

Adolescent

Reproductive Health

in East and Southern Africa

**BUILDING
EXPERIENCE**

Four Case Studies

BEST AVAILABLE COPY

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Best of luck to all of you.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
DANIDA	Danish Development Agency
DISH	Delivery of Improved Services for Health
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IOC	International Olympic Committee
IPPF	International Planned Parenthood Federation
JHU/CCP	Johns Hopkins University/Center for Communication Programs
MCH	Maternal and Child Health
MYSA	Mathare Youth Sports Association
NGO	Non-governmental Organization
NORAD	Norwegian Aid
ODA	Overseas Development Agency
PATH	Program for Appropriate Technology for Health
PPASA	Planned Parenthood Association of South Africa
SHAPE	School HIV-AIDS and Population Education
SMF	Stromme Memorial Fund
SOMARC	Social Marketing for Change
STDs/STIs	Sexually Transmitted Diseases/Infections
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
YIC	Youth Information Centres

This paper highlights four innovative adolescent health initiatives from various countries in Eastern and Southern Africa. All four models strive to change health behaviour, and all have successfully empowered young people, nurtured leadership skills and linked information to services. The programmes described below illustrate important lessons that have emerged within different political and socio-economic contexts. The intention of this paper is to share practical experiences with those interested in supporting or implementing similar initiatives.

CASE DESCRIPTIONS

The Mathare Youth Sports Association (MYSA) was launched in 1987 to promote sports and slum clean-up activities among boys – *and later girls*—living in one of Kenya’s worst slum areas. This small, self-help project has become a highly-successful, uniquely-run programme that also offers reproductive health education and strives to build positive relationships between males and females.

MYSA’s emphasis on youth participation is its most unique and exciting feature: it truly is for the youth, and run by the youth. Founded on principles that were carefully formulated by the youth themselves, the office uses the skills of members to carry out management duties and utilizes a bottom-up structure for decision-making. This programme is also notable as an example of how sports can be used as an entry point to raise sexual and reproductive health issues and promote healthy lifestyles.

“Safer Sex or AIDS: the Choice is in Your Hands” is an AIDS prevention campaign for young people in Uganda that began in May 1995. In a country where HIV prevalence rates are alarmingly high, and where young people lack a sense of empowerment and appropriate information about their sexuality and the consequences of certain behaviours, the Delivery of Improved Services for Health (DISH) project’s media effort addresses myths and misinformation about AIDS. It also encourages young people to be pro-active through its message of hope: that they can protect themselves from HIV/AIDS through responsible decision-making by abstaining from sex before marriage, using condoms, and resisting peer pressure.¹ The scope of this campaign is impressive. It targets in-school and out-of-school youth using a wide variety of mutually-reinforcing mass media and community-level activities.

SUMMARY

Case Study 1
Developing Skills and
Building Self-Esteem:
Outreach Through Sports

Case Study 2
Getting the Right
Information and Making
Responsible Decisions:
Combined Media Effort

1. Lewicky, N., et al. 1996. *Reaching Young People and Fighting Against AIDS in Uganda: The “Hits for Hope” Music contest*, (DISH Project). Paper presented to the International Health Section, 124th American Public Health Association, New York, November 17, 21, 1996.

Case Study 3
Becoming Motivated to
Adopt Healthy
Behaviour: School-
based Education and
Anti-AIDS Clubs.

School HIV/AIDS and Population Education (SHAPE), is an NGO based in Swaziland which trains teachers to teach primary and secondary school students about sexuality, STDs, population and basic life skills. Students are encouraged to form and manage Anti-AIDS Clubs in their schools and selected students are trained to provide peer education. SHAPE's strength lies in placing sexuality into a meaningful, school-based reproductive health curriculum, and in utilizing teachers and peers as important models of responsible behavior.² Launched as a pilot project, SHAPE has been institutionalized into nearly the entire educational system.

Case Study 4
Seeking Appropriate
Sexual and
Reproductive Health
Services.

The Adolescent Reproductive Health (ARH) Project, managed by the Planned Parenthood Association of South Africa (PPASA) is one of the few efforts in Eastern and Southern Africa to provide clinical reproductive health services exclusively for adolescents in a way that is defined by adolescents. The project offers important insight into the elements which appeal to young people (i.e. services that are "youth-friendly") and which motivate them to seek the services they need. This paper focuses on two aspects of the ARH Project: health education and service delivery. PPASA's service delivery centres are run by young professionals (generally one nurse and one educator) and offer contraceptives services, STI treatment, counselling and pregnancy tests for both urban and rural young people in a youth-friendly environment.

DISCUSSION

Experience is the best teacher – it enables us to avoid common mistakes and makes us aware of potential problems. Sharing experiences allows us to benefit from other programmes who have encountered obstacles, experimented with solutions and pulled together the elements required to reach their objectives. By understanding the unique programmes highlighted in this paper, we can identify the following themes and principles for successful programming and become inspired to find creative ways of working together to reach common goals.

A Broad-based Approach to Adolescence

To effect behaviour change, programmes must be linked to a network of services which work together to *develop talents and build self-esteem*; offer information that enables *responsible decision-making*; provide motivation to

2. Birdthistle, I. and Vince-Whitman, C. 1997. *Reproductive Health Programs for Young Adults: School Based Programs*. Washington, DC: FOCUS on Young Adults Program.

take *healthy action*; and provide appropriate *services and support*. To accomplish this range of objectives and to address other reproductive health issues, three of the four programmes have used HIV/AIDS as an entry point.

Programmes must also include an element of empowerment—which can be enriched by recognizing the contributions of adolescents. The programmes all found that incentives and rewards bring out the best in young people and keep them motivated. The programmes established mechanisms to discover what adolescents actually *want* and *like*, and addressed adolescents' most pressing needs first. Above all, young people want skills and knowledge to take control over and feel positive about their lives.

Building Support

Since the support of beneficiaries, communities and decision-makers is critical, each programme found a way to overcome traditional attitudes about adolescent sexuality and to nurture acceptance from stakeholders. Asking key groups, especially beneficiaries, to identify problems and suggest solutions proved to be highly effective in creating a sense of ownership and trust in the project managers and was a great source of ideas. The commitment of project teams was maintained through selective recruitment, training, involvement and support.

Programme Design

The use of management tools is a crucial element in each programme's design. For example, nearly all programmes used research to guide project development and established monitoring mechanisms which allow them to adapt to changing needs and priorities. Beneficiaries and stakeholders contributed to the development of programme strategies that are appropriate and acceptable. Project management is strengthened through supportive policies, a clear delineation of responsibilities, and the formulation of guidelines and standards. All programmes emphasized training to build the skills and confidence of youth volunteers and adult staff members.

Sustainability

Although not easily quantified, a number of factors stand out from these case studies as important for sustainability. Long-term commitment to programmes can be ensured by creating ownership at community, programme and national levels and by building partnerships with other interested agencies. Programmes experimented with charging user fees although none developed a deliberate strategy to recover costs. Several programmes are forward looking and have developed a strategy for sustainability, by starting small and going to scale.

CONCLUSION

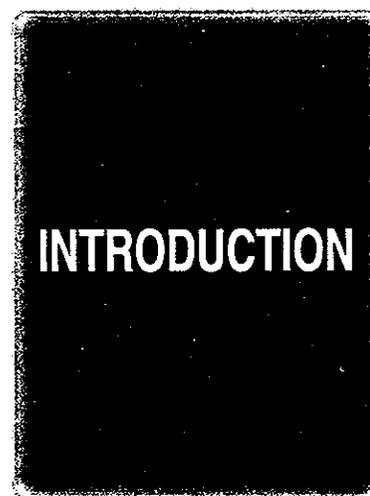
The experience being built in adolescent reproductive health is evident in these four programmes. As we broaden this base of experience, we can begin to establish a dependable frame of reference to measure current and future efforts. We are learning the importance of certain elements such as: involving young people in the management of their own programmes; gaining community support; and developing monitoring systems that allow for adaptability. We also note that there are no golden rules which can be applied to all programmes to guarantee success. We are now challenged to uncover truly unique and effective initiatives and give them the kind of support they need to be sustainable and/or taken to scale.

As countries and communities examine their commitment to reproductive health, they find themselves faced with urgent, and highly sensitive problems such as early and high-risk pregnancy, sexually transmitted diseases including HIV/AIDS, sexual abuse and unsafe abortion. To confront these problems, many countries have begun challenging traditional attitudes and cultural beliefs. In this changing context, attention is beginning to focus on the sexual and reproductive health of adolescents. Schools, parents and clinical providers, for example, are increasingly willing to address young people's needs amidst ignorance about adolescent sexuality and prohibitions against practical attempts to improve their health.

The Health Status of Adolescents

Since addressing the needs of young people is an investment in the future, donors, government ministries and programme planners are devoting more resources to adolescents. Their commitment is extremely crucial in sub-Saharan Africa—a region where adolescent fertility decline has been the lowest and which has the greatest rates of HIV among 15-24 year olds. Based on the sheer number of young women in sub-Saharan Africa, demographers estimate a 23 percent increase in teenage births between 1995 and 2020.³

Although adolescents are generally healthy, they are in a period of increased risk-taking and susceptibility to behavioural problems – which all too often lead to health concerns. Factors such as decreased age of first menarche, increased age at marriage and changing social norms are creating greater potential for non-marital sexual activity.⁴ However, adolescents are not getting the information and services they need to protect themselves. For example, less than six percent of currently married women between ages 15 and 19 use contraceptives. Women under the age of 20 are at greater risk for pregnancy-related complications and are more likely to die from childbirth than women between ages 20 and 35. Adolescents have an increased likelihood of needing care due to the complications of unsafe abortion. Adolescents are also at risk of sexually-transmitted diseases. According to one WHO report, in Kenya, 57 percent of all female STD patients are under the age of 20.⁵ Globally, at least half of those infected with HIV are estimated to be under 25.⁶



3. United States Department of Commerce, Bureau of the Census. 1996. *Trends in Adolescent Fertility and Contraceptive use in the Developing World*. Washington, DC: United States Department of Commerce, Bureau of the Census. pg. v.

4. UNFPA. 1997. *Thematic Evaluation of Adolescent Reproductive Health Programmes*. Evaluation Report Number 13. Summary Report prepared by Judith Senderowitz.

5. World Health Organization (WHO). 1989. *Youth and Sexually Transmitted Diseases: The Health of Youth, Facts for Action (Number 10)*. Geneva: WHO.

6. World Health Organization (WHO). 1989. *The Health of Youth. Background*

Learning from Experience

To bolster this critical commitment, a pause for reflection is invaluable. It is timely *now* to look back on what has been tried, to learn from experience and to be strategic about allocating resources. Ingenious programmes have been initiated as a direct response to need but these efforts are all too often small, isolated, and under-funded, albeit commendable for the risks they take. Most are still in formative stages and have not developed systems for monitoring or assessing their impact. However, much can be learned from those pioneers who have encountered obstacles, experimented with solutions and pulled together the elements required to reach their objectives.

We are beginning to identify factors that are essential to successful adolescent health programming. Several frameworks have been formulated which list essential criteria for programme planning and implementation, including, for example, the World Health Organization's *Guidelines for Improving Services for Adolescents* and AIDSCAP's guidelines on *How to Create an Effective Peer Education Project*. The FOCUS on Young Adults project has developed several documents that provide a framework and define criteria for various programme approaches. The Johns Hopkins University Center for Communication Programs has published a working paper on *Reaching Young People Worldwide: Lessons Learned from Communication Projects, 1986-1995*.

We have learned from research that decisions about sexuality are strongly linked to self-esteem, aspirations and perceptions of opportunities. In order to achieve responsible adulthood, adolescents first need to develop skills in problem-solving and life planning; to have access to information that enables responsible decision-making; to acquire the skills and empowerment to take control of their actions; and to get appropriate services and support. And although many programmes address adolescence from a broad perspective, no single programme *can*, or *should*, address *all* needs of *all* adolescents.

Case Studies for Adolescent Health

Four adolescent health initiatives from Eastern and Southern Africa are highlighted in this paper. They have been selected for their bold and creative attempts to address the needs of young people. Many other innovative programmes exist but criteria considered for the selection of these four include diversity of approaches; level of youth involvement; years of experience; and variation in political support. All four models strive to change health behaviour, and all have successfully empowered young people, nurtured leadership skills and linked information to services. The range of programmes illustrate important lessons that have

emerged within different political and socio-economic contexts. Together, they begin to form patterns, and offer insight into successful programming elements.

