UNFPA

# SEXUAL & REPRODUCTIVE HEALTH AND RIGHTS

FOR OUT OF SCHOOL YOUNG PEOPLE IN EAST AND SOUTHERN AFRICA

## PROGRAMME GUIDE

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# ABOUT THIS GUIDE

This document is intended to provide guidance on how to work effectively and systematically with out of school young people through an essential programming package for UNFPA Country Office staff and implementing partners within the East and Southern Africa Region (ESAR). The package includes Comprehensive Sexuality Education (CSE) manuals and workbooks, videos and songs, pamphlets and brochures, a Mobisite called TuneME and linkages with health and other support services. The guide proposes identifying and working with the different categories of young people and not treating young people as a homogeneous group hence requiring targeted programme materials and approaches. Gender and human rights are critical aspects of the essential programme package recommended by this guide.

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# SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

## Programming Guide for Out of School Young People

This document is intended to provide UNFPA Country Offices and implementing partners with guidance on how to work effectively with out of school young people in a gender and rights focussed manner towards their optimal health and well-being. It aims to assist them to plan and implement an essential package of services for out of school young people

Adolescents and young people aged 10–24 make up about a third (33 percent) of the population in Eastern and Southern Africa (ESA). The percentage of young people who are out of school varies considerably across ESA. For example, in Botswana, South Africa, the Seychelles and Kenya, less than 5 percent of all adolescents are out of school. In Malawi, Lesotho and Uganda, between 20 and 25 percent are out of school, while in Swaziland, Mozambique and Ethiopia, 33-39 percent are. In Eritrea and Burundi, more than half of all 10-to-19-year olds are out of school. Rates of secondary and higher education enrolment remain low in many countries and girls are more likely to be out of school compared to boys. (PRB and UNFPA, 2012)

# WHY FOCUS ON OUT OF SCHOOL YOUNG PEOPLE?

In addition to representing a significant proportion of young people in many countries in the region, out of school youth, especially those who are unemployed, are at higher risk for sexual and reproductive health and other problems than those in school. They may be more likely to start having sexual intercourse, get pregnant or get someone pregnant, and get married early. For some young people, especially girls – they may in fact be out of school because they got pregnant and/or got married. Out of school young people are also more likely to take drugs or alcohol, which in turn impair judgement and increase sexual risk-taking.

Out of school young people by default cannot benefit from in-school comprehensive sexuality education that is being provided in the region, and are excluded from other school based social and health interventions that are systematically delivered within the formal education system. Because they are out of school and, therefore, do not regularly gather together, they are harder to reach, requiring extra effort. This is especially true among young married girls who are largely consumed by their duties as homemakers and mothers and socially isolated as well as disabled young people who have additional challenges.

## Key sexual and reproductive health issues for out of school youth

UNPFA's ESARO's programme for out of school young people is focused on addressing the following key issues:

### Adolescent pregnancy

Adolescent fertility rates remain high at about 108 live births per 1,000 girls aged 15–19 for the ESA region as a whole. In 2011, the number of births per 1,000 girls aged 15-19 ranged from 21 in Burundi to 168 in the Democratic Republic of Congo (PRB and UNFPA, 2012). The rates are especially high in Democratic Republic of Congo, Malawi, Mozambique, Uganda and Zambia. In Malawi, for example, more than 50 percent of women had given birth by the age of 20. By age 17, at least 20 percent of young women in six countries in the region have started childbearing (UNESCO, 2013).

With a few notable exceptions (Namibia and Swaziland), most adolescent childbearing occurs within marriage. For example, in Zimbabwe, 41 percent of women ages 20-24 had their first birth before age 20 in marriage compared to 6 percent who had it before marriage; in Uganda, the figures are 5 percent in marriage compared to 12 percent before marriage; and in Malawi, 59 percent in marriage compared to 8 percent before marriage (UNDESA, 2013). In some cases, although the birth takes places after marriage, the girl became pregnant before getting married. Although adolescent childbearing is often the result of child marriage, unmarried adolescents are also at risk for unintended pregnancy since they may face obstacles to accessing contraceptives and health services. In addition, some adolescents become pregnant due to rape.

Medical complications from pregnancy and childbirth are among the leading causes of death for girls aged 15–19. Pregnancy in adolescence carries higher risk for obstructed labour, postpartum haemorrhaging, fistula, pre-term delivery, low birth weight, still births, neonatal mortality, unsafe abortion, and maternal death. The youngest mothers are the most likely to experience complications or death due to pregnancy and childbirth. Adolescent pregnancy often leads to a girl dropping out of school, resulting in long-term social and economic consequences for a girl, her family and the broader community.

### STIs and HIV

The ESA region remains the epicentre of the global HIV epidemic. HIV prevalence rates among young people aged 15-24 years range from 0.2 percent (Eritrea) to 15 percent (Swaziland). In 2012, an estimated 2.6 million young people (15–24 years old) were living with HIV in the ESA region. The regional HIV prevalence among young women is four percent, more than two times higher than among young men of the same age (UNESCO, 2013). Some adolescents were born with HIV while others acquired it sexually.

HIV prevalence among young people is falling in many countries; however, there are still an estimated 430,000 new infections per year among young people 15-24 in ESA (UNESCO, 2013). Condom use remains low and few adolescents get tested for HIV. In addition, girls continue to face a higher risk of HIV infection than boys.

