAHEFA worked, the situation for youth is even more challenging than in other parts of the country. In 2012, the MAHEFA program conducted a baseline survey which revealed that 64 percent of young women aged 15-24 years have given birth and 46 percent have done so before the age of 19 years⁶. MAHEFA used a mentoring approach between community health volunteers (CHVs) and youth peer educators (YPEs) in selected areas to increase access to and utilization of FP services among young people. MAHEFA worked in 24 districts made up of multiple *communes* (the smallest territorial division as defined for administrative purposes). FP activities targeted youth in the capital *communes* of each district.

1. Source: WHO <http://www.who.int/mediacentre/factsheets/fs351/fr>

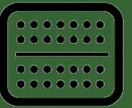
2. Idem

3. Enquête démographique sociale (EDS) 2008-1009

4. Institut National de la Statistique. 2012. «Enquête Nationale sur le suivi des objectifs du millénaire pour le développement à Madagascar, 2012-2013 »

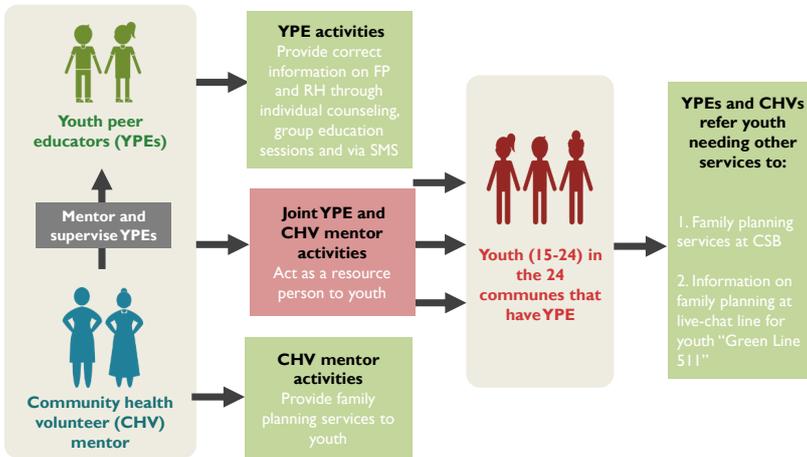
5. Government of Madagascar, Ministry of Public Health, 2012. National Policy for Reproductive Health

6. CBIHP/MAHEFA Baseline, 2012



MAHEFA's youth approach is presented in Figure 1 below. Through the mentor pairs, YPEs and CHVs worked together to provide FP education and services to youth in the target *communes*. YPEs were trained to provide accurate information and refer youth who needed FP services to

Figure 1. MAHEFA “Mentoring” Approach to Increase FP Services and Utilization Among Youth



CHVs or to government health facilities called *Centres de Santé de Base* (CSB). In doing so, YPEs increased demand generation. Youth who were referred to CHVs by YPEs received more in-depth FP counseling and services. This was the first time a mentoring approach like this had been used to promote better access to health information and services for youth in Madagascar.

Key Activities

1. Selected sites to establish YPE activities. After a rapid assessment, MAHEFA implemented the YPE approach in each of the 24 district's capital *communes*. Capital *communes* were chosen because they had youth clubs previously implemented by the Ministry of Youth and Sports and there were higher numbers of unmarried youth in urban *communes*.

2. Identified partners for the YPE activities. MAHEFA implemented the YPE activities in collaboration with multiple public sector partners and two private sector partners. The private sector partners were *Fondation Telma (FT)* and *Serasera Fanantenana Association (SFA)*. Starting in September 2014, FT partially funded the SMS activities for 277 YPEs and SFA managed GreenLine 511, which was a live chat line for youth seeking more information on RH and seeking FP services. The GreenLine activity began in February 2015.

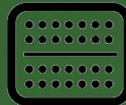
3. Introduced YPE activities for local buy-in. MAHEFA regional teams held workshops to introduce the mentoring approach to local authorities. While there were other YPE activities in MAHEFA regions, the approach of pairing YPEs with CHV mentors was innovative. Therefore, community members wanted an explanation of how the approach would work, what the expected benefits for youth were, and what the roles and responsibilities of all community members would be.

4. Assisted communes in selecting YPEs. During the workshops described above, local leaders, along with the CHVs who were expected to mentor YPEs in their area, identified and selected the YPEs. After being selected, all YPEs were registered in the Regional Youth and Sport Directorate (RYSB). The RYSB served the important role of supporting all YPEs, including the newer ones that were being supported under the MAHEFA mentorship program.