This paper features an outreach through sports approach in Kenya; a mass media campaign in Uganda; a school-based education programme in Swaziland; and facility-based service delivery in South Africa. These programmes were selected on the basis of innovation, management structure, community-level involvement, involvement of adolescents, sustainability, maturity and results achieved. The programmes were identified through consultations with individuals and organizations in Eastern and Southern Africa, who were asked to assess the programmes, as well as the criteria they used to measure their success.

Implications for Programme Planning

This document does not necessarily include the *best of the best* – to locate all programmes and evaluate them based on currently-defined criteria would have taken more time and resources than this exercise allowed. Each description provides information on the programme and its objectives; the specific needs and opportunities it responds to; how the programme was initiated and how it is managed; specific activities; and relevant lessons learned. The document concludes with a discussion of the common themes and principles for successful programming – evidence that we are, indeed, gaining experience to address the health needs of adolescents. It is hoped that this paper goes beyond the theoretical definitions of “model” programmes and gives practical, experience-based advice to those interested in supporting or implementing similar initiatives.

There is an urgent need to help young people learn sexual responsibility and to provide them with life skills they can use to choose a positive, healthy lifestyle. This paper is written for those dedicated to young lives.

**DEVELOPING
SKILLS AND
BUILDING
SELF-ESTEEM
OUTREACH THROUGH
SPORTS**

MATHARE YOUTH SPORTS ASSOCIATION - KENYA

The Mathare Youth Sports Association (MYSA) was launched in 1987 to promote sports and slum clean-up activities among boys living in an environment of single-parent homes and transient fathers. In the last ten years, this small, self-help project has become a highly-successful, uniquely-run programme that also offers reproductive health education and girls' sports. MYSA responds to the need for recreation and for environmental cleanliness in the Mathare slum; helps create awareness about AIDS and promotes responsible sexuality; and assists in building positive relationships between males and females. It also gives youth an opportunity to become team players, coaches, health educators and managers in a congested urban setting where the norm is to drop out of school and become pregnant, and where few constructive ways exist for young people to spend their time.

MYSA's emphasis on youth participation is its most unique and exciting aspect: it truly is a program for the youth, run by the youth. Any Mathare youth is eligible to join the Association and there are no age limitations. Founded on principles that were carefully formulated by the youth themselves, the office uses the skills of members to carry out management duties and utilizes a bottom-up structure for decision-making. It prides itself on accountable and

BACKGROUND

Mathare, which consists of ten ghetto villages in Nairobi, is one of the largest and poorest slums in Africa. It is congested with uncollected garbage and waste. Many of the several thousand people who live there are adolescents with little opportunity for social activity or space for recreation. Teenage pregnancy, sexually transmitted infections and sexual abuse are common in an environment where schools, churches and government either ignore or are opposed to sexuality-related programmes. Even if formal institutions were willing to address these issues, many Mathare youth are not in school or employed, and are therefore difficult to reach.

transparent management, and a set of ethics, team pressure and role models that are applied both on the playing field and in the office. Based on the tenet: "You do something for us, we'll do something for you," MYSA builds self-esteem and channels the skills of young people into self-improvement and their community.

Without a solid project design or direction for the future, MYSA has changed the lives of thousands of young people in Kenya. It has successfully demonstrated that, without huge financial investments, young people can become empowered and form a new generation of role models and responsible members of society. MYSA is a notable example of how sports can be used as an entry point to raise sexual and reproductive health issues and promote healthy lifestyles.

MYSA is a notable example of how sports can be used as an entry point to raise sexual and reproductive health issues and promote healthy lifestyles.

PROGRAMME DESIGN

Programme Initiation

MYSA was established by an individual who believes ordinary people living in desperate circumstances are capable of achieving great things — if they are given opportunities that nurture self-respect. It was developed as a direct response to the increasingly desperate living conditions of a large number of youth who had too much leisure time. With financial support from private individuals and NORAD, MYSA was started as a 'non-governmental, non-profit, non-political, self-help project to organize sports and clean-up activities for Mathare's youth.'⁷ It began with a football team comprised of street kids who were unused to discipline and teamwork. Its motto is: "*Giving Youth a Sporting Chance.*"

MYSA's vision is:

*"The youth in Africa are the future leaders of Africa. The youth in the Mathare slums have linked sports and environmental improvement since 1988. If we give more youth 'a sporting chance,' on and off the playing field they can make a major contribution now and later to securing our common future."*⁸

Programme Management

A total of 22 youth run the MYSA office on a rotational basis and are paid either salaries or through educational sponsorships. They carry out management duties, such as bookkeeping and publicity, formulate their own programme priorities, and are in the process of learning to write

7. Githongo, John. 1997. MYSA: A Sporting Chance. *Executive*. March. Nairobi.

8. Summary of the Statement to the UNEP/IOC Conference on Sport, Environment and Development in Lillehammer, 12 February, 1996, no. 2.

proposals and donor reports with assistance from the Population Council. MYSA maintains a basic management principle of accountability and transparency. Staff work hard to maintain detailed records (both game reports and accounts) which are open to scrutiny by other members and the public.

One of MYSA's major strengths is its principle of respect and appreciation for members' contributions, no matter how small. But this respect goes both ways — all members must internalize the code: *you do something for us, we'll do something for you*. Staff and volunteers invest much time in and get a lot of satisfaction from their work. They also know that if they are not serious about their duties, they will be replaced. In addition, MYSA maintains a clear policy on theft; efforts are made to keep the accused out of jail but the accused must decide their own punishment. MYSA's bottom-up, decision-making structure does not allow for adult involvement. This insulates the Association from outside influences and from becoming vulnerable to political maneuvering. All decisions are made by consensus and recorded for any member's reference. MYSA believes that you get better results when you let the members make their own decisions.

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One of MYSA's major strengths is its principle of respect and appreciation for members' contributions, no matter how small.

Adult Contribution

MYSA's initial success was dependent on one highly-motivated and experienced "patron" who helped develop the concept, set up its management systems and establish its principles. Over time, this patron has become less important for daily operations and has taken on a fund-raising role. As a non-voting member of all committees, he listens and advises, but allows youth management to make decisions. A few other adults have been elected to the Executive Council to help with fund-raising.

Resource Development

Over the years, MYSA has developed a broad network of support. Local businesses and friends make contributions, and donate free services and generous discounts. For example, a local accounting firm advises the Executive Council on bookkeeping and audits the accounts annually as an in-kind contribution. Fund-raising has been effective in part due to publicity at major international forums, such as "World Conference on Sport and the Environment" sponsored by UNEP, the International Olympic Committee (IOC) and the Norwegian Government. MYSA receives grants from international funding organizations (including DANIDA, the British High Commission and a number of Norwegian associations). International football heroes publicize the programme by coming to Mathare and leading training clinics for hundreds of girls.

Sustainability

MYSA's largest continuing expense is sports and slum clean-up equipment. Other major expenses include office and first aid supplies, rent, training, printing and salaries.

In order to become a self-sustaining organization, MYSA has developed a five-year plan that calls for buying its own playing fields, a multi-purpose community centre, and at least one garbage truck. Eventually, trained garbage collectors will not only help clean up Mathare, but can hire out the truck to generate income. MYSA also hopes to earn revenue by grooming professional players, by developing a sports career training centre, and by hiring out their expertise to other interested youth groups through a youth leadership training programme. The development plan includes a decentralization process so that eventually there will be a functional MYSA office in each zone to help maintain its local entity.

MYSA members take pride in their responsibilities and carefully portray themselves as models of good conduct to the community.

PROGRAMME ACTIVITIES

Although originally formulated as a boy's football league, MYSA now includes five main components: the boys football league, the girls football league, environmental clean-up, AIDS awareness, and support for education.

Boys Football League

Extremely popular, the boys' programme is growing by at least 1,000 members per year. Age-specific teams are run by local committees of coaches and captains. Most of the league's several hundred volunteer coaches, referees and organizers are 16 years old or younger, and members who actively coach and referee other games are given the opportunity to try out for the All Star Team. Committees are composed entirely of young people elected by their peers. Committee Chairmen makeup the Sports Council and are responsible for all MYSA sports programmes. This bottom-up approach helps to expand the MYSA network and spread information.

MYSA members take pride in their responsibilities and carefully portray themselves as models of good conduct in the community. The teams have adopted eleven basic rules for winning on and off the field. Most of these rules govern sportsmanship although the last rule addresses healthy behaviour more generally: "I will not smoke, drink alcohol or use illegal substances. I will promote environmental awareness and improvement as healthy athletes need a healthy

environment.”⁹ When members violate the rules, disciplinary measures are enforced; for example, players who abuse a referee are suspended from playing until they have refereed 10 games in the younger leagues. However, the need for such rules has decreased as the programme and the players mature.

The MYSA Programme for Girls

The activity began in 1992 with leagues for under-12 and under-14 girls. The main organizer and initiator, a long-time MYSA coach, was also a leader in weekly garbage clean-up projects and a member of the Executive Council. The girls’ leagues were the first in Kenya or Africa for these age groups. By 1994, the girls’ league included 25 teams. Now there are over 2000 girls between ages 12 and 15 playing for MYSA.

The girls’ programme has encouraged positive interaction between boys and girls. Girls under 12 are allowed to play on mixed teams where they participate as equal athletes. Girls have been asked to referee for the boys’ league which has earned them respect for their athletic and leadership abilities. The all-male MYSA leaders, however, have found that organizing the girls’ leagues is much different and more difficult than organizing for boys. A major challenge was changing traditional attitudes toward women and sports. Practical considerations had to be overcome — for example, girls had family responsibilities (e.g., caring for younger siblings, helping with household chores, fetching water, etc.). They also faced a shortage of footballs, basic equipment and appropriate sports clothing.

When the Executive Council analyzed the difficulties in organizing girls’ football, they found parents needed to be convinced of the benefit of developing girls’ leadership and organizational skills; younger siblings needed to be taken care of while girls played ball; and new staff were required to focus on the girls’ programme. Most importantly, new female leaders had to be identified and trained as coaches, referees and organizers so that girls could take over the organization of their own programme.¹⁰

On the basis of lessons learned during its first year of operation, a three-year development plan was prepared and submitted to potential donors. A new partner, the Stromme Memorial Fund (a Norwegian NGO specializing in “help for self-help”), offered technical assistance and NORAD provided funding for the joint proposal to expand the programme.

MYSA leaders, however, have found that organizing the girls’ leagues is much different and more difficult than organizing for boys.

9. MYSA. 1996. MYSA in Brief, Project Report. Nairobi: MYSA.

10. MYSA. 1997. Notes on MYSA Programmes for Girls, Project Report. Nairobi: MYSA.

Community Service/Environment Programme

One of MYSA's key tenets is that sports is linked to health and the environment. Instead of paying a fee to play on the football teams, members participate in regular environmental clean-up projects. Every weekend, between 25 and 30 teams clear the garbage and ditches in their neighbourhoods. Teams can earn points in the league standings for every completed clean-up project.¹¹ Not only does this effort instill a sense of community pride in the youth, it helps build trust in, and appreciation for MYSA and inspires adults to become involved as well. The programme is organized by the community and the MYSA Community Service Council.

AIDS Programme

The programme began in 1994 when MYSA members recognized AIDS as a huge problem in their community. The reality of the HIV pandemic hit home when a well-liked Mathare teen died with AIDS. MYSA members wanted their peers to have the information and protection they needed to keep them from becoming infected with HIV. To create awareness about AIDS, risky sexual behaviour that contributes to STIs and unwanted pregnancy, and other reproductive health issues, a 10-15 minute talk is given to both players and supporters before each game. Players are encouraged to ask questions about AIDS and inquire about where to get condoms and reproductive health services. Every zone has two leaders who offer information about reproductive health, provide a limited level of counselling, instructions on the proper use of condoms, and other information to interested members.

MYSA has also established links with reproductive health service providers in Mathare. For example, the Family Planning Association of Kenya's Youth Welfare, Guidance and Counselling Centre supplies condoms, which are distributed at no charge at the MYSA office. Leaders and health educators can also refer members to other facilities for further counselling and reproductive health services, when necessary.

Over 50 MYSA youth – boys and girls – have also received special training and now lead an HIV/AIDS awareness, prevention and counselling programme for their peers in the Mathare slums. The first MYSA health educators were players from the professional team, selected because as role models, they could encourage responsible sexual activity effectively. Mathare youth are now being recruited as peer educators. While there are no educational or age constraints, parental permission is required before youth can attend training workshops. This is an effort to inform and involve parents, who are themselves often ill-equipped to discuss sexuality with their children.