Adolescents are vulnerable to acquiring STIs and HIV because of their age, biology and legal status. The types of relationships that they engage in (especially multiple and concurrent partnerships and inter-generational and transactional sexual relationships) are also a major factor. In six countries (Eritrea, Lesotho, Madagascar, Mozambique, Swaziland, and Tanzania), more than one in four young men aged 15–24 report having had more than one sexual partner in the previous 12 months (PRB website, DHS data). In seven countries in the region (Burundi, Democratic Republic of Congo, Ethiopia, Lesotho, Rwanda, Swaziland, and Zimbabwe), more than 10 percent of young women report having had sexual relations with a man more than 10 years their senior in the previous year. These relationships put young women at higher risk of STIs, HIV and pregnancy because their partners are more likely to have had multiple partners, are more likely to have HIV, and because it is more difficult for the young women to negotiate condom use due to the power difference. Transactional relationships for money, gifts such as cell phones, clothes, jewellery, alcohol, and protection, are also common and further disempower the person receiving the benefits, usually girls or young women. Studies have found that the greater the benefit, the less likely it is for safe sex to be practised (UNESCO, 2013). Young women need confidence and competence to negotiate condom use and young men must recognize the importance of consistent condom use for their own health and that of their partners. (PRB and UNFPA, 2012)

Access to treatment has transformed the future prospects of adolescents and young people living with HIV. Most should be able to live long, healthy and productive lives. As they move into adolescence, they need to be able to negotiate their sexual and reproductive lives safely and special attention must be paid to their particular needs. Yet many adolescents living with HIV have not been tested and/or treated. This means that, while HIV-related mortality has fallen for children under 10 and for adults, it has risen for adolescents aged 10 to 19. Increasing testing, treatment literacy and adherence is as necessary as fighting stigma and discrimination against adolescents living with HIV. Because testing is a life-saving intervention and HIV-positive persons should start treatment immediately (Test and Treat) before the virus destroys their immunity, it is important that all age restrictions to testing are removed from national policies.

## Sexual and Gender-based Violence (SGBV)

For many adolescent girls in the ESA region, sex, marriage and pregnancy are not voluntary, consensual or informed (UNESCO 2013). Sexual violence and coerced sex are common in relationships and, for many, their first sexual encounters are forced. Between 9–36 percent of girls aged 15-19 report having experienced sexual violence at some point in their lives in the nine countries where data are available. Except in the Democratic Republic of Congo, the rates are higher for women aged 20–24, ranging from 18 to 31 percent (UNESCO, 2013, PRB and UNFPA, 2012). SGBV is not only a violation of the rights of young people but also exposes them to unintended pregnancies and STIs, including HIV. Rates of SGBV are much higher among male and female young people with disabilities.

## Alcohol and Drug Use and Abuse

Many people try smoking, alcohol and drugs during adolescence and youth. These behaviours can have a negative impact on young people's well-being and also lead to poor sexual and reproductive health outcomes. Alcohol use may contribute to risk behaviours, such as multiple sex partners, inconsistent condom use and transactional sex. Young people who use drugs are at higher risk of HIV infection due to lack of access to information, sterile injecting equipment and services such as HIV testing and counselling. While all substance

use is associated with risk-taking and higher HIV rates, young people injecting drugs have much higher HIV rates than their peers. Together with injecting drug users, young key populations whose behaviours are criminalized such as LGBTIs (Lesbian, Gay, Bisexual, Transgender, and Intersexed) and sex workers have higher rates of HIV infection than their age mates, another concern to explore in national programming and the harmonisations of laws and policies.

## Child marriage

An estimated 36 percent of women aged 20–24 in 21 ESA countries were married or in union by the age of 18 (UNICEF, 2016). Despite progress in many countries, the practice remains prevalent in some areas and has direct negative consequences for the health, education and social status of girls and young women. Some of these marriages are forced and often the girl has no say in the selection of her spouse. In addition to being a violation of the fundamental human rights of girls, child marriage typically results in the end of the girls' education, early pregnancy, and births (see below). Most often girls are married to significantly older men. These men may have had multiple sexual partners and unprotected intercourse and, as a result, are more likely to have STIs and/or HIV, putting their young wives at risk of STIs and HIV. The marital relationships between these older men and their child brides are often difficult and marked by unhappiness and intimate partner violence, including rape. A study conducted in South Africa found that young women who were subjected to intimate partner violence were 50 percent more likely to be HIV-positive than those who were not subject to it. Child marriage rates are highest among girls that are uneducated or undereducated, poor, and living in rural areas. Maternal mortality among adolescent females is also highest among girls with the same characteristics, indicating the level of inequities in education, health services, employment, and other opportunities for these girls. Ending child marriage is a top priority because it contributes to most of the negative health outcomes that UNFPA is working to combat in young people, for example, preventing early pregnancy, child spacing and planning the number of children a couple has, uptake of contraception and safer sex practices.

## Other Harmful Practices

Other practices that are harmful to sexual and reproductive health are found in many countries in the region. They vary significantly across and within countries. Some that deserve particular attention are female genital mutilation (FGM), dry sex, and sexual intercourse during or immediately after initiation ceremonies. FGM is a human rights violation and is unacceptable under any circumstances. The prevalence of FGM varies significantly across the region: among adolescents aged 15 to 19, 78 percent and 62 percent have had FGM in Eritrea and Ethiopia (although the data are old), 15 percent in Kenya, 7 percent in Tanzania, and 1 percent in Uganda. Although the prevalence rate of FGM is different among countries, it is often universally practiced by members of the same ethnic groups. Although in every country in the region where female genital mutilation is practiced the prevalence has come down, the rate of reduction has been very slow and millions of girls are still at risk.

Dry sex is the practice of using drying substances to reduce moisture (natural secretions) in the vagina to make it feel tighter, and/or hotter and to cause more friction during intercourse. For women, it can make sex uncomfortable and even painful. During dry sex, the friction can cause tearing to the delicate lining of the vagina. Although the practice is said to make sex more pleasurable for men, it can make penetration both more difficult and painful and can also result in tiny tears to the tissues of the penis. The lack of lubrication can contribute to condoms breaking as well. Vaginal tears and inflammation, tears on the penis, and increased condom breakage make the transmission of STIs and HIV more likely when dry sex is practiced. Dry sex has been reported in Democratic Republic of Congo, Kenya, Malawi, South Africa, Zambia, and Zimbabwe.

Initiation rites during adolescence mark the transition from childhood to adulthood and typically occur when

signs of puberty are noticeable. Because they vary widely across countries and ethnicities, the potential for harm to young people also varies depending on the specific practices. During initiation ceremonies, young people may be given counselling on the passage to adulthood, physical changes, how to care for themselves when menstruating for girls, how to be a good future spouse, sexual feelings and emotions, sexual behaviour, how pregnancy occurs, and STIs, HIV and safer sex. They may be advised to avoid sex, encouraged to seek it out, or initiated into sexual activity, sometimes under pressure or by force during or immediately after the initiation. In these circumstances, such as in some parts of Malawi for example, an older man called Fisi (Hyena) may have sex with multiple girls as part of initiation, most often without condoms or other contraception. Boys may also be pressured to practice their manhood by having sex.