5. Conducted pre-service and refresher trainings for CHV mentors and YPEs. MAHEFA provided a three-day pre-service training to YPEs and CHV mentors. The training taught YPEs and CHVs what skills were required to be a successful YPE/CHV in their communities, the accurate information on family planning and reproductive health, and how to refer youth needing FP services to CHVs and CSBs. The workshop concluded by YPEs and CHVs developing a joint action plan. At the end of the training, each YPE was provided with job-aids and information education communication (IEC) materials to help them in their new roles as peer educators. Beginning in September 2014, the second training provided to YPEs was on short message service (SMS) use to send FP and RH messages to youth who YPEs recruited to be part of their outreach activity. YPEs were also trained to refer their peers for more FP information (through the live chat line) and for FP services from the CHVs or CSBs.

6. Established the referral system between YPEs and CHVs or CSBs. MAHEFA established a referral system between the YPEs and CHVs or CSBs. The YPEs and CHV mentors received trainings and tools to make the referral system between these two actors effective.

7. Supported YPEs to conduct FP activities. As shown in Figure 1, YPEs played three important roles for youth in their communities. They provided accurate information on FP and RH practices, acted as a resource for their peers, and referred youth, as needed, to CHVs. Each YPE was equipped with and trained to use a cell phone for SMS-based work. YPEs received regular SMS messages on FP, RH and other health information from the MAHEFA SMS automated messaging program. They then used their phones to text these SMS messages to their peers. YPEs sent activity reports on a monthly basis to allow the program to record how many youth had received key messages. At least once a quarter, YPEs and CHV mentors conducted joint education FP/RH sessions for an average 15 youth. These sessions took place at either existing



youth centers or other public spaces. YPEs and CHVs used these meetings to increase knowledge and awareness on family planning, reproductive health, early marriage and early pregnancy for their local communities.

8. Supported YPEs and CHV mentors through monthly meetings and monitoring visits. During the monthly meetings at the CSB, all YPEs and CHV mentors discussed their work in the previous month and set targets for the next month. Each YPE and CHV mentor received a quarterly supportive supervision visit from a CSB head or from MAHEFA technical staff.

Results

Since beginning YPE activities in 2013, 884 YPEs were selected by their communities and received training by the MAHEFA program. Of these, 235 or 27 percent left their role as YPE very early on in the activity due to a desire for paid work, to continue schooling, or a lack of interest in continuing in the YPE role. After discussions with CHV mentors and communities, it was decided that the communities would not recruit more YPEs but would work with the remaining 649 until the end of the program. Therefore for the entirety of the program, there were 649 YPEs working in 22 *communes* in the six MAHEFA regions. About half of them were young men and half were young women (49 percent and 51 percent respectively).

All 884 YPEs received pre-service training but only 277 received the additional training on SMS technology. Only YPEs that worked in *communes* that received cellphone service were trained in the SMS services and given a telephone with monthly credits. As with the CHVs, YPEs were required to attend the monthly meeting to discuss work progress, establish targets and submit monthly reports. The average attendance rate for YPE was 70 percent; ranging from a maximum rate of 87 percent to a minimum rate of 15 percent during the exam periods.

As seen in Figure 2, when the YPE activity started to work well, MAHEFA observed substantial increases in the number of youth referred (from 972 in 2014 to 8,152 in 2015). The program ended in early 2016 therefore the data for 2016 is only for two months. Despite this, there was a substantial increase in the number of youth referred for FP services. The figure shows a tremendous potential for increasing utilization among youth using the YPE approach.

Since the beginning of the SMS activity in September 2014, YPEs received and sent 166,190 SMS messages to their peers on family planning, reproductive health, early marriage, gender based violence, early pregnancy, good citizenship behaviors, and economic advancement through education.

In addition to referring their peers for FP services, YPEs also referred them for information and counseling through a live chat line called GreenLine 511. From the February 2015 to February 2016 28,939 youth called the GreenLine 511 for information on the topics presented in Table 1.

Challenges

High YPE turnover. As discussed earlier, many YPEs left after a few months of work to seek paid employment, to continue schooling or to pursue other opportunities. Therefore, early on in the program, the turnover rate for YPEs was high. At 27 percent, the MAHEFA program staff felt that resources were wasted on the initial recruitment processes and multiple pre-service trainings.