To create awareness about AIDS, risky sexual behaviour that contributes to STIs and unwanted pregnancy, and other reproductive health issues, a 10-15 minute talk is given to both players and supporters before each game.

11. MYSA. 1996. MYSA in Brief, Project Report. Nairobi: MYSA

Training includes topics on personal growth, drugs, communication skills and group dynamics. Health educators are given a refresher course after six months, at which time they discuss the challenges they face in their new role. Previously-trained educators conduct the training, using a Peer Education curriculum developed by PATH which they have adapted to a level appropriate for these youth. Health materials have been made available by the Kenya NGO Consortium, but are too advanced for the target audience.

Girls and boys use different approaches when conducting health education sessions. Since girls are normally shy about discussing sexuality, interactive discussion is encouraged in small groups of eight or so girls who know each other. Boys tend to lecture to larger groups. However, for both, MYSA's AIDS education stresses abstinence, gender relationships and how to say no to sex. Because the leaders do not want to be perceived as supporting sexual activity, they are hesitant to actively encourage peers to seek contraceptive services.

Educational Opportunities

MYSA developed a Youth Leadership Education Fund, which provides scholarships to top MYSA members to help them stay in school. Contributions go into a pool, which is used to pay scholarships directly to schools. Even youth who are not interested in sports can earn education scholarships by working in the MYSA office. In the future, MYSA wants to strengthen the education component for the girls' programme, in order to keep them in school beyond Standard Eight.

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MYSA members are becoming aware of their role in developing their community and country, and of what it means to be a responsible citizen with a stake in the future. This attitude has become internalized and is being applied to personal health behaviour as well.

INDICATORS OF SUCCESS

Although MYSA keeps very accurate financial and game reports and maintains a roster of members, it has never conducted an evaluation to document its impact on behaviour. Other than anecdote, the best way to gauge its success is through participation statistics. These sheer numbers are impressive – since 1987 over 10,000 youth in the Mathare slums have participated in the programme. In 1995, over 4,500 boys and girls and 300 teams from 50 slum villages and estates participated in the football league and environmental clean-up activities. As MYSA's success is becoming known, members have been asked to help establish programmes in South Africa, Namibia, Zambia, Eritrea and Zimbabwe.

MYSA members claim that they have become more conscious of the health hazards that surround them and are empowered by their active participation in neighbourhood improvement. MYSA members are

becoming aware of their role in developing their community and country, and of what it means to be a responsible citizen with a stake in the future. This attitude has become internalized and is being applied to personal health behaviour as well.

Athletic Achievements

Mathare won its first national championship in 1988 and has usually been placed first or second in Kenyan youth tournaments since then. In 1992, it won the Youth Football Games sponsored by Pele during the Earth Summit in Rio de Janeiro in Brazil. Since 1990, teams have qualified for the final rounds in the Norway Cup, the world's largest youth tournament with 1,200 teams from 30 countries. In 1995, the under-12 years team won the Norway Cup. In Kenya's national Premier League and Super Leagues One and Two, there are about 200 MYSA members.¹²

Environmental Achievements

MYSA received the UNEP Global 500 award for environmental innovation and achievement during the 1992 Earth Summit in Brazil. UNEP's Executive Director described MYSA's programmes as being:

*"Unique and innovative. It is already the largest youth sports group in Africa organized by and for the kids themselves...Kenya can be proud that some of their poorest youth have demonstrated that anyone and everyone can help improve the environment."*¹³

Health Achievements

The AIDS awareness programme has trained over 75 leaders (including 25 girls) who have reached over 10,000 youth. Testimony from health educators points to a huge demand for reproductive health information, condoms and referrals. Members claim they have noticed a drastic decrease in the number of team members who have dropped out because of pregnancy.

Educational Achievements

Many more MYSA members are in school now because 1) they feel motivated by their peers, and 2) they can afford school fees through programme scholarships. Of the 26 members of MYSA's top team, five are in school, 15 recently graduated from high school, one is at university, and another is a college graduate.¹⁴

The AIDS awareness programme has trained over 75 leaders (including 25 girls) who have reached over 10,000 youth.

12. Githongo, John. 1997. MYSA: A Sporting Chance. *Executive*, March. Nairobi, pg 32.

13. *Ibid.* pg 32.

MYSA has created new heroes for its members who come from single parent households and lack positive male role models.

LESSONS LEARNED

Youth Involvement

One of the keys to MYSA's success is that it treats the skills and ideas of youth as its strongest resource. The programme is organized and run by youth with an average age of 16 years. A few key adults have helped MYSA set up systems, and worked closely with MYSA leaders to transfer the skills and knowledge required to manage the programme. Now, all decisions are made by elected youth leaders. This leadership is now perpetuated through peer-to-peer and on-the-job training.

MYSA's clearly-defined responsibilities and codes of behaviour have encouraged responsible behaviour on the playing field, in the office, and also in the larger community. Its fair but strict disciplinary action has set boundaries for MYSA members. Over time, members have come to pride themselves on this code of behaviour and the need for discipline has diminished. MYSA's commitment to recognizing contributions has also kept its members motivated. This effective incentive scheme is based on rewards suggested by members. These rewards are not expensive; for example, certificates are given when training is completed, donated sports gear is given to contributing members.

Project Management

The principle of learning by doing has made this programme vital. MYSA was not established according to a project document with a set of goals, or bound by limited funds; instead, it emphasizes unlimited learning experiences, adaptation and is responsive to local needs. However, as it has grown, MYSA has established a set of management principles to ensure good governance and accountability. All meetings, records and accounts are open to members and the public. All meetings start with the approval of expenditure since the previous meeting, and the accounts are audited annually.

Role models

MYSA has created new heroes for its members who come from single parent households and lack positive male role models. Girls are given an opportunity to become leaders and have gained respect from their male peers. Younger players are now more likely to stay in school and to adopt healthy behaviours because the older MYSA players and leaders do. Scholarships have been effective incentives for top MYSA leaders to stay in school. Indeed, some of these leaders have gone on to university.

**DELIVERY OF IMPROVED SERVICES
FOR HEALTH
INFORMATION CAMPAIGN FOR
YOUTH — UGANDA**

“Safer Sex or AIDS: the Choice is in Your Hands” is an AIDS prevention campaign for young men and women in Uganda that began in May 1995. In a country where HIV prevalence rates are alarmingly high, and where young people lack a sense of empowerment and appropriate information about their sexuality and the consequences of certain behaviours, the Delivery of Improved Services for Health (DISH) Project’s media effort addresses myths and misinformation about AIDS. It also encourages young people to be pro-active through its message of hope: young people can protect themselves from HIV/AIDS through responsible decision-making by abstaining from sex before marriage, using condoms, and resisting peer pressure.¹⁵

**GETTING
CORRECT
INFORMATION
AND MAKING
RESPONSIBLE
DECISIONS**

**COMBINED MEDIA
EFFORT**

BACKGROUND

According to a baseline survey conducted prior to the project, 62% of boys and 38% of girls were sexually active. Mean age at first encounter was 15 years for females and 14 years for males. Most of the sexually-active respondents (56%) had had more than one partner.¹⁶ When asked why they engaged in high-risk sexual behavior, they cited peer pressure.¹⁷ The study also found that AIDS awareness existed, but much of the information respondents had was inaccurate and/or did not always lead to a change in behavior. Most of those who were sexually-active (70%) said they had discussed HIV/AIDS with their partners before having sex, and nearly half used a condom during their last sexual encounter. Those who did not said they believed their partner was not infected (38%) or that they did not know about condoms (37%). Of those who used a condom, most (87%) did so to protect themselves against AIDS.

15. Lewicky, N., et al., DISH Project. 1995. Action Plan, HIV/AIDS Prevention Campaign. Kampala: DISH Project.

16. Lewicky, N. Lettenmaier, C., Sengendo J., Gamurorwa, A. and Roberts P. 1996. *Reaching Young People and Fighting Against AIDS in Uganda: The “Hits for Hope” Music Contest*, (DISH Project). Paper presented to the International Health Section, 124th American Public Health Association, New York, November 17-21, 1996.

17. Leewicky, N. and Wheeler M. 1996. *HIV/AIDS and Adolescents: Key Findings from the Youth HIV/AIDS Baseline Survey in Seven Districts of Uganda*. DISH

The scope of this campaign is impressive. It targets in-school and out-of-school youth using a wide variety of mutually-reinforcing mass media and community-level activities. National activities, such as the *Hits for Hope* music contest and a weekly radio programme, have created widespread awareness and opportunities for more customized, community efforts. Initiatives arising from the community, such as school anti-AIDS clubs, are relatively low cost and benefit from the support of important stakeholders. Although the hugely-publicized national activities are not sustainable on an on-going basis, the programme has garnered valuable experience in building capacity and ownership at district health management and community levels. The programme now faces a serious challenge: it has successfully created a demand for services that communities do not have the capacity to meet.

PROGRAMME DESIGN

Although traditionally conservative when discussing sexuality, Ugandan youth, like youth anywhere, respond to entertainment and other types of popular culture. Therefore the DISH Project chose this medium to address the AIDS problem in Uganda. The DISH Project is supported jointly by USAID and the Uganda Ministry of Health. Pathfinder International is the prime contractor; other subcontractors include INTRAH (training), E. Petrick & Associates (health financing), and JHU/CCP (IEC). The "safer sex or AIDS" campaign is part of a five-year communication strategy.

Communication Strategy Development

The overall communication strategy was developed at a meeting with District Health Educators, representatives from the Health Education Division of the Ministry of Health, various NGOs, and DISH staff. The campaign message and media strategy were based on research findings from the project sites. Elements of the strategy include:

- ◆ **Primary audience:** 15-19 year old boys residing in the DISH Project districts who are unmarried; have at least a Primary Five education; believe they cannot control whether or not they become infected; and are concerned about proving their manhood. The campaign focused on boys because the baseline research indicated that boys have more control over condom use and sexual relationships than girls do. It is also believed

The campaign focused on boys because the baseline research indicated that boys have more control over condom use and sexual relationships than girls.

that boys who adopt safer sex practices during their teens will continue the practices into their adult years.

- ◆ **Secondary audience:** 15-19 year old girls in the DISH Project districts who are potential sexual partners of the primary audience.
- ◆ **Communication objective:** To increase the number of people in the target audiences who consistently practice safer sex, including: delaying first sex, reducing the number of sexual partners, engaging in non-penetrative sex, and using condoms.
- ◆ **Key promise:** You can avoid becoming HIV positive if you practice safer sex.

The message itself must be positive: give the audience hope! By emphasizing that AIDS can be prevented, youth feel empowered to exercise control.

Principles of the Mass Media Campaign

The DISH Project team developed the programme based on the following principles:

- ◆ The best way to capture young people's attention is through entertainment and social activities that are informative and fun.
- ◆ Youth are particularly interested in, and influenced by, popular culture.
- ◆ Music is a powerful medium. People of all ages and environments respond to music, especially when it is locally produced.
- ◆ Radio meets a large demand for information and is a good vehicle for stimulating debate and discussion on sensitive issues. Combining information and entertainment in a programme's format is highly effective and allows for discussion of many topics.
- ◆ Young people tend to be uncomfortable discussing sexuality. Positive role models can show them that sexuality is something they can talk about.
- ◆ The message itself must be positive: **give the audience hope!** By emphasizing that AIDS can be prevented, youth feel empowered to exercise control.

PROGRAMME ACTIVITIES

The programme has two levels: a national campaign, and district-level activities that build on the campaign and focuses on local situations.

National Campaign

The communication strategy takes a multi-media approach using various channels to get the message out. TV is a very powerful medium but only reaches a very small proportion of youth — predominantly in urban areas. Therefore, radio and print materials were selected as the main media channels for the campaign. Radio spots and jingles were broadcast on both Radio Uganda and FM stations. Radio Uganda was selected to broadcast the weekly programmes as it is the most popular radio station for the target population and because it is the only station which broadcasts completely vernacular programmes.¹⁸ The DISH Project provided orientation to Radio Uganda staff to help ensure quality broadcasting.

A step-by-step procedure was followed to ensure that all activities were appropriate for the intended audiences, and that project effectiveness was monitored.¹⁹ All media materials were pretested before implementation to make sure products were appealing, appropriate and understood. A local advertising agency was contracted to design mass media and print materials with technical input from DISH Project IEC staff.