Male circumcision and female genital mutilation may also be part of these ceremonies. For example, every year, young men may have their penises injured or die during initiation ceremonies accompanied by traditional male circumcision. Similarly, young girls are injured or die from female genital mutilation procedures. Some ceremonies involve beating and bullying. Research done in Malawi found that young people who have been initiated are more likely to have had sex and to have had multiple partners in the last year. In some instances, incorrect information about sexual and reproductive health is provided during initiation rites. Although traditional authorities are trying to eliminate the harmful aspects of initiation ceremonies, some harmful aspects still continue in rural areas. Programmes will need to analyse the specific initiation rites where they are operating and assess the harms that may result, if any, to identify what needs to be addressed or changed.

## Key Behaviours

For each key issue above, the table below indicates the health outcomes that we want to achieve. It also shows the key behaviours that young people need to adopt to achieve these outcomes. The required knowledge, attitudes, values, beliefs, intentions, motivation, and personal agency and skills that are needed for the young person to adopt the behaviours are indicated in summary form. These are the areas that any programme for young people must address in order to achieve the required healthy behaviours and health outcomes. They are outlined to guide you in the essential areas to cover when you undertake programmes for out of school young people.

Programmes often focus a great deal on providing information and spend too much time talking at young people. It has been clear for decades that providing information is not enough to change behaviour. This led to programmes focused on developing life skills. However, even with information and skills, young people still may not adopt behaviours that will protect their health and well-being. Therefore programmes must also explore their values, attitudes, beliefs, desires and motivations with them, help them to think through what they intend to do in different situations that they are likely to face and encourage them to personalise the information that they have learned and apply it to their own lives. This systematic approach to behaviour change is critical for programming for out of school young people. Youth workers must be able to master the content in the table for each health outcome they plan to achieve and each health behaviour they want to either promote or help young people discard.

To better understand the table below, first read the columns from the right to the left, e.g. start with **Health Outcomes.** Then look at the next column on **Key Behaviours** that will lead to the health outcomes. After that, read the column on Skills that are necessary to perform the key behaviour. Then look at the column on **Attitudes, Values, and Beliefs.** It shows what needs to change in order to bring about the **Intentions, Motivation, and Personal Agency** required to adopt the **Key Behaviour**. The final column on the left, **Knowledge**, indicates that to modify the **Attitudes** we should have implemented some important **Activities** (not shown on this table) that provided the necessary **Knowledge** to start the behaviour change process. These activities could be lessons, educational materials, videos, songs or discussions focusing on the specific behaviours that we want the adolescents/young people to adopt.

# Guiding framework

| Knowledge | Attitudes, Values, Beliefs, Intentions, Motivation, and Personal Agency | Skills | Knowledge | Health outcomes |
|---|---|---|---|---|
| • Understand the consequences of child marriage<br>• Know that child marriage violates their human rights<br>• Know the international and national laws that protect them from child marriage | • Understand the consequences of child marriage<br>• Know that child marriage violates their human rights<br>• Know the international and national laws that protect them from child marriage | • Able to argue effectively against child marriage<br>• Able to decide not to get married as a child | • Speak out against child marriage<br>• Resist being married before they are 18 years old<br>• Object to their siblings or others being married before they are 18<br>• Refuse to allow their own children to marry before they are 18<br>• Remain in or return to school | **Prevent child marriage** |
| • Know that cultural practices can be beneficial, harmless, or harmful and that beneficial practices should be promoted; harmless ones left alone, and harmful ones changed or eliminated<br>• Understand the consequences of the common harmful practices in their community<br>• Know their human rights related to the harmful practices common in their community and the relevant national laws, if any | • Believe that the harmful practices are wrong for themselves, their siblings, their children and others<br>• Desire not to participate in or support harmful practices<br>• Want to protect themselves, their children and others from the harmful practice | • Able to argue effectively against harmful practices.<br>• Able to decide not to participate or support harmful practices for themselves or others | • Speak out against harmful practices<br>• Refuse harmful practices for themselves<br>• Object to harmful practices being done to or by others<br>• Refuse to allow harmful practices to be done to their children | **Prevent or change other harmful practices, such as dry sex and risky sexual activity associated with initiation rites** |
| • Know how pregnancy happens<br>• Be able to separate myths from facts about pregnancy prevention<br>• Know how to prevent pregnancy<br>• Know the different contraceptive methods, including emergency contraception, how they work, and where to get them<br>• Know in detail how to use the pregnancy prevention method that they have chosen<br>• Know in detail how to use condoms correctly<br>• Understand the need to use condoms to prevent STIs and HIV even if they are using another contraceptive method<br>• Know their rights and responsibilities related to relationships, sex and protection<br>• Understand that male and females have equal responsibility for protection<br>• Know where to get family planning services and counselling, emergency contraception and legal assistance if raped | • Don't want to get pregnant or make someone pregnant during adolescence<br>• Accurately assess their own risk of an unintended pregnancy<br>• Plan to wait to have sex until they are older and/or to use contraception to avoid an unintended pregnancy when they have sex<br>• Believe that they are in control of their bodies<br>• Believe that they are able to discuss and use contraception with their partners<br>• Belief that both partners have the responsibility to prevent pregnancy | • Able to delay sexual intercourse if they choose to do so.<br>• Able to discuss and negotiate contraceptive use with any potential sexual partner before having sex.<br>• Able to decide which contraceptive methods to use before having sex<br>• Able to refuse unprotected sex<br>• Able to obtain contraception and condoms<br>• Able to use condoms correctly<br>• Able to correctly use the contraceptive method they choose | • Don't get married before the age of 18<br>• Wait to have sex until they are older<br>• Refuse to have unprotected sex<br>• Discuss and agree on contraception with sexual partners<br>• Get contraception before they need it<br>• Use contraception correctly every time they have sex<br>• Use condoms correctly every time they have sex | **Prevent Unintended Pregnancy** |