Lack of dedicated space for youth activities. YPEs without a work space found it difficult to conduct their outreach activities. While YPE educational sessions can be conducted in any public space, the MAHEFA team found that YPEs in *communes* with a Youth House (provided

Figure 2. Youth Referred by YPEs for FP services with CHVs

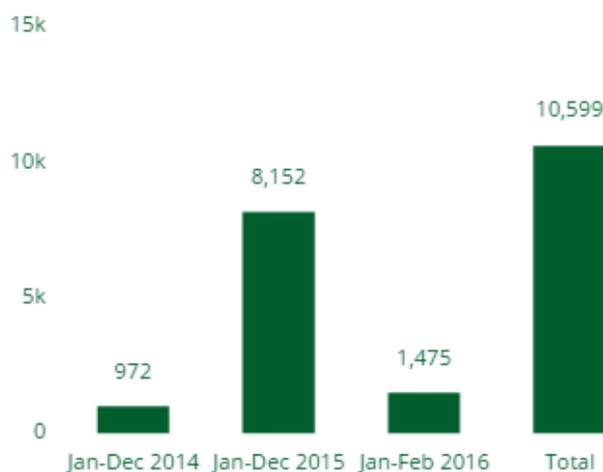
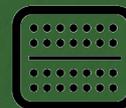


Table 1. Calls to the GreenLine by Youth in MAHEFA Program Regions (February 2015 – February 2016)

| Call topics | Number of calls |
|-----------------------------|-----------------|
| FP/RH | 9,456 |
| STI | 5,255 |
| HIV | 4,793 |
| Substance Abuse | 3,983 |
| Physical Abuse | 2,800 |
| Miscellaneous social issues | 2,106 |
| Total | 28,393 |



by UNFPA or UNICEF) had carried out more often their activities and reached more youth as a result.

Need for improved collaboration with government counterparts. While MAHEFA included the GOM's Regional Youth and Sport Directorate in YPE activities, the program's main government counterpart was with the Ministry of Health. Therefore, these YPE activities have not been transferred to and owned by the Directorate. If it remains as a program under MOH, this may present sustainability challenges after MAHEFA ends.

Need to increase linkages between YPEs and CSBs. YPEs meet on a monthly basis with their CHV mentors and the CSB heads, but the CSB heads have not yet utilized the YPEs to their full potential. YPEs should be engaged to convey other important key health messages to their peers on topics such as malaria, nutrition and WASH.

Lessons Learned and Recommendations

The mentoring approach has shown promising results. It is a good model for sharing accurate information on RH to young people and connecting them with FP services.

Improve the YPE selection process. When the community develops YPE selection criteria, they need to base the criteria on the scope of work of the YPEs. And the scope of work needs to be communicated clearly to the YPE candidates before they apply for the position. At the beginning of the MAHEFA program, there was a misunderstanding with regards to YPEs roles and responsibilities. This may be why many left the program after just a few weeks of work.

Engage CHV mentors as leaders. MAHEFA has observed that successful CHV and YPE pairs require a close and effective working relationship. CHV mentors need to feel comfortable taking on leadership roles. Additional training on mentorship and on-the-job support should be provided to CHV mentors to strengthen their capacity and confidence to mentor YPEs.

Hold regular meetings between YPEs, CHV mentors and CSB staff. Monthly meetings with YPEs and CHV mentors were good forums to improve working relationships, increase technical knowledge, and form a closer link between YPEs and the public health system.

Establish links with existing youth activities or youth clubs. Efforts should be made to expand the mentoring approach to YPEs working outside of externally funded programs. In cases where existing YPEs have a high workload and new YPEs are needed, these new YPEs should be integrated into the existing system.

Collaborate closely with regional and national youth programs. Close collaboration with the GOM's Regional Youth and Sport Directorate can provide extra resources and support for training YPEs and integrating youth activities into the Directorate's annual work plan. This partnership could lead to a reduction in YPE turnover rate, as they would be viewed as important members of the public health system.

Consider ways to monitor impact of YPE activities separately from other community health activities. In MAHEFA's case, it was not possible to distinguish results linked to YPE activities from results linked to broader program activities. Future programs that face similar challenges could address this need by developing tracking tools for CHVs to identify youth referred by YPEs and/or staggering the timing of the YPE approach. Delaying the timing of the YPE approach may also have the benefits of increased knowledge of specific challenges faced by youth in those areas and of working with CHVs mentors who have more experience and have gained confidence in their skills.

FOR MORE INFORMATION, PLEASE CONTACT:

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