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Elements of the campaign include:²⁰

- ◆ **Radio spots and jingles:** Three 30-second radio spots and one 30-second jingle with messages on abstinence, avoiding peer pressure and condoms use were broadcast on three radio stations in English and four vernacular languages during prime listening times for youth.
- ◆ **Radio programme:** A recurring, 30-minute radio programme called *Straight Talk* was broadcast on Radio Uganda in English and two vernacular languages. Hosted by a young, lively DJ, the programme includes popular music, quizzes, letters from listeners,

18. DISH Project. 1995. Action Plan. HIV/AIDS Prevention Campaign. Kampala: DISH Project.

19. John Hopkins University Center for Communication Programs (JHU/CCP). 1995. Reaching Young People Worldwide: Lessons Learned from Communication Projects, 1986-1995. Working Paper Number 2, October, 1995. Baltimore, MD: JHU/CCP.

20. DISH Project. 1995. Action Plan. HIV/AIDS Prevention Campaign. Kampala:

stories and interviews with youth from the districts, and a ten-minute serial drama about a group of adolescent boys growing up in Uganda.

- ◆ **Straight Talk:** Two special issues of *Straight Talk*, a newspaper insert for Ugandan youth, were produced in English and three vernacular languages. They used photographs, articles, testimonies, letters and cartoons to encourage youth to practice safer sex. The inserts were distributed nationwide in three daily newspapers, as a newsletter during the campaign events and also through mass mailings to all secondary schools and youth groups in the project districts.

In these contests, more than 500 amateur musicians entered original songs about HIV/AIDS based on the DISH Project campaign messages.

- ◆ **“Hits for Hope” song competition:** In partnership with Kenya’s Group Africa Road Show, a commercial promoter, the DISH Project sponsored two *Hits for Hope* music contests for youth. In these contests, more than 500 amateur musicians entered original songs about HIV/AIDS based on the DISH Project campaign messages. The concerts attracted between 2,000 and 8,000 community members in each district. District finalists competed in a traveling road show in which young judges and audiences chose winners to receive cash prizes and enter the national competition. The song by House Lane B called *Ray of Hope* was chosen as the winner of the first contest and adopted as the campaign’s theme song. This song and seven others were professionally recorded for distribution on a *Hits for Hope* cassette. House Lane B has toured various districts and used peer education, radio and television appearances to spread the campaign messages.

These contests were significant and multi-faceted. Youth heard the campaign messages during publicity for the events, auditions, concerts (average attendance: more than 10,000 participants), and follow-up activities organized by the project which included discos, schools visits and district-level activities.

- ◆ **Poster:** A poster that challenged youth to “wait” or “use condoms” to avoid HIV/AIDS was produced in English and three vernacular languages and distributed to schools, youth centres, and other public places.

- ◆ **More Time Video translation:** The project translated and dubbed the video *More Time*, a drama about responsible sex and HIV prevention, into two vernacular languages. These videos were played during district video tours.
- ◆ **Matter of Fact Quizzes:** Quizzes were conducted about HIV/AIDS, STIs, pregnancy prevention, and safer sex for youth during Group Africa Road Shows in May/June and September/October 1996 and again in May/June 1997. During the quiz events, prizes (e.g., radio cassettes, Hits for Hope tapes, and Straight Talk T-shirts) were awarded to contestants who correctly answered the questions. During the quiz slots on the road show in 1996, winners of the Hits for Hope contests performed their winning songs live (lip synching to the professionally produced tape); Hits for Hope tapes were made available for sale, as well as Straight Talk T-shirts that advertised the radio programmes; and Straight Talk newsletters were distributed to the audiences.

District IEC Action Committees (comprised of representatives from District Government and non-governmental organizations) were created to plan, organize, implement and monitor complementary and reinforcing activities at the local level.

District Level Activities

District Health Educators and DISH Project staff formed District IEC Action Committees (comprised of representatives from District Government and non-governmental organizations) were created to plan, organize, implement and monitor complementary and reinforcing activities at the local level. These District Health Management Teams were given their own budgets to carry out their work plans and were trained by headquarter staff in information campaign development processes (ways, methods and skills). The District Health Educator served as chairperson of each Action Committee, and was responsible for disbursing funds and submitting reports of activities and expenditures on a quarterly basis. Members of DISH Project headquarters staff made monthly monitoring visits to each action committee offering ideas and advice, to collect reports and to listen to concerns and requests.

Community-level activities included:

- ◆ **Sensitization meetings** with community and religious leaders, youth leaders and youth discussion groups.
- ◆ **Drama contests and tours:** A number of drama contests were held and three separate drama groups toured communities and schools. For example, in one district, a school drama entitled "The Lifesaver" was performed for more than 4,000 secondary

school students and drew such high praise from district officials that the script was translated into Luganda and distributed to primary schools.

- ◆ ***Bicycle rallies:*** Bicycle rallies to promote the “safer sex” message were particularly popular. Contestants were drawn from “boda bodas,” the young men who use their bicycles as taxis. In one district, over 15,000 people attended the local bicycle rally co-sponsored by Coca-Cola.
- ◆ ***Rap Music Contest*** in one district.
- ◆ Formation of ***School Anti-AIDS Clubs*** in one district.

Among those who reported being sexually active during the evaluation, there were increases in the proportion who said they had used condoms at last sex, and who knew where to get condoms.

INDICATORS OF SUCCESS

The first phase of the campaign was evaluated at the end of 1996. Results showed that more than 90 percent of youth interviewed had been exposed to at least one of the campaign media; most had been exposed to four. Since the baseline study had been conducted no change was seen in the proportion of youth who reported being sexually active from 1995 to 1996. There was an overall improvement in positive attitudes toward safer sex, and the respondents’ perception that they were capable of avoiding HIV/AIDS.

Among those who reported being sexually active during the evaluation, there were increases in the proportion who said they had used condoms at last sex, and who knew where to get condoms. Respondents seemed more willing to participate in the study and discuss sexuality — possibly indicating greater openness about the topic, a first step in behaviour change. Most of the young people wanted to continue their discussions and many asked the evaluators to return at a later date. More respondents requested condoms and many schools asked that a supply of condoms be left behind for later distribution.

LESSONS LEARNED

Developing A Communication Strategy

The development of a communication strategy was valuable for keeping the messages consistent and focused which helps audiences internalize

Positive behaviour changes — such as condom use, abstinence and talking with one's partner — can be initiated through a communication campaign even before health and other support services are in place.

the information. Internationalization takes a long time and requires constant reinforcement, drilling and the use of multiple approaches. Additionally, mixing media expands the reach and increases the repetition of messages. One reason this campaign was successful is because it reached almost everyone in the intended audience more than one time through different channels. This was achieved by disseminating the same message through several media. The communication strategy included mechanisms for involving the audience and for ensuring that the messages delivered were of high quality. District level music contests encouraged community involvement and created new local heroes. Not only were award winners effective national crusaders for responsible sexuality, as in the case of House Lane B, they earned new respect for the talents and ideas of young people.

Radio staff often don't know the information as well as technical experts do and considerable time and resources should be spent to ensure the program carries accurate messages and is appealing. The programme should be regularly reviewed and critiqued.

Creating Public Support

Communities were involved from the beginning in order to lend support to the campaign messages. It became acceptable to tell young people to use condoms, as long as they were also encouraged to delay sex. The way was paved for the radio programme, newsletter, posters and local activities by carefully pretesting everything with youth and their teachers. Project managers anticipated and managed controversy by identifying key supporters and opponents, giving them accurate information through sensitization seminars about adolescent sexuality and its consequences, and inviting them to participate in the design process. Influential community members became advocates when they were invited to sit on advisory committees. Grassroots activities, such as bicycle rallies, soccer games and drama, involved entire communities. The Catholic Church was not supportive, nor was it obstructive.

District Level Ownership

Sustainability of media campaigns which are relatively expensive relies on ownership. The DISH Project made every effort to encourage the District Health Teams to adopt the information campaign as their own, and continuation will depend on the teams' motivation and capacity to secure additional funding. This remains a major challenge, as decentralization is relatively new in Uganda and many District Health Teams are not yet pro-active in their programming.

Linking Information to Services

Programmes must be designed and implemented within a broad, realistic context. However, positive behaviour changes — such as condom use, abstinence and talking with one's partner — can be initiated through a communication campaign even before health and other support services are in place. The campaign could then be strengthened by establishing a common meeting or recreational center for youth in their communities and by providing social support, counselling and reproductive health services for sexually-active youth. Another challenge the DISH Project now faces is to sensitize and train providers who are reluctant to serve adolescents, and to establish alternative sources of care.

Building Partnerships

Building partnerships expands the resource base and potential for project activities. The DISH Project worked with NGOs, district government officials, volunteers and Ministry of Health staff. While the DISH Project only had four IEC staff persons, it expanded its resources by forming Action Committees to help implement events at the district level; hiring an advertising agency to produce and place mass media materials; working with other organizations like UNICEF to build on existing newsletters; and working with existing youth groups in the districts to increase distribution of materials.

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BECOMING MOTIVATED TO ADOPT HEALTHY BEHAVIOUR

SCHOOL-BASED
EDUCATION AND
ANTI-AIDS CLUBS

SCHOOL-BASED HIV-AIDS AND POPULATION EDUCATION PROJECT—SWAZILAND

School HIV-AIDS and Population Education (SHAPE), was initiated by the government of Swaziland as a collaborative project to address young people's sexual and reproductive health needs and has now become a registered NGO. The SHAPE project trains teachers and college lecturers to teach primary and secondary school students about sexuality, STIs, population and basic life skills. Students are encouraged to form and manage Anti-AIDS Clubs in their schools and selected students are trained to provide peer education. The unity and support of the Anti-AIDS Clubs help students subscribe to a positive code of behaviour and motivate them to adopt a healthy lifestyle. Swaziland's small, tight society makes it difficult for parents and children to discuss issues of sexuality openly. Therefore, SHAPE's strength lies in placing sexuality into a meaningful, school-based reproductive health curriculum, and in utilizing teachers and peers as important models of responsible behaviour.²¹ Although the SHAPE project originally focused on

BACKGROUND

In 1990, a national survey of secondary schools student revealed that one-half were sexually-active by the age of 15-16, with pregnancies accounting for between one-quarter and one-half of all school drop outs. HIV prevalence was 27% among students aged 15-19 who were treated for STIs, and the rate for girls was double that for boys.²² The baseline study conducted in the Hhohho Region Primary Schools revealed that students had very little knowledge about their sexuality. Although only a very small proportion said they had matured physically, a significant number had already experienced intercourse. Alarming, roughly one-third of reported sexual encounters were incidences of incest. More than one-third of the respondents admitted that it would be hard to refuse having sex even if they did not want it.²³

21. Birdthistle, I. and Vince-Whitman, C. 1997. *Reproductive Health Programs for Young Adults: School Based Programs*. Washington, DC : FOCUS on Young Adults Program, pg 2-4.

22. Gule, Gugulethu. 1995. Hhohho Primary Schools HIV/AIDS Baseline Survey Report. Statistics and Demography Department, University of Swaziland, Mbabane, November 1995. pg iv.

23. Birdthistle, I. and Vince-Whitman, C. 1997. *Reproductive Health Programs for Young Adults: School Based Programs*. Washington, DC : FOCUS on Young Adults

AIDS, it has evolved and now addresses young people's needs for broader information and for the skills and confidence to take responsibility in their own lives. Programmatically, SHAPE is flexible and willing to adapt to changing needs identified during the periodic assessments it conducts. It has also been very successful at soliciting community support and allies. Launched as a pilot project, SHAPE has been institutionalized into nearly the entire educational system. By continuously nurturing government involvement, it maintains a long-term vision of being absorbed into the public education system.

PROGRAMME DESIGN

Project Initiation

The government of Swaziland began looking for ways to arrest AIDS when the very first HIV cases were diagnosed. In 1989, given the changing family structure and the lack of sexuality and reproductive health education in Swaziland schools, the Minister of Health asked CARE International to implement a school-based HIV/AIDS education programme. A meeting was then convened with Heads of Schools to introduce the idea and solicit their support. With additional support from WHO, CARE International initiated the SHAPE project in 1990 with the following mission:

"To prevent and control the spread of HIV/AIDS and STD infection and to reduce the incidence of teenage parenthood, by promoting responsible reproductive health behaviour amongst the youth in Swaziland"

SHAPE began as a pilot project in 25 schools, which was to be expanded throughout the country after 18 months. Soon after it was launched, CARE left Swaziland but not until SHAPE had registered as an NGO and secured commitments of support from both the European Union and Shell Swaziland. Additional funding has subsequently been secured from UNICEF, UNFPA and the Ministry of Education.