| Knowledge | Attitudes, Values, Beliefs, Intentions, Motivation, and Personal Agency | Skills |
|---|---|---|
| • Know the facts about STI transmission, signs & symptoms (and lack thereof), health consequences & treatment<br>• Know the facts about HIV transmission, disease progression, testing, treatment and positive living<br>• Be able to separate myths from facts about STIs and HIV<br>• Know how to prevent and reduce the risk of STIs and HIV.<br>• Know in detail how to use a condom.<br>• Know the behaviours and types of relationships that increase the risk of STIs, HIV and unintended pregnancy, especially multiple, concurrent partners, partners more than five years older and those who provide benefits (e.g. cash or gifts) in exchange for sex, and drinking and drug use<br>• Understand dual protection from STIs, including HIV, and pregnancy<br>• Know their rights and responsibilities related to relationships, sex and protection and related to living with HIV<br>• If HIV positive, understand how ART works and why they need to take it according to the health provider's instructions | • Want to avoid getting an STI or HIV<br>• Accurately assess their own risk of getting an STI or HIV<br>• Believe that using condoms is normal and good<br>• Plan to wait to have sex until they are older and/or to use condoms to protect themselves when they have sex<br>• Want or prefer to have partners who are close to the same age as they are<br>• Believe that it is not okay to exchange sex for benefits, even if you need the benefits<br>• Intend not to have more than one partner during the same time period<br>• Intend not to drink alcohol, or not get drunk or use drugs<br>• Want to know their HIV status<br>• Believe that they are in control of their body<br>• Believe that they are able to discuss and use condoms with their sexual partners<br>• Believe that both partners are responsible for preventing STIs and HIV<br>• Believe that it is okay for girls to talk about sex and protection and to carry condoms | • Able to delay sexual intercourse if they choose to do so<br>• Able to discuss and negotiate condom use with any potential sexual partners before having sex<br>• Able to refuse unprotected sex<br>• Able to obtain condoms<br>• Able to use condoms correctly |

| Knowledge | Health outcomes |
|---|---|
| • Don't get married before they are 18<br>• Wait to have sex until they are older<br>• Refuse to have unprotected sex<br>• Negotiate condom use with sexual partners before they have sex<br>• Get condoms<br>• Have condoms with them at all times<br>• Use condoms correctly every time they have sex, even if using another contraceptive method at the same time<br>• Resist pressure to do something they do not want to do, such as getting drunk or using drugs<br>• Have only one sexual partner at a time<br>• Don't have partners who are five or more older than they are<br>• Don't accept benefits in exchange for sex<br>• Get tested for STIs and HIV, including when pregnant<br>• Get tested for HIV with one's sexual partner before having sex and/or before marriage<br>• If HIV positive, take ART exactly as instructed<br>• Treat people living with HIV the same way they treat everyone else | **Prevent STIs and HIV** |

| Knowledge | Attitudes, Values, Beliefs, Intentions, Motivation, and Personal Agency | Skills | Knowledge | Health outcomes |
|---|---|---|---|---|
| • Know the characteristics of healthy and unhealthy relationships<br>• Understand gender, gender stereotypes, power and gender inequality<br>• Understand the effects of gender inequality on women and girls, men and boys, on relationships, and on society<br>• Know the basic facts about of sexual and gender-based violence, including types and consequences, where violence can happen and situations that can lead to violence and abuse<br>• Know their human rights related to sexual and gender-based violence and the relevant national laws<br>• Understand that the perpetrator is responsible for the violence that they inflict, not the victim (or survivor)<br>• Know what to do and where to go for help if they or someone they know has experienced sexual or gender-based violence | • Believe that males and females are equal in life and in relationships<br>• Believe that sexual and gender-based violence is always wrong<br>• Believe that it is not their fault if they are a victim of violence<br>• Want to be in a mutually loving and respectful relationship in which conflicts and issues are resolved without violence.<br>• Intend not to be violent<br>• Intend not to stay in a violent relationship<br>• Believe that they can solve conflicts and problems without violence<br>• Intend to avoid situations that may lead to violence | • Able to communicate about problems effectively<br>• Able to negotiate solutions to problems non-violently<br>• Able to get help if they are violent or are experiencing violence in a relationship | • Go to a health clinic or service for survivors of violence if they have been raped to get emergency contraception and post-exposure prophylaxis | **Prevent sexual and gender-based violence** |
| • Know the basic facts about alcohol and drugs, including the negative effects and possible consequences on themselves and others<br>• Know that peer pressure is one reason adolescents start using alcohol and drugs<br>• Know how to drink alcohol responsibly<br>• Understand that it is easier never to take drugs than to stop once you are addicted to them<br>• Know signs of drug addiction and where to get counseling and rehabilitation | • Intend never to start using drugs<br>• If drinking alcohol, intend to drink with moderation<br>• Believe that alcohol and drugs may lead to sexual risk-taking that can result in pregnancy, STIs and/or HIV<br>• Believe that providing alcohol or drugs to a minor<br>• Believe that drugs and alcohol can have negative effects on one's future and health.<br>• If addicted, believe that they can overcome drug addiction if they are committed to doing so. | • Able to refuse to take alcohol and drugs<br>• Able to resist pressure from peers to do things they do not want to do<br>• Able to get help for problems with alcohol and drugs if they need it | • Don't drink at all or don't drink to excess<br>• Refuse to take drugs<br>• Seek counselling and rehabilitation if addicted to alcohol or drugs | **Prevent substance use and abuse** |

# PROGRAMMING OPTIONS FOR KEY BEHAVIOURS

To address these issues, a strategic and systematic approach is needed. Random or ad hoc activities that superficially address one or two issues will not bring about healthy behavioural development or lasting behaviour change in young people. As indicated above, young people need to have the knowledge, attitudes, values, beliefs, behavioural intentions, motivation, agency, and skills required to adopt the behaviours that will result in the desired outcomes. Young people must also have a supportive environment to participate in programmes so orienting parents and other community leaders about the objectives of out of school youth programmes are essential to their success.

As programme implementers, you need to carefully think through how you can ensure that the young people you work with receive sufficient inputs to adopt those behaviours and how you are going to bring about change systematically. Limited resources require strategic thinking and planning about what will be most effective at changing risk behaviours and adopting healthy behaviours among the largest number of young people possible in each community, district and nationally to saturate geographic areas and make impact. Limited resources mean that programme implementers could focus on a set of behaviours first and another set of behaviours at a later date, with the aim of eventually addressing all issues to ensure that young people are well informed and empowered. Decisions around geographic priorities and focussed behaviours should be determined by local data to determine, for example, where rates of HIV, or unintended pregnancies, early marriages, harmful traditional practices, etc. are most prevalent.

## The programme implementers need to decide on the following:

1. Which groups of out of school young people should we focus on first? Adolescents living with HIV? Young sex workers? Those involved in substance use/injecting drug users? Those working in and around the markets? All out of school adolescents in the community? Which age group will the programme focus on? What data or evidence justifies that we start with these groups?
2. For each sub-group of adolescents and young people, what health outcomes and key behaviours does the programme want to address? What research has been carried out to identify young people's knowledge levels and challenges they face in adopting healthy behaviours or accessing services?
3. What educational package should the programme offer to each sub-group and do we have this package?
4. How will we deliver the package to each sub-group or category of youth? Face-to-face trainings? Outreach through peer educators? Video shows? Songs? Dramas? Combination of all?
5. How long should each package last for each sub-group if the programme plans to address all the behaviours? This could be a one-week training followed by single weekly sessions to complete the manual, together with videos, songs, and a trip to a health facility to acquaint the youth with services; or a two-week training with the manual, followed by video shows and community outreach, etc. Or it could involve, for a period of two months, two sessions per week from the manual until completed, followed by video shows, songs and distribution of educational materials, linkage with mass/social media programmes and visit to the clinic, or bring the health providers to describe the services available, or any other combination.
6. How will we monitor and ensure that each group of youth got the essential package designed for them and that all the behaviours are addressed so that each group becomes well informed and empowered youth?

7. How will the programme monitor the effectiveness or quality of each of the activities being carried out? Will there be supervisors doing spot checks? Will there be checklists to document both numbers of youth participating and quality of each programme activity? Will there be photos? Pre- and post-tests to compare the knowledge of the young people before and after the programme? Do we have these tools or do we need to develop them? Do our partners have these tools, which could be adapted? How many of these tools do we need to print or will we use electronic ways of capturing the programme data?
8. How will the programme analyse and compile the data from all programme activities into a results-oriented report? This report will "sell" your programme to donors and government officials and should be prioritized.

UNFPA, together with partners, have developed a comprehensive regional resource package of teaching and learning materials for working with out of school young people in East and Southern Africa after reviewing the many materials currently used within the region and the need to update and consolidate materials that are aligned to international standards for the sake of promoting clear and consistent messages to young people.

There is first this programming guide to assist with planning programmes with out of school young people. Then there is the Regional CSE for Out of School Young People Facilitator's Manual and its accompanying Participant's Workbook. National adaptation of this regional version of the manual and workbook, through a wide consultative process among government, implementing partners, and young people is encouraged.

There is also some pamphlets and 10 songs with music videos (album called 'We Will') that support the lessons in these manuals or may be used on their own through various Social and Behaviour Change Communication modalities. Another exciting tool included in the out of school package is TuneMe.org that is a free interactive mobisite aimed at giving information, answering questions, and linking young people with services though health clinic finder feature. This last feature will be launched in Zambia by the 3rd quarter of 2016 and in several other countries in 2017.

Additionally, there is a special resource dedicated to young people living with HIV called, iCAN that includes a facilitator's manual and participant's workbook. Plans are underway to also produce dedicated CSE materials for young people with the range of disabilities.

Some of the programme options below draw from these materials and aim to guide you to design and implement SRHR/CSE programmes for out of school youth. Please review and use it as you see fit, together with any other materials that you may be currently using. The information provided here is not meant to be prescriptive but to guide your decisions according to your organizational capacity and technical and financial resources available.

Outlined in the following pages are some sample methods to reach young people with information and services. Your organization can select two or three complementary methods, based on your programme objectives and resources.

# SAMPLE EDUCATIONAL PROGRAMS

## Comprehensive sexuality education

UNFPA's regional office has developed a regional comprehensive sexuality education manual for out of school youth mentioned above that addresses a comprehensive set of health outcomes and key behaviours outlined earlier in this document. It is aligned with international standards on CSE which includes participatory methodologies and engaging in the different learning domains, cognitive, affective, and skills building, throughout the lesson plans and clear key messages. This manual can be used in a number of ways, including:

- Train facilitators to use the manual, including staff of NGOs and youth-led organisations (the manual can be completed in about 10-12 days and a TOT 11-15 days).
- Conduct two-week trainings for young people to cover the whole manual.
- Conduct one week of training followed by weekly sessions of a couple of hours until you have covered all the sessions in the manual.
- Organize one or two sessions of a couple of hours per week with a group of young people until you have covered all the sessions in the manual. Then start sessions with another group of youth and continue for the whole year until you have reached all out of school youth in each community, thus saturating a geographic area of young people that have undergone similar CSE programming.
- Select and conduct the activities that are appropriate for the young people in your group and for your programme goals. You can add activities that you know work well. You may need to use other modes of covering all the behaviours that you need to address, such as songs, dramas, social media, radio programmes, etc. The iCAN package can be covered with adolescents living with HIV following the same process as the Regional CSE for Out of School Young People manual above.
- At the beginning or end of an educational programme, have each group select a name for itself to give them a sense of belonging. Call them for further programmes or follow-up on activities using their name (e.g. the Leopards, the Tigers, the Well Informed, the Wisdom group).

## Targeted Education

Some groups of young people have different needs than others. To address their specific needs, you can organize education sessions designed for those groups. Make sure that you understand their needs and have clear behavioural goals for these programmes.

- Potential sub-groups of adolescents could be, e.g. single mothers, young married girls, young people living with HIV, sex workers, adolescents aged 10-14, young people with disabilities, etc. When implementing education or other community programmes, identify and keep track of the young people who belong to these different groups.
- To recruit sub-groups (e.g. all young people living with HIV in district X or all adolescent single mothers or married girls), use the snowballing method. Ask the first ones to bring their friends from their localities and continue until you think you have identified all.
- Inform them about the programme and plan ways to reach them with programme activities over a period of time. Select and train peer educators from each group and work with them to systematically reach their peers. If the marginalized adolescent sub-groups do not want to identify themselves, just refer to them with the name they prefer.
- To avoid stigmatization, you should not share with the community what categories they belong to, nor in front of other youth — unless, for example, they are carrying babies that indicate their status as parents, etc.
- Monitor progress with each sub-group as well as overall progress. This will allow your programme to be sensitive to the diverse needs of diverse young people.