Management

SHAPE maintains an office in Mbabane, which is staffed by three full-time professionals. Two staff members are seconded by the Ministry of Education, a demonstration of its commitment to the project. This office answers inquiries, disseminates information to the public, schedules

SHAPE's strength lies in placing sexuality into a meaningful, school-based reproductive health curriculum, and in utilizing teachers and peers as important models of responsible behaviour.

Adolescents still faced peer pressure, and were vulnerable to overtures from older men because of economic and self-esteem problems. These findings pointed to the need to expand the project's scope to issues besides AIDS and to use peer pressure to meet its objectives.

speakers for schools and organizations, and supports the Anti-AIDS Clubs.²⁴

Project Adaptation

The evolution of SHAPE is evident in its changing name. Initially created as the *Schools HIV/AIDS Pilot Education Project*, it became the *Schools HIV/AIDS Partnership Education Project* in 1991 and finally the *Schools HIV/AIDS and Population Education* in 1993. The original name and goal was chosen following a baseline survey of knowledge, attitudes, behaviour and practices among both teachers and students. Course content was developed using experiences and materials from elsewhere in Africa, as well as from other agencies in the country.

At the end of the pilot period in 1993, a rapid assessment was conducted. It found that knowledge and attitudes about AIDS had changed significantly, but that behaviour had not, because the underlying reasons for risky behaviours and a whole range of other reproductive health problems young people were experiencing had not been addressed. For example, adolescents still faced peer pressure, and were vulnerable to overtures from older men because of economic and self-esteem problems. These findings pointed to the need to expand the project's scope to issues besides AIDS and to use peer pressure to meet its objectives.

Soliciting Community Involvement

In the initial baseline study, teachers mentioned teenage pregnancy, STI, AIDS, drug and alcohol abuse, and crime and violence as problems their students faced. Contributing factors included ignorance on the part of parents and teachers, peer pressure, lack of self-esteem/assertiveness and the negative impact of the media.²⁵ When asked which interventions should be included in the project, teachers overwhelmingly suggested introducing health education into the curriculum. They also suggested that community members and parents receive education on the subject and that they cooperate with the schools.²⁶

In order to involve parents and other community members, SHAP presented the results of its 1996 Rapid Assessment during a meeting with Regional Secretaries, *Tindvuna te Tinkhundla* (Primary Government) and Regional Councillors. Participants were asked to suggest solutions to the problems adolescents were experiencing, which resulted in a clear consensus on the need for urgent action. Their recommendations included a policy for health education (including reproduction) in schools and training specialist teachers/counsellors to handle reproductive health education. Other more indirect solutions included monitoring the licensing of bottle stores; reviewing customary Swazi Law regarding

24. SHAPE. SHAPE Activity Summary Report for 1995. SHAPE Project pg 6.

25. *ibid.* pg 12.

reproductive health issues; and providing reproductive health education to all information officers with the Ministry of Broadcasting to ensure accurate information is given to the public.²⁷ These recommendations will be presented by the local government to Cabinet and Parliament in 1997.

Sustainability

SHAPE's long-term goal is to institutionalize reproductive health education into the school system. To do so, it hopes that the government will eventually take over programme management, incorporate the reproductive health course into the school curriculum, and hire designated teachers to teach it. SHAPE has nurtured government commitment from the programme's inception and the results are evident. The Ministry of Education has established a health unit which oversees the project, and has seconded two professionals to work with SHAPE. The Minister of Health publicly encourages young people to join the Anti-AIDS Clubs.

Through active lobbying efforts, SHAPE has secured commitment to the programme at numerous levels. It has involved community members, parents, teachers and the youth themselves. The private sector has taken an interest and is supporting components of the programme. SHAPE has built partnerships with a number of agencies, task forces, and others which helps create a network of support.

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PROGRAMME ACTIVITIES

Training

A five-day training workshop gives teachers accurate information on human sexuality, STD/AIDS, population and development. They are also taught how to establish and run Anti-AIDS Clubs, and are given a chance to improve their counselling skills, since many will be speaking openly about sensitive issues of sexuality for the first time. The course encourages teachers to explore their cultural and personal attitudes toward reproductive health issues, and to clarify their values about sexuality and gender relations, which, in turn, helps them serve as good role models. In follow-up conversations, teachers say they appreciate the training and feel it contributes to their personal growth and ability to meet their students' needs.

Pulling teachers out of school has proved problematic, so training is now conducted during holidays. SHAPE's limited staff has found it impossible to meet the demand for training workshops and outreach, so

The course encourages teachers to explore their cultural and personal attitudes toward reproductive health issues, and to clarify their values about sexuality and gender relations, which, in turn, helps them serve as good role models.

27. Shongwe, Thandi, J. Kunene P. and Nkosi, S. 1996. *Community Feedback Report on Rapid Assessment Report of Secondary/High Schools in Swaziland for Regional*

SHAPE has been revised and adapted several times as different priorities are identified in mid-term assessments.

it has co-opted a team of teachers who serve as master trainers and volunteer to co-facilitate courses. In 1997, SHAPE began conducting pre-service training in Teaching Colleges and has found it a much more cost-effective way to recruit programme participants. Student teachers are already resident at college, don't have to pay extra room and board, and can complete an entire course in one week. It is hoped that, in the future, every student teacher will receive this training.

Curriculum and Teaching Methods

SHAPE has been revised and adapted several times as different priorities are identified in mid-term assessments. Content is also influenced by students' age and whether the school is public or mission, urban or rural. The current curriculum is based on the belief that integrated life skills help young people make responsible decisions and adopt healthy behaviours that they maintain throughout their lives. It teaches negotiation and assertiveness skills which can be used to prevent reproductive health problems, and includes value clarification to help adolescents avoid peer pressure and make choices appropriate for their own lives.

The way the course is taught is influenced by the commitment of the Head Teacher and the ingenuity of the trained teachers.²⁸ Because no established policy for health education exists, some schools offer it in separate lessons, some infuse it throughout the school curriculum, and others use their spare time to teach it. In addition to classroom-style teaching, trained teachers use participatory methods such as drama, role plays, music, poems and debates. However, follow-up evaluation found that most Head Teachers are not aware of how reproductive health education is taught in their schools.

As they assume a counselling function within their schools, trained teachers encounter problems they cannot solve alone. Therefore, schools must find a way to link the counselling and education they provide to other services their students may require. With assistance from the Career, Guidance and Counselling Department of the Ministry of Education, the training helps them to acquire skills on how to counsel students on sexuality-related issues and where to refer for additional support.

Other problems teachers cite include insufficient time to carry out educational activities; lack of parent-teacher communication; lack of support from other teachers; and radio programmes that contradict the messages they are trying to emphasize. In response, SHAPE is about to offer parent education and is promoting teacher teams as a supportive model.

28. SHAPE. 1996. Individual in Depth Interviews on AIDS Education in the Primary School Pilot Project in the HhohhoRegion, pg 8.

Anti-AIDS Clubs

In 1993, SHAPE initiated the Anti-AIDS Clubs to foster peer support and education. Club formation is encouraged by trained teachers or by youth clubs in other schools. Each Club writes its own constitution, selects board members and registers with SHAPE. This affiliation gives them access to transportation, learning materials, participation in special events and opportunities to be trained as peer educators. Clubs meet on a regular basis and reach out to their peers through classrooms, school assemblies, workshops and on a one-to-one basis. Each is supervised by a Patron, most commonly the teacher in their school who has participated in SHAPE training. This Patron provides guidance and advice, access to resources, permission for out-of-school events, and helps enforce discipline if necessary.

Students join the Clubs out of interest and concern for sexuality-related issues and by joining, receive encouragement and support by their peers to adopt responsible behaviours. Not only do they take a pledge to abstain from sex but they also agree not to indulge in other potentially harmful behaviours such as alcohol and drug use. Other pledges suggested by SHAPE and modified by each Anti-AIDS Club include:

- ◆ Promote chastity followed by lifetime faithfulness.
- ◆ No one should be allowed to contract HIV through ignorance.
- ◆ Promote responsible behaviour in peers that maximizes protection from STD and HIV.
- ◆ Increase peers' self-confidence and assertiveness in their relationships with others.
- ◆ Foster a new youth identity as members of a relatively HIV-uninfected group.
- ◆ Enable peers to make better use of available resources to improve health.
- ◆ Appreciate girls and women as equal partners to boys and men in society.

By abiding by a code of behaviour, members set a good example for their fellow classmates. Any member who violates the code can be asked to leave. Each Club is free to initiate its own activities. For example, one

Each Club is free to initiate its own activities. For example, one Club introduced a "Hotline" consisting of a box in which students could leave written questions to be answered.

Each year, two students from each Club are selected to attend a one-week, residential peer education training camp. They, in turn, go back to their clubs and train other members to become peer educators.

Club introduced a "Hotline" consisting of a box in which students could leave written questions to be answered, also in written form, on the Club notice board. In addition to in-school activities, Club members are invited to participate in events organized by SHAPE, such as: competitions, fora to perform original songs, poems and plays, and television appearances. Although individual Clubs have very few day-to-day costs, they may organize fund-raising activities such as selling roses on Valentine's Day.

Each year, two students from each Club are selected to attend a one-week, residential peer education training camp. They, in turn, go back to their clubs and train other members to become peer educators. Course content includes: human growth and development, relationships, health, life skills/empowerment, population and development, and how to cope with peer pressure. Students benefit from living healthier, positive lifestyles, and also by gaining confidence and leadership skills. Through the peer education course they are given training in group facilitation and public speaking, and are given opportunities to practice these skills. They learn basic organizational skills by participating in special events.

Awareness Raising

Schools are encouraged to extend educational activities into their communities. In 1995, two Anti-AIDS Clubs came up with the idea of establishing their own rural outreach campaign. In order to do so, they rallied all Anti-AIDS Club chairpersons to organize and sponsor a "Walk to Awareness" to raise funds. As a result of vigorous publicity, the event attracted 5,000 people including 44 schools and organizations. Although the Walk was a huge success in terms of raising awareness, sponsorship funds were not sufficient to cover its costs.

Partnerships

SHAPE actively collaborates with other initiatives in Swaziland and is often called upon for its expertise in adolescent sexuality. For example, SHAPE is vice-chair of Swaziland's Population Health and Welfare Sector Committee for National Strategy Development and is a member of the IEC Action Group of the Swaziland National AIDS Programme. SHAPE attends regular meetings with the Ministry of Education to assist in formulating a comprehensive Reproductive Health policy in the schools.

SHAPE also works closely with the Swazi Action Group Against Abuse. Through this group, teachers can refer students who require services for situations such as rape, pregnancy or child abuse. SHAPE has developed a partnership with the Family Life Association of Swaziland

(IPPF affiliate) to develop adolescent-friendly reproductive health clinical services. Corporations ask SHAPE to introduce their programme as a part of their employee health and education services. SHAPE also facilitates adolescent reproductive health training workshops on behalf of other agencies such as the Scouts and Girl Guides, church groups, police, army and prison guards, and commercial sex workers.

INDICATORS OF SUCCESS

By early 1997, over 500 teachers and Head Teachers had gone through the seven-day training. Over 100 student teachers had received pre-training through their college, and over 100 community members had been consulted. Out of the 128 schools where SHAPE is active, 49 reported having Anti-AIDS clubs, with membership in each club ranging from 5 to 100.

According to the 1996 Rapid Assessment, 80 percent of the schools included in the survey offered HIV/AIDS education. When the remainder were asked why they did not, most cited a lack of trained teachers; only a few reported negative attitude from parents and/or teachers. Focus group discussions indicate that students who have undergone HIV/AIDS education have much better knowledge and attitudes towards reproductive health.²⁹

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LESSONS LEARNED

Monitoring and Adaptability

Continuous monitoring can uncover useful changes. The SHAPE programme is constantly being adapted as new priorities are identified (including new issues, such as incest, teen pregnancy and the need for life skills, and new activities, such as Anti-AIDS Clubs) and the programme now has a more holistic approach than its original AIDS focus.

Training and Teaching Issues

Teachers must be committed and be offered support. SHAPE programme assessments found that the success of the teacher training was dependent on a number of factors including: the support of the Head Teacher; in-school time allocated for SHAPE activities; and selection of teachers based on demonstrated interest and concern for adolescent reproductive health. It also found that teams should be formulated

Continuous monitoring can uncover useful changes. The SHAPE programme is constantly being adapted as new priorities are identified and the programme now has a more holistic approach than its original AIDS focus.

29. SHAPE. 1996. *Focus Group Discussion Report on AIDS Education in the Primary School Pilot Project in the Hhohho Region*. November 1996. pg 13.