## Community Outreach

Organizations often undertake community outreach to create awareness and provide limited education or information. The main risk with community outreach is that it can easily become ad hoc, one-off interactions rather than providing enough prolonged interaction to make a difference in all the behaviours to be addressed. When undertaking community outreach, some points to remember are:

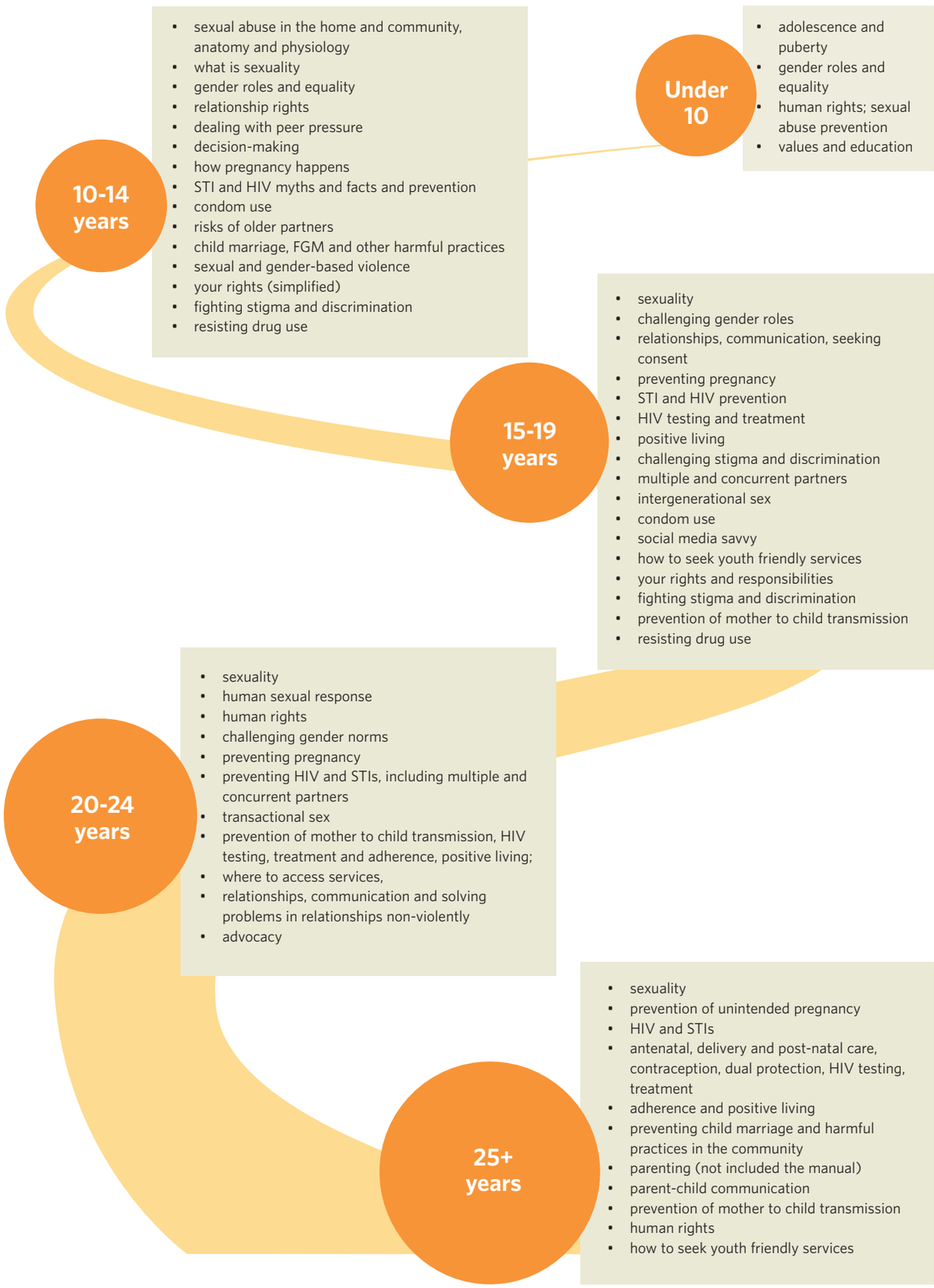
- If you are conducting discussion sessions with young people, do not try to have discussions with a whole group. Young people need to be separated by age because 24-year-olds face very different issues than 16-year-olds, who in turn are dealing with different issues than 10-year-olds. Divide the young people into groups by age: under 10s, 10-14, 15-19, 20-24 year olds, and 25+. Use five facilitators to run age-appropriate discussions and programmes for these groups instead of talking to all of them together.
- Plan what you will do with young children and adults who may show up. During community mobilization, typically people of all ages show up. To talk freely and openly, young people need to have their own space without adults. Therefore, you need to have a plan for engaging those outside the youth age range.
- Plan in advance what topics you will address and how you will address them. Do not talk at young people. The attention span of most people is no more than 15 minutes when listening to someone talk. Instead, plan interactive activities that will enable you to find out what they already know, what misconceptions they have, what they think about the topics or issues, what they want to know or do, and activities that engage them in their own learning process. Use the Out of School Youth CSE manual for ideas. Some examples of topics that can be addressed with different age groups are included on page 15.
- Don't be superficial (e.g. just raising awareness) because it won't make a difference. Get in-depth into the topics and make sure you cover all aspects of the issue – knowledge, values, attitudes, and any related skills and protective behaviours.
- Encourage and assist youth to go back to school or to get more training so they can move towards economic self-sufficiency.
- Mobilize young people to reach out to peers, tell them about the programme and share what they learned.
- For each community, make sure that young people watch a set of videos and link with existing mass media or social media programmes so their learning can be reinforced over time.
- Whatever educational programme you are implementing, link the young people with services.