Offering local government (Tinkhundla system) representatives an opportunity to understand the issues turned them into vocal supporters and advocates for a reproductive health education policy in schools.

within each school to ensure that teachers get support from their colleagues, and that the responsibilities of the trained teachers should be clearly defined by the Head Teacher to give his/her activities credibility.

Training also required time away from schools that teachers can ill afford. In response, SHAPE began incorporating its course into pre-service training. This step will help ensure that the course is institutionalized, will help avoid the lack of continuity which occurs when teachers get transferred, and will allow training to be carried out in a more cost-effective manner.

Community/Parental Involvement

Sharing adolescent health survey information with community members, and asking them to suggest solutions, proved to be a very effective way to convince people of problems. Community members consistently recommended more education as the response. The community also requested education programmes on the subjects of health and sex, and parents were asked to cooperate with the schools to support the project activities. Offering local government (Tinkhundla system) representatives an opportunity to understand the issues turned them into vocal supporters and advocates for a reproductive health education policy in schools, and the tabling of the issues in the Cabinet and Parliament.

Youth Involvement

The success of an Anti-AIDS Club is dependent on both its members' initiative and its schools' support. An adult "patron" is necessary to give guidance and discipline if necessary. To ensure that the Clubs aren't losing their most dynamic members as they graduate or transfer, peer educators must train their replacements continuously, and at younger ages.

ADOLESCENT REPRODUCTIVE HEALTH PROJECT: PLANNED PARENTHOOD ASSOCIATION OF SOUTH AFRICA

**SEEKING
APPROPRIATE
SEXUAL AND
REPRODUCTIVE
HEALTH
SERVICES**

**REPRODUCTIVE HEALTH
SERVICE DELIVERY**

The Adolescent Reproductive Health (ARH) Project is one of the few efforts in Eastern and Southern Africa to provide clinical reproductive health services exclusively for adolescents in a way that is *defined by* adolescents. Currently being implemented by the Planned Parenthood Association of South Africa (PPASA), the project offers important insight into the elements of service delivery which appeal to young people (i.e. that are "youth-friendly") and which motivate them to seek the services they need.

This paper focuses on two aspects of the ARH Project: service delivery and health education. The projects service delivery centres are run by young professionals (generally one nurse and one educator) and offer contraceptives services, STD treatment, counselling and pregnancy tests for both urban and rural young people in a youth-friendly environment. PPASA's ARH centres are intended as pilots, offering opportunities for individual centres to develop and grow in response to their own particular environments and clients. The centres face many challenges including the ability to

BACKGROUND

South Africa's young people are becoming increasingly sexually-active. As a result, four out of ten babies are born to teenage mothers. Estimated STD prevalence is 7.4% among black youth between the ages of 15-30 years. A baseline study carried out in 1996 found that adolescents expressed a positive outlook on life in general, but nearly one-half felt they lacked control over life events. Three-quarters of the 15-25 year olds had had sexual intercourse, and almost half had had more than one sexual partner during the last six months. The majority did not want children, but only about one-third were currently using any contraceptive method. Although most interviewees were aware of STDs, there was a low-level of perceived personal risk. Young peoples problems stemmed from their relationships with their family.³⁰ Although friends were mentioned as a valuable source of information, nearly three-quarters of young people indicated they would like to speak to an adult about issues related to sexuality. Clinics were their preferred source for reproductive health informaton, services and products.³¹ However, most clinics do not provide an environment in which young people feel comfortable to seek the services they need and desire.

30. Richter, Linda M. 1996. *A Survey of Reproductive Health Issues Among Urban Black Youth in South Africa*. Centre for Epidemiological Research in South Africa. Society for Family Health, June 1996, pg 78.

31. *Ibid.* pg 70

Youth need services that are designed specifically for them; young people should be involved in the design, monitoring and management of such services; and service provision and education are mutually-reinforcing.

be creative, to institutionalize monitoring systems that measure successes and experience, and to reach the project's long-term objective of being absorbed into the government system. However, this post-apartheid period offers a uniquely open and realistic environment. Along with the new government, though, are the challenges of providing health services to previously underserved and undersupported populations in the old homelands.

PROGRAMME DESIGN

Programme Initiation

The Adolescent Reproductive Health (ARH) project was developed by PPASA to respond to the needs of young South Africans who were particularly vulnerable to reproductive health problems. It introduces experimental service delivery systems into provinces that are struggling to improve the health status of formerly under-resourced and badly managed "homelands."³² One of its main goals is to create a replicable model, by developing a carefully-defined methodology and by marketing the programme to Government, other NGOs and donors. The pilot phase intended to introduce the models in seven provinces and carefully monitor experiences over a limited time period.

The programme's basic principles were formulated from experience and comprehensive reviews carried out by the European Union and the World Health Organization: youth need services that are designed specifically for them; young people should be involved in the design, monitoring and management of such services; and service provision and education are mutually-reinforcing.³³

The stated purpose of the service delivery centres is:

'to provide local youth with otherwise unavailable educational programmes and skills to assist them in making responsible choices about sexual values and interpersonal relationships; to provide them with friendly reproductive health services; and to highlight the risks of early sexual activity which will lead to early pregnancies, STDs and HIV, and to reduce the incidence of them.'

Although each provincial office uses the same basic process during start up, each model has been adapted to suit its own situation. All centres evolved from a set of basic elements:

32. PPASA. 1996. Adolescent Reproductive Health Services Programme. Project Request from PPASA to the United Nations Population Fund. January 1996. Johannesburg: PPASA.

- ◆ Staffed by one nurse and one educator;
- ◆ Use of participatory research and monitoring techniques;
- ◆ Focus on delivery of contraceptives, STI management, pregnancy testing, counselling and peer education;
- ◆ Use of youth committees to steer programme development and decision-making; and
- ◆ Expand based on experience.

The first centre opened in 1994 in Carlton Shopping Centre in downtown Johannesburg. By 1995, centres were established in six additional locations: New Cross Roads (an informal settlement outside Capetown), Winterveldt (an informal settlement in North West Province), Motherwell (a township outside Port Elizabeth in the Eastern Cape), Nhlanguwini (a rural village in southern Kwazulu/Natal), Bothsabeleo (a sprawling formal and informal settlement area outside Bloemfontein) and Namitwa (a rural area in Northern Province). It is worth noting that Namitwa is the only centre based in the compound of a local clinic and has been targeted for integration by the provincial government after two years. The centres receive funding from ODA, Population Concern, UNFPA, NORAD, the World Bank and some local corporations.

Start Up Activities

Preparatory activities take ten months on average. They include:

- ◆ ***Planning Workshops:*** Before the project was launched, a one-day workshop was held with various youth groups and PPASA branches to identify needs. Before introducing each new centre, a one-day, branch-level workshop is conducted to look at relevant studies and to standardize survey instruments as much as possible to ensure comparison between centres. Staff with experience at existing centres are invited to the workshop to share their experiences with the new team.
- ◆ ***Baseline studies and needs assessments:*** Before a new centre is established, studies are carried out to determine the community's knowledge and attitudes toward adolescent sexuality and reproductive health, and the needs of local adolescents. Provincial staff identify a research institution to train their researchers and

Before a new centre is established, studies are carried out to determine the community's knowledge and attitudes toward adolescent sexuality and reproductive health, and the needs of local adolescents.

To help design the project, participatory learning exercises were used to explore the local needs of youth, and to ensure sensitivity to local and cultural differences.

help conduct a needs assessment in their communities. Research (data collection) activities are carried out by project staff (e.g., nurse coordinator and educator/counsellors) as well by youth volunteers who have been previously trained by PPASA through its youth clubs. Consultations with parents and community members serve to gather information, and also to help new staff and volunteers orient themselves to the project, and to institutionalize participatory processes and skills, (e.g. allowing free participation, not making decisions for people, managing group discussion, and workshop facilitation).³⁴

- ◆ **Planning activities with youth:** The project is based on the principle that young people will use services designed specifically for them and that *young people should be involved in the design, monitoring and management of those services*. Therefore, activities to involve youth are on-going. To help design the project, participatory learning exercises were used to explore the local needs of youth, and to ensure sensitivity to local and cultural differences. In one such exercise carried out at Carlton Centre, young people were asked to name the most important factors in clinic choice. They were: staff attitude (95%); environment including location, decor, atmosphere, etc. (89%); contraceptive method (85%); and operating hours (81%).³⁵ Respondents also stated which services they would like in a clinic, what operating times were convenient, what decor they preferred, and what the centre should be named. As a consequence, the services offered are not called "clinics" and are not furnished like them either.

During provincial planning workshops, youth also developed a list of issues/themes that were important to them. The three most commonly mentioned were: sexuality education/physical development; advice about STIs and AIDS; and explanation of painful menstruation. Other issues which could not be addressed directly through this project included: sportsfields, multipurpose community hall, place with light to do homework, cinema, (recreation, education, infrastructure like electricity and water). The project staff try to link up with other NGOs or Government departments who can assist in fulfilling such requests.

- ◆ **Identifying the service site** is one of the biggest challenges, since it must be located where the youth are. For example, the Carlton Centre was to be located in the Soweto township, until it was discovered that youth from the township congregated at shopping

34. PPASA. 1996. Breaking Silence: Interim Report on the Adolescent Reproductive Health Service Needs Assessment at Nhangwini, September 1996, pg 4.

35. Reproductive Health Research Unit. 1996. 100 voices: A User's Perspective of the

centres in downtown Johannesburg after school and on weekends. The project team conducted a head count at the Carlton shopping centre to confirm that it was indeed a very popular meeting place.

- ◆ **Government involvement:** Extensive lobbying is needed to ensure national implementation and support. As the project develops, PPASA meets frequently with government officials to discuss the project status and to get their input. PPASA also invites officials to serve on project committees, holds monthly meetings with government clinics, and provides centre utilization statistics. The Ministry of Health contributes to the programme by donating supplies and contraceptives once the facility has become “licensed” according to government standards. PPASA’s ARH centres and Ministry of Health facilities have established a two-way referral system. To fulfill its own objective of providing adolescent friendly reproductive health services, the Ministry of Health is seconding a nurse and educator to the Carlton Centre to receive on-the-job training and to help deal with the increasing numbers of clients.
- ◆ **Consultation with adult stakeholders:** The National Programme Coordinator and PPASA Branch Staff conduct formal and informal meetings with adult stakeholders (including community leaders and parents) as part of an on-going consultation process. Centre staff are included to give them an opportunity to hear adults’ opinions about youth sexuality, and to assess the amount of support they can expect. Discussions include a briefing about reproductive health services, its possible integration into existing youth services (non-health), staffing, training and selection of possible trainee researchers. If key individuals are resistant, project staff pursue one-on-one discussions, which have been effective at building support.
- ◆ **Youth committee creation:** Youth committees ensure on-going youth involvement. Members receive training and are given opportunities for personal development; they are generally highly-motivated and sincere about wanting to help their peers. Youth in new programmes will be involved in choosing a location, developing and delivering educational programmes and advertising strategies. Their commitment is encouraged by giving them responsibility for the design and direction of the services. Youth committee members must participate in health education workshops and undergo peer education training as well.

The Ministry of Health contributes to the programme by donating supplies and contraceptives once the facility has become “licensed” according to government standards.

Although youth do visit the centres because they need private, one-to-one counselling on issues ranging from rape and pregnancy to relationships and family problems, many become reproductive health clients after attending the centre for other reasons.

Sustainability

The long-term goal is to integrate the project on a greater scale into the government system. Therefore, although it slowed down the start-up process, PPASA began preparatory negotiations with government and community structures at an early stage and maintained the relationships on a continuous basis. Meetings were held to iron out problems and to seek ideas from potential supporters. Since South African communities and government personnel are struggling to define themselves within a new political structure, and government policies are still being formulated, certain administrative decision-making required for the project to commence was delayed.

To ensure sustainability, PPASA has also lobbied strongly for the integration of reproductive health into youth activities and centres run by other NGOs. As centres are introduced into new communities, PPASA is exploring the feasibility of concurrent teacher training and education programmes. Project planners are also looking at ways to add reproductive health services into existing programmes, such as multi-purpose youth centres and clinics. The pilot phase offers an opportunity to test integrated models with government ministries as well, for example, by introducing programme elements from the Ministries of Education and Welfare.

PROGRAMME ACTIVITIES

Recruitment and Training of Staff

The centres are run by two paid, young professionals (generally one nurse and one educator) recruited for their empathy and sensitivity to youth. Staff receive training at the Life Line counselling programme which specializes in issues such as rape and HIV. They are also trained in basic management, including conflict resolution, policy development and project planning, and use of computers.

All other activities are dependent on volunteers. These include peer educators, who are trained to work at the centres, and youth committee members who become trainers as well as sources of ideas for day to day management and marketing.

Delivery of Services

Although the PPASA's ARH centres were designed to provide contraceptive services, STI treatment, counselling and pregnancy tests to adolescents, their names – "*Information Centres*" and "*For the Youth*" – attract young people who are in need of information on a range of issues

and/or a social place where they can spend time with friends after school. Although youth do visit the centres because they need private, one-to-one counselling on issues ranging from rape and pregnancy to relationships and family problems, many become reproductive health clients after attending the centre for other reasons. Although each centre is different, most offer some form of entertainment, such as recreational and educational videos and health literature. Each has an attractive reception area where youth can congregate as well as a number of small, private rooms for counselling and services. Staff refer clients to other clinics and social services as necessary.

Educational Activities

Each centre has a health education programme, developed onsite by project staff with help from the branch director and the national programme coordinator, and with input from local community organizations and project committee members. Generally, education is offered through workshops and group discussions, and is facilitated by staff and volunteer peer educators. The workshops are five-day courses completed over a few weeks for a few hours every day. They address sexual health as well as underlying social problems, e.g. unemployment, parent/child problems, and sexual abuse. They employ innovative participatory methods which use participant's life experiences to help them understand and deal with the complexities of issues such as sexuality. By focusing on life skills as well as basic reproductive health information, the workshops help give youth the confidence and motivation to make responsible decisions about their sexuality. These youth-centered activities are complemented by PPASA's other projects such as teacher and parent trainings.

In addition to centre-based activities, the project includes an innovative peer education programme. Peer educators – youth who have demonstrated interest during workshops and who display leadership ability – are trained again over a five-day period in leadership skills, decision-making, goal-setting, conflict resolution and facilitation. Highly-motivated educators can be trained as master trainers for other peer educators. These peer educators talk to their peers at schools, workplaces and other contact points in the community, and recruit youth to the centres. They also participate in educational activities at the centres. Their work is strictly voluntary, but job satisfaction comes from knowing that they can help other young people in their community, and from developing leadership skills.

By focusing on life skills as well as basic reproductive health information, the workshops help give youth the confidence and motivation to make responsible decisions about their sexuality.

Feedback is solicited from youth through exit interviews, suggestion boxes, and discussion groups to determine whether educational strategies are well-focused and behavioral change is taking place.

Launch and promotional activities

An official launch is usually conducted several months after the initiation of services. The Carlton Centre's launch was held at the shopping centre and was attended by 10,000 youth. Women's and youth magazines featured articles publicizing the new centre, radio announcements were broadcast, and calendars and flyers with enclosed condoms were distributed. In other centres, promotion was carried out through community radio, pamphlets, T-shirts, visits to schools, and articles and announcements in local youth magazines and periodicals.

INDICATORS OF SUCCESS

Initial baseline studies have not yet been followed by full-fledged evaluations. To date, success must be measured by looking at process indicators. Since PPASA has not yet developed a standardized information system and has been weak at monitoring the centres' performance, attendance rates are not uniformly available. However, attendance at clinics and workshops has been increasing since the programme began. For example, the centre in Winterveld/North West province serves about 20 clients a day and performs one pregnancy test per week. Isa-Labasha averages 40 clients per day; in one quarter, it served 629 male and 537 female clients. Centre staff are beginning to see more youth come in with partners, which indicates more equal sexual responsibility. Youth's attitudes towards condom use is improving dramatically. Staff have even noticed a change in the personal appearance of young people, reflecting increased pride, confidence and self-esteem.

Feedback is solicited from youth through exit interviews, suggestion boxes, and discussion groups to determine whether educational strategies are well-focused and if behaviour change is taking place. In addition, a survey was conducted one year after the Carlton Centre opened. The survey found that 88 percent of the clients were between ages 15 and 25, and most (76%) were defined as regular clients (meaning they had visited more than 3 times). When asked why they used the Carlton Centre, 69 percent mentioned staff attitude as the primary reason. Next in importance were operating hours (29%) and variety of contraceptive methods (28%). Most use the Carlton Centre for contraceptive services (79%), followed by condom supply (28%) and counselling (25%). Although emergency contraception is offered, very few clients request it, possibly indicating a low-level of awareness about this method. Utilization of STI treatment and pregnancy testing was also low — in part due to the existence of another STD clinic located near the Centre.

Most youth heard about the Carlton Centre through word of mouth and peer communication (58%), while 23 percent noticed the Centre en route to somewhere else.³⁶

LESSONS LEARNED

Adolescent-Friendly Services

Needs assessments and continuous input from youth committees and clients is helping PPASA develop an understanding of the elements that make a service appealing and “friendly” to young people. Many have been incorporated, while others remain mere ideas due to resource limitations. One fundamental principle is clear: a programme that intends to meet the reproductive health needs of youth must take a holistic approach. In addition to services, the programme must help build skills and meet the social and emotional needs of adolescents. Elements of youth-friendly services include:

- ◆ **Staff:** who are young, friendly, smile, wear casual clothes, listen to concerns, care about youth, and act as role models.
- ◆ **Facilities:** that are full of posters (created by youth, if possible), music, and videos; that offer space to hang out as well as private rooms for education and counselling; and where other activities are obviously happening in addition to reproductive health services.
- ◆ **Quality:** providing immediate attention, time to talk, and choice.
- ◆ **Location:** where the youth are or where they pass on their way home from school, accessible.
- ◆ **Hours of operation:** usually 10:00a.m – 6:00p.m on week days and Saturday mornings. in rural areas, young people have less opportunity to visit the centre during evenings or weekends.

To create a receptive environment, project staff are young, mature, empathetic, and understanding of adolescent issues. However, young staff often require extensive training to gain the confidence they need to manage a pilot project. Young professionals and volunteers are constantly growing and developing new capabilities, and the training they receive makes them marketable and able to move on to better-paying jobs. This is healthy for the young people, but restricts project continuity.

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36. Reproductive Health Research Unit . 1996. *100 voices: A User's Perspective of the Youth Information Centre* (January 1996). Johannesburg, pg 3.

Young people rarely mention family planning services as their top priority. They want to have fun.

Youth Centre Name

The name of the youth centre is important. For example, Isa-Labasha was named by youth and means “for the youth.” The Carlton Centre discovered that the name “Youth Information Centre,” implies that it is not merely a clinic that provides family planning services exclusively. The name is also vague enough to trigger curiosity – youth stop by and inquire about what is offered, or assume they can get information about the shopping centre there.

The Needs of Adolescents

Although centres meet reproductive health needs, they do not necessarily address the top concerns of youth. For example, Nhlanguwini youth wanted, more than anything else, a place with electricity and tables where they could do their homework. Young people rarely mention family planning services as their top priority. They want to have *fun*. Consequently, special activities such as outings and cultural events have become more of a priority to ensure that the young people remain motivated. Funds have been secured from NORAD to do more peer work and exchange visits between projects so that a cross-pollination of ideas may happen and the young people will work harder to ensure their project is a success.

Some centres have yet to be made attractive – one can still find white walls and few appealing images, and some do not have games, videos and music. Young people often have a hard time being imaginative, since growing up under apartheid has dissuaded them from showing initiative, and has restricted their opportunities to develop the skills and confidence to develop creative solutions.

Other factors influence the centres’ effectiveness. They still lack resources to address non-clinical needs. Peer educators do not have health education tools for their outreach activities, and clinics could use more equipment, videos and games. Youth get conflicting messages about sexuality from homes, schools, communities, peers and the media. Although the Carlton Shopping Centre did not object initially to the centre, the management is relatively conservative and has reacted negatively to some of the centre’s bold advertising. This kind of conflict needs to be addressed carefully by programme managers.

Support from the Community

The variety of participatory approaches PPASA used to involve community members created a sense of ownership of the project and trust in the managers, and were a great source for ideas. As a result, parents, teachers and others in the community were often willing to contribute to

activities. For example, after discussions were held with a Catholic priest in Nhangwini, he recognized the need for the services, visited the premises and thereafter offered the use of the mission hall for workshops. He also promised to refer clients for counselling. In another case, the local Chief offered a goat to help celebrate the centre's official launch. In Northwest Province, the Mayor and two of the councillors volunteered to be part of the outreach committee. Parents visit the centres, and bring their children for services.

Collaboration with other community organizations is also important and effective. In almost all provinces, the local hospital and MCH clinics supply contraceptive supplies and drugs to the centre. Other youth clubs, school-based programmes, women's clubs, health committees, social workers, community development committees, and traditional authorities have demonstrated commitment to the project. To help coordinate this input, it helps to have a project manager who knows the community well. Nationally, the Youth Development Trust, a grant-making organization, is working to bring together all youth-serving agencies to ensure that a holistic approach is taken and that the programmes complement each other.

Youth Involvement

The youth committees have proven to be a good mechanism for ensuring on-going youth involvement – volunteers become highly motivated. However, expectations regarding “incentives and rewards” must be clear to avoid frustration and conflict with project staff.

Pilot Programming

While pilots should be flexible and open enough to allow individual models to evolve according to local circumstances, they must be monitored carefully. Unfortunately, PPASA has had weak mechanisms for monitoring and documenting the process and few formal mechanisms exist for the centres to learn from each other. This has led to internal confusion about objectives and the overall pilot project, resulting in lack of standardization, a lack of direction, and feelings of insecurity by some project staff. Staff may view the project – and their jobs – as temporary, and feel less committed as a result.

Sustainability

The long-term viability of the project is based on the premise that the government will replicate the model on a larger scale, using PPASA to train centre staff, manage the centres, and conduct research. Although the Department of Health has been cautious in embracing the project

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If government had been involved *more* from the beginning, decisions affecting cost may have been made differently. Such lessons are helping to shape the PPASA's ARH project as it develops and matures.

because it failed when trying to implement youth centres several years earlier, lobbying by an ex-PPASA staff member who now works with the Department of Health is stimulating interest and commitment. However, future sustainability is threatened because the PPASA's ARH project (and internal policies) has raised certain expectations that government programmes cannot meet (e.g. higher salary levels for staff, relatively expensive rent for youth centres). If government had been involved *more* from the beginning, decisions affecting cost may have been made differently. Such lessons are helping to shape the PPASA's ARH project as it develops and matures.

The ARH project has not yet implemented effective or consistent strategies for cost recovery. The centres have developed different fee structures depending on the area; i.e., in downtown Johannesburg where young people tend to have more money and can afford to pay for services. Individual centres are exploring income-generating ideas such as membership fees, a charge for certain recreation activities (e.g. entertaining videos) and training workshops, vending machines, social marketing of condoms and payment for pregnancy testing.

Experience is the best teacher – it enables us to avoid common mistakes and makes us aware of potential problems. By understanding the unique model programmes highlighted in this paper, we can identify common themes and principles for successful programming and become inspired to find creative ways of working together to reach common goals.

A BROAD-BASED APPROACH TO ADOLESCENCE

Building a Network of Services

Possibly the most important lesson learned is that access to information and services will have little impact if adolescents do not have the skills and confidence to change their behaviour. No matter what approach is taken, it must include an element of empowerment and be linked to a network of services which work together to:

- ◆ *develop talents and build self esteem;*
- ◆ *offer information that enables responsible decision-making;*
- ◆ *provide motivation to take healthy action; and*
- ◆ *provide appropriate services and support.*

Each of the four programmes focused on one or two elements in this continuum of needs, but their links to other services varied in nature and degree. For example, MYSA builds self-esteem, provides information, and encourages responsible sexual behaviour; the DISH Project provides information with a strong motivating element. However, both programmes could be strengthened by establishing stronger links to service delivery. SHAPE has evolved from an AIDS awareness programme to one which also builds life skills. Although services are not offered through the schools, the programme is strengthening its referral system. PPASA's ARH project is one of the few programmes that focuses on service delivery and health education. It is also making efforts to coordinate its activities with other youth-serving organizations to ensure that youth's continuum of needs are met.

Each programme uses its daily operation as a training ground for building leadership skills and self-esteem. Youth are called upon to help with decision-making, management and programme activities, and youth leaders motivate their peers and serve as positive role models. Both MYSA and SHAPE use peer pressure, clearly-defined responsibilities, codes of behaviour and disciplinary action to encourage responsible behaviour.

DISCUSSION

Access to information and services will have little impact if adolescents do not have the skills and confidence to change their behaviour.

Reproductive information and services were rarely mentioned as top priorities. One effective way to meet the reproductive health needs of adolescents is by addressing their more pressing needs first.