*Individual discussions: Whenever you are working with out of school youth, get to know them individually. Know their names and/or the nicknames that they have selected. Have private discussions with them to understand who they are and what they need. Help them develop long-term goals for themselves. Provide them with individualized guidance and referrals to specialized services and care (legal services, rehabilitation services for drug abusers if such services exist, or to social services, income generation programmes, and schools, as needed).*

## Using Media

Use a variety of media developed by your country or regional organizations to educate while entertaining and to reinforce messages. These may include radio or TV programmes, music, videos, print materials, mobile platforms such as TuneMe, websites and other forms of communication. Monitor the quality and coverage of media programmes.

# AGE-APPROPRIATE TOPICS



## Music

The Regional Office has developed eleven songs about different sexual and reproductive health issues. For example, Jack and Jill is about having multiple, concurrent partnerships, whereas Busi is about sexual abuse of adolescent girls and the role of different community members in protecting them. Another song, Private Party educates young people about most common STIs who are trying to get into the private parts of adolescents while the condom aka "Rubberman" prevents the army of STIs from entering. The songs have now been changed to videos. These songs can be found on https://www.youtube.com/channel/UNFPA_ESARO and in the Out of School Youth package. Some ways that you can use them include:

- Present the songs when teaching the related topics with the Comprehensive Sexuality Education manual.
- Play the songs as a lead into a discussion while doing community mobilization.
- Share the songs with the young people by sending them to their phones.
- Use them at community events, health fairs, mobile clinic sites, etc.
- Put them on your website.

## Videos

The Out of School Youth package includes video clips of the 10 songs mentioned above, two videos on pregnancy and condoms with a discussion guide by Soul City and UNFPA, and a cartoon called "No hoodie, No honey" from UNFPA Nigeria. To use these videos:

- Watch the video first and decide what questions you will ask to generate discussion. You can use some or all questions from the discussion guides available or you can create your own discussion guide if none is available. Make sure that your questions will help young people to apply what they learn from the video to their own lives.
- Use the videos during education programmes, community mobilization, youth festivals, one-on-one with adolescents in your family, and any other relevant events.

## Print materials

The resource package for out of school young people includes pamphlets on HIV testing, rights, youth-friendly services, and social media safety that you can print out. You can also make your own materials on topics of particular interest to the young people you know. These materials can be made available to young people during community mobilization activities and other youth events.

## Social Media

Young people are increasingly using social media to get information, to keep in touch with their friends and family, and to meet new people. When working with young people:

- Find out what social media they are using and what they use it for.
- Help them learn what the risks are and how to stay safe when using social media. See the pamphlet on using social media safely and the activity Being Savvy about Using Social Media in the manual.
- Link youth to the TuneMe mobisite at https://www.tuneme.org/ and to other youth-oriented websites that provide reliable information.
- Use Twitter, Instagram and Facebook to publicize your programmes and to reinforce key messages for young people. Link the young people you are working with together so that they share information and feel that they are members of an important network of informed and empowered young leaders who can lead their fellow young people.
- Monitor the ongoing social media traffic and discussions to improve your programme and outreach.

## Community mobilization

Community mobilization focuses on understanding the issues that a particular community is facing and helping them to plan how to address those issues themselves and to implement their plan of action. Community mobilization is especially useful for engaging youth and communities in reducing harmful practices and gender-based violence and addressing gender equality. To carry out community mobilization, programme implementers combine multiple community education and engagement methods, including participatory learning and action; community conversations; house-to-house outreach; community outreach; community meetings in chiefs' compounds; street rallies; campaigns such as Condomize!; community radios; music, dance and dramas (MDD) or edutainment activities; and outreach using peer educators or other community educators.

Community mobilization often aims to both educate the community about a specific issue (e.g. the need to address HIV; increase services for young people, fight child marriage or gender-based violence) or to encourage the community to take specific actions around public health issues. For example, chiefs in Malawi drafted by-laws that prohibited any chief from presiding over marriages of children under 18 or lose their chieftaincy if they do. Four chiefs were stripped of their chieftaincy and only reinstated when they vowed not to infringe the by-law again. In Senegal and other countries, communities led by their chiefs adopted a declaration banning any form of female genital mutilation in their communities.

It is therefore important that programme planners think through what type of community mobilization and engagement they want to carry out and to ensure that proper methodology is followed for each of the methods selected. Some key issues to consider for community mobilization include:

- Act as a facilitator of a process where community members analyse their issues, understand how the issues affect them, come up with viable solutions and implement such solutions. The community is thus more likely to own the solutions over time.
- Allow young people to identify the issues of concern to them.  You can give them broad categories, such as gender or sexual and reproductive health, give them the facts about the issues, and help them prioritize their issues and find their solutions.
- Have participants identify what the problem and underlying factors are.  If they do the analysis themselves, they will understand it better and believe it more than if you tell them.  Provide any information they might need.
- Help the community analyse cultural practices that affect adolescent sexual and reproductive health and classify them as Positive (to be promoted), Negative (to be eliminated) and Existential (those neither harmful nor beneficial that can be left as is). Help them come up with ways of addressing these practices, including finding alternatives to the harmful practices.
- Allow them to come up with their own solutions and to plan what they can and want to do about the issue.  Provide guidance and encourage them to become agents for change.
- Provide follow-up support to help them undertake their own plan of action.
- Monitor progress, especially of by-laws, political commitments to youth issues, and community declarations.

Community mobilization often aims to both educate the community about a specific issue (the need to address HIV in the community; increase services for young people, fight child marriage or gender-based violence) or to encourage the community to take specific actions against public health issues. For example, chiefs in Malawi put together bylaws that prevented any chief to preside over marriages of children under 18 and that any chief who does that will lose his chieftaincy. Four chiefs were stripped of their chieftaincy and only reinstated when they vowed not to do it again; Also in Senegal and other countries, communities led by their chiefs came together and adopted a declaration that will ban carrying out any form of female genital mutilation in their communities. It is, therefore, important that programme planners think through what type of community mobilization and engagement they want to carry out but to ensure that proper methodology

is followed for each of the methods that has been selected. Some key issues to consider for community mobilization include:

- Act as a facilitator of a process where community members analyse their issues, understand how they affect them, come up with viable solutions and implement such solutions. Community is more likely to own the solutions overtime.
- Allow young people to identify the issues of concern to them. You can give them broad categories, such as gender or sexual and reproductive health, give them the facts about the issues they face and help them prioritize their issues and come up with their solutions.
- Have them identify what the problem is and what the underlying factors are. If they come up with the analysis themselves, they will understand it better and believe it more than if you tell them. Provide any information they need if they do not have it themselves.
- Help the community analyse cultural practices that affect adolescent sexual and reproductive health and let them divide to positive (to be promoted), Negative (to be eliminated) and existential (those not either harmful or beneficial that need to be left as is). Help them come up with ways of addressing these including alternatives to the harmful practices.
- Allow them to come up with their own solutions and to plan what they can and want to do about the issue. Provide guidance on what they can do and encourage them to become agents for change.
- Provide follow up support to help them undertake their own plan of action.
- Monitor Progress—especially of bylaws, political commitments to youth issues, and community declarations.