Using HIV/AIDS as an Entry Point

Three of the four programmes have used HIV/AIDS as an entry point for addressing other reproductive health issues. It appears that both governments and communities acknowledge the reality of HIV/AIDS and are open to novel ways of confronting the problem. Parents, teachers and community leaders feel ill-equipped to deal with the issue and are changing their traditionally-conservative attitudes about making reproductive health information and services available to young people. As is the case in MYSA, SHAPE and the DISH Project, the programmes are called AIDS programmes but other reproductive health concerns are addressed as well.

Recognizing the Contributions of Adolescents

Incentives and rewards bring out the best in young people and keep them motivated. In MYSA, the principle of respect and appreciation for member contribution is evident in the code: *you do something for us, we'll do something for you*. MYSA recognizes the efforts of members by giving sports clothes and equipment (donated to the programme), educational scholarships and opportunities to audition for professional teams and tournaments abroad. The DISH Project gave out awards and provided national level publicity for the winner of the *Hits for Hope* event. PPASA invites outstanding youth to participate in residential workshops away from home, where they are treated as adults. However, PPASA has learned that when working with trained volunteers, it is important to be clear about expectations so that they are not disappointed with the incentives given.

Discovering What Adolescents Want and Like

All programmes established mechanisms during the formative stage and on a continuous basis to find out what youths' needs were and how they felt about the programme. Reproductive information and services were rarely mentioned as top priorities. One effective way to meet the reproductive health needs of adolescents is by addressing their more pressing needs first. Youth expressed the following needs fairly consistently, in order of importance:

- ◆ respect;
- ◆ practical elements (e.g., space for studying or meeting friends);
- ◆ recreation and entertainment;
- ◆ opportunities for learning skills;

Since young people want skills and knowledge to take control over their lives and feel positive about their futures, programmes must be positive and upbeat. For example, the message in the DISH Project is one of hope – that young people can do something to protect themselves against AIDS. The MYSA motto is also positive: “*Give Youth a Sporting Chance.*”

Opportunities for recreation and social interaction attract young people and hold their attention. They are particularly interested in, and influenced by, popular culture and will respond to social activities that are informative and fun. Entertainment was the primary approach used by the DISH Project; football was used by MYSA; and drama used by SHAPE. The service delivery centres in South Africa tried to make their space appealing by offering video shows, music and an attractively-decorated place to spend time with friends.

However, finding out what young people want requires special facilitation. They are often not used to being asked for their opinions and ideas. Limited exposure to new ways of doing things can also limit imagination and creativity. Examples of ingenuity do exist, such as the creation of a “hotline” by one of SHAPE’s Anti-AIDS Clubs – which was simply a box in which students could leave questions about sexuality and related issues. Allowing opportunities for youth to interact and share experiences – an important part of the SHAPE programme – is one way to stimulate creativity.

BUILDING SUPPORT

Since the support of beneficiaries, communities and decision-makers is critical, each programme found a way to overcome social conservatism about adolescent sexuality. Asking key groups, especially beneficiaries, to identify problems and suggest solutions proved to be highly effective in creating a sense of ownership and trust in the project managers, and was a great source of ideas.

Beneficiaries

Involving young people in design, implementation and monitoring helped ensure programme ownership and success. PPASA used youth to help conduct baseline studies for the programme; the DISH Project used students to reach parents by sending them home with questions meant to trigger discussion about sexuality. Young people in Uganda helped write articles for the Straight Talk Newsletter and their ideas were solicited for the DISH Project radio programme. PPASA and MYSA created youth committees to ensure youth input on a regular basis.

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Stakeholders (e.g community members, parents, church leaders)

In order to ensure their programmes were well-grounded at the community level, the DISH Project, SHAPE and PPASA gave community leaders and potential collaborators accurate information about adolescent sexuality and its consequences. Community members had the opportunity to express their ideas and concerns about the young people in their community, and to help identify solutions. Only MYSA chose to avoid potential problems in the restrictive environment of Kenya by keeping its programme removed from influential institutions such as government, schools or churches.

Resistance was overcome and, in fact, parents, teachers and others in the community were often willing to contribute to programme activities. Mathare parents are now participating in community clean up with their children. Project managers for the DISH Project anticipated and managed controversy by identifying and working with high-level supporters and opponents, and by asking influential community members sit on advisory committees. The SHAPE programme provided an opportunity for local government (*Tinkhundla* system) to understand adolescent health issues, thereby creating vocal supporters and lobbyists for a policy of reproductive health education in schools and a plan to table the issues in the Swaziland Cabinet and Parliament.

Implementors

The commitment of project teams must be maintained through training and involvement. One reason for PPASA's success is that its organizational mandate has always been one of addressing adolescent needs. SHAPE and MYSA were also instituted as youth-serving organizations by already-committed staff. The DISH Project worked to sensitize district level implementors by training district health teams and through regular monitoring visits by headquarter staff. PPASA ensures that staff receive special training and are recruited for their centres based on their empathy for adolescents. PPASA also involves new centre staff in conducting community-based assessments. To ensure that Head Teachers support the SHAPE programme, they are encouraged to attend a three-day orientation session. Teachers are selected for the SHAPE training course on the basis of demonstrated interest and concern for adolescent reproductive health.

PROGRAMME DESIGN

Information-based programme development

All programmes except MYSA conducted baseline studies to guide project development and evaluation. These studies helped the DISH

Project formulate its message development strategy, determined the content of SHAPE's health education curriculum, and determined the type of centres developed by PPASA. Each of these programmes established monitoring mechanisms which allow them to gauge their progress, to be flexible, and to adapt to changing needs and priorities. For example, periodic midterm assessments encouraged SHAPE to expand its focus to incorporate broader reproductive health issues. Because PPASA lacks a standardized management information system and monitoring mechanisms, it is difficult for centres to compare their efforts, and to be flexible and creative.

It must be noted that the youth programmes featured in this paper do not lend themselves well for defining indicators of success. Outputs and outcomes are wide-ranging and varied. One commonly used measure for all four programmes is that of participation, which is usually difficult to interpret in terms of actual outcome. In addition, many programmes have the same young people participating in programme activities more than once, which may lead to double counting in many instances. The DISH Project discovered another problem in measuring behaviour change resulting from their information campaign. During the final evaluation, youth reported that they were more sexually active, a finding the DISH Project interpreted as being a sign of greater openness in discussing what had previously been a taboo topic.

On the other hand, MYSA's experience demonstrates that a well-designed monitoring system is not crucial for success, and that there are no *golden rules* for developing a perfect adolescent programme. In fact, real community-based initiatives are often less sophisticated in their management, but possess other elements, like ownership, which lead to success. Although the absence of formal monitoring mechanisms makes it difficult for MYSA to measure programme impact, it believes that its loose design has allowed it to be very flexible and responsive to the real needs of its beneficiaries. MYSA measures its success through: the sheer numbers of its growing membership; testimonies of many youth whose lives have been changed; its success as a sports club in world class tournaments; and the decreasing need to enforce its disciplinary actions.

Strategy development and decision-making

To ensure that programmes are appropriate and acceptable, beneficiaries and stakeholders must contribute to their design. For example, the project team for the DISH Project worked with District IEC Action Committees to plan and organize local activities. SHAPE held consultative meetings with community members, whose ideas were used

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Project management is usually strengthened through supportive policies, a clear delineation of responsibilities, and the formulation of guidelines and standards. Since most adolescent reproductive health programmes are still relatively new, such management tools are often weak or non-existent.

for programming and policy, and with Ministries of Health and Education and Heads of Schools to develop its programme strategy. Finally, PPASA held a series of planning workshops so that branch offices could share experiences before new centres were launched.

Again the exception, MYSA believes that you get better results when you let the members make their own decisions. MYSA utilizes a bottom-up structure for decision-making and does not allow adults into the process. This ensures that 1) leadership and management skills are transferred, 2) ownership is felt at all levels, and 3) plans are realistic. This approach insulates the Association from outside influences and from becoming vulnerable to political manoeuvring. All decisions are made by consensus and recorded for any member's reference. Because the community has come to support and trust the programme, they do not interfere.

Capacity Building

Training is crucial to build the skills and confidence of youth volunteers and adult staff members. To help youth help themselves, MYSA has developed a strong system of mentoring, which perpetuates management capability through peer-to-peer, on-the-job training. SHAPE, PPASA and MYSA have all developed a core group of master trainers: peers who are responsible for training other peer educators.

The DISH Project has emphasized capacity-building at the district level and spent time training and supporting district health teams. SHAPE has developed a group of teachers who volunteer to help train other teachers and establish programmes in other schools. PPASA is now providing on-the-job training to government staff. However, the challenge with young staff is that they often require extensive training to give them the confidence they need to manage a pilot project.

Infrastructure

Project management is usually strengthened through supportive policies, a clear delineation of responsibilities, and the formulation of guidelines and standards. Since most adolescent reproductive health programmes are still relatively new, such management tools are often weak or non-existent. Examples are evident in the four programmes featured. Although SHAPE is currently lobbying for a policy on health education in schools, its activities have evolved differently within each school due to a lack of clear policy. Confusion exists within PPASA about how flexible they are allowed to be as a pilot project, although there are standards or protocols to guide staffing, service delivery and outreach. On the other hand, MYSA makes all meetings, records and accounts

available to members and the public to reinforce good governance and accountability. With codes of behaviour and guiding principles, members know what is expected of them. This is also true of SHAPE's Anti-AIDS Clubs.

SUSTAINABILITY

Many issues necessary for sustainability have already been discussed. They include the integration of social, economic and health strategies; the institutionalization of frameworks and decision-making processes; and accountable management systems. Other programme elements that contribute to sustainability include:

Create Ownership

In order to create district ownership, District Health Management Teams adapted the DISH Project's general media strategy to fit their own situations and were given their own budget for implementing the activities in their workplans. By involving IEC Action Committees and schools, key individuals have become committed and contribute to the programme from within the community. If their efforts are supported by District Health Teams and other community members, they will likely continue to push the programme forward even after the end of the official implementation period. Unfortunately, mass media campaigns tend to be expensive and are not necessarily sustainable in the long term. Many of the activities are one-off events. Continuation of low cost, on-going elements will be dependant on the priorities and initiative of District Health Teams.

Establish Partnerships

PPASA is trying to ensure the ARH project's continuation by lobbying strongly for the integration of reproductive health into youth activities and centres run by other NGOs, and introducing new centres in conjunction with teacher training and education programmes. By actively collaborating with other initiatives in Swaziland and offering its expertise, SHAPE is creating a network of support from the government and community. MYSA has strong partners that help ensure funding and other contributions.

Recover Costs

None of the programmes developed a deliberate strategy to recover costs, and all of them could benefit from technical assistance with cost-recovery. PPASA centres have experimented with various fees, but are

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The experiences of MYSA, the DISH Project, SHAPE and PPASA demonstrate the importance of certain elements, such as: involving young people in the management of their own programmes; gaining community support; and developing monitoring systems that allow for adaptability.

generating only nominal income. Individual SHAPE Anti-AIDS Clubs have also experimented with ways of raising funds – these efforts should be recognized and supported. MYSA is in the process of developing a five-year plan which includes fundraising elements (see below).

Start Small, Go to Scale

Both SHAPE and PPASA expect that their programme will be absorbed into the government system and become national in scope. In order to ensure this, they have nurtured government involvement from the outset. However, in PPASA's case, the pilot model has raised certain expectations or set standards that the government programmes cannot meet (e.g. higher staff salaries, relatively expensive rent for centres). If government had been involved *more* from the beginning, decisions affecting cost may have been made differently.

Develop a strategy

In order to become self-financing, MYSA has developed a five-year plan to raise capital to purchase its own playing fields and garbage trucks. MYSA also hopes to earn revenue by grooming professional players, by developing a sports career training centre, and by hiring out their expertise to other interested youth groups through a youth leadership training programme.

CONCLUSION

The experience being built in adolescent reproductive health is evident in these four programmes. As we broaden this base of experience, we can begin to establish a dependable frame of reference to measure current and future efforts. The experiences of MYSA, the DISH Project, SHAPE and PPASA demonstrate the importance of certain elements, such as: involving young people in the management of their own programmes; gaining community support; and developing monitoring systems that allow for adaptability. We also note from MYSA's experience that there are no golden rules which can be applied to all programmes and guarantee success. From these examples, we gain a clearer understanding of our challenges such as the need to link services to information, the need for more clinical services targeted at adolescents, and the need to be bold and creative in designing programmes. We are challenged to uncover truly unique and effective initiatives and give them the kind of support they need to be sustainable and/or taken to scale.

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