## Peer Education

Some educators, funding officers and program planners may believe that peer education (or other types of peer involvement) is not helpful in planning, implementing or operating a programme designed to change attitudes, norms and behaviours. The international NGO, Advocates for Youth requested a literature review to either refute or substantiate that belief. Extensive research published in the last two decades has shown that peer programs that are well designed and financed can have statistically significant effects on attitudes, norms, knowledge, behaviours, and health and achievement outcomes (Advocates for Youth, 2007).

Despite some skepticism, peer education programmes have been shown to be effective in increasing young people's knowledge about various health issues such as abstinence, STIs, contraceptives, smoking and drugs, and to link young people with services. Peer educators are better placed to reach out to most at risk young people (sex workers, Men who have Sex with Men, single mothers, drug users, etc.) who may feel more comfortable speaking with young people who belong to the same category as they.

However, the effectiveness of peer education programmes depends on how peer educators are recruited, trained, incentivized, retrained, and monitored over time. Young peer educators are in a transitional stage of their lives. This translates into predictable high turnover, which means that new peer educators must be trained as others leave. In addition, some programme planners put the whole responsibility of youth programmes on peer educators, instead of making peer education a support intervention for a programme driven by paid staff (young or old) and not the whole intervention.

**Peer education functions** could be divided into four categories: **Peer education** (educating young people about SRHR issues); **Peer counselling** (counselling youth to make informed decisions about their health issues, including protection and using services, etc.); **Peer contraceptive distribution** (educating young people in the community, distributing contraceptives, including condoms, and other commodities); and **Linking young people with youth-friendly services** through referral, helping them navigate the services, and organizing educational activities.

An important issue in working with peer educators is to ensure that they are given clear strategies for reaching other young people (for example, each youth should reach two young people per week, or 50 over

a period of one year); and tools (reporting forms, referral cards/referral lists, brochures, videos, manuals, question and answer booklets, and models for demonstrating male and female condoms).

## Youth-Friendly Services

In order to fully exercise their right to health, protect their sexual and reproductive health, and get help with problems like violence and rape, all adolescents and young people require access to a range of youth-friendly services. Youth-friendly services should be safe, effective, affordable and acceptable to young people. These services include:

- General health check-ups, including checks on physical development, vision, hearing, etc.
- Advice on puberty concerns and help with menstrual hygiene and problems
- Education and counselling on sexual and reproductive health, sexuality, sexual abuse, and referrals
- Contraceptive education and a range of modern contraceptive methods, including male and female condoms and emergency contraception
- Pregnancy testing, antenatal, obstetric and post-natal care
- Pregnancy options counselling, safe abortion where legal, and post-abortion care
- STI education, diagnosis and treatment, including partner notification
- HIV education, counselling, testing and referrals for treatment, care and support services
- Voluntary Medical Male Circumcision
- Screening for cervical cancer (Pap smear or acetic acid test)
- Immunizations for human papillomavirus (genital warts) and hepatitis B
- Assistance for survivors of sexual and gender-based violence. This should include post-rape counselling, treatment, including emergency contraception and post-exposure prophylaxis (medicine to reduce risk of HIV infection after exposure), antibiotics to prevent some STIs, collection of evidence, and referrals for legal assistance
- Pre-exposure prophylaxis (prevention of risk of new HIV infection by giving ARVs to most at risk young people including young key populations such as young sex workers, drug users, prisoners, and MSMs
- Referrals to other legal, social, and health services not available in the area
- In addition to supporting the government and NGO service providers to develop services that are truly youth-friendly, you need to help young people to access these services. You can:
- Invite young people to the clinic and introduce them to the services.
- Map all the youth resources available in your community and build a referral list with specific contact people that you know you can refer youth to. The services on your referral list should include psychosocial counselling, drug rehabilitation, skills development and training in entrepreneurship, STI and HIV testing, violence counselling and support, antenatal care, homes for pregnant girls, and adoption agencies, if available.
- Make personalized referrals by calling your contacts and telling them who you are sending to see them. Ask the young people to report back to you how they were received and served. For Referrals, you can design bar-coded vouchers that young people can take to service providers and they can scan them and keep tally of how many young people referred have actually accessed services.
- You can give vouchers that young people can take to private services providers where such services is not easily available.

There is widespread recognition that there are SRH services that effectively improve adolescent health (WHO, UNFPA, UNICEF, 1999). There is also evidence to show that young people of varying ages are involved in sexual relationships and therefore need services. However, the delivery of SRH services to adolescents and young people is made complex by legal, cultural and religious norms. Young people continuously report being scolded, judged and their privacy not respected. It is therefore, important to bring health providers and young people together and try to bridge gap between them.

## Monitoring and Evaluation

Youth-serving organizations implementing programmes for out-of-school youth need to document the effectiveness of their strategies and activities in bringing about the results they intended to achieve among their target audiences. To achieve this, they need to build in monitoring and evaluation into the programme from the design stage. They may need to develop a results framework which outlines the programme outcomes, outputs, key actions, and indicators together baseline and targets. The programme needs to develop tools for monitoring all programme activities in terms of quality of strategies and activities being implemented and numbers of young people reached. The programme would also need to disaggregate the numbers of adolescents reached by age, gender, background and vulnerability status and programme activities accessed.

The Programme must develop and/or adopt various tools for documenting all programme activities including workshops, outreach activities, TOTs, press events, rallies, radio programmes etc. Pictures and short videos of programme events are critical in being used for documentation of best practices if they emerge from the programme.

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