Youth-Friendly Services: Ghana
End of Program Evaluation Report

African Youth Alliance (AYA)

December 2005

TABLE of CONTENTS

List of Acronyms

AYA	African Youth Alliance
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
CHAG	Christian Health Association of Ghana
ECP	Emergency Contraceptive Pills
FP	Family Planning
IUD	Intra Uterine Device
GHS	Ghana Health Service
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
NYC	National Youth Council
NGO	Non Governmental Organization
NTCD	Nontraditional Condom Distributor
PATH	Program for Appropriate Technology in Health
PPAG	Planned Parenthood Association of Ghana
PSP	Peer Service Provider
SDA	Seventh Day Adventist
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNFPA	United Nations Fund for Population Activities
VCT	Voluntary Counseling and Testing
YFS	Youth-Friendly Services

EXECUTIVE SUMMARY

The African Youth Alliance (AYA) was launched by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Fund for Population Activities (UNFPA) in the fall of 2000. The three alliance partners subsequently launched AYA in Ghana in April 2001. AYA sought to improve overall Adolescent Sexual and Reproductive Health (ASRH) and reduce the spread of HIV/AIDS and other Sexually Transmitted Infections (STIs) in four African countries – Botswana, Ghana, Tanzania, and Uganda. Pathfinder International was responsible for the implementation of two of the six component areas of AYA, namely Youth-Friendly Services (YFS) and institutional capacity building in each of these countries. AYA was funded with a grant from the Bill and Melinda Gates Foundation and administered through the U.S. Committee for the UNFPA.

The YFS component of the AYA program, which is the focus of this evaluation, sought to increase the provision of services that can effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining young clients for continuing care. To achieve the objective of the YFS component area, three implementation approaches were adopted: 1) integration of YFS within existing reproductive health services offered at static facilities, 2) outreach by Peer Service Providers (PSPs) and Nontraditional Condom Distributors (NTCDs), and 3) institutionalization of YFS into pre-service training of nurses and midwives.

The process of integrating YFS into existing services included the selection of facilities and assessments of those facilities to identify gaps or potential improvements to be made. Based on assessment results, action plans were developed to address those gaps. The implementation of the action plans included facility upgrades and improvements to the overall quality of services. As the overall strategy acknowledged the importance of linking clinic-based YFS delivery to outreach services, AYA therefore established new outreach programs and grafted outreach sexual reproductive health education, counseling and services onto existing youth programs. PSPs and NTCDs were recruited, trained, and deployed through local partners. Monitoring and evaluation tools and systems were put in place in both the facility and outreach programs, which ensured that the program was implemented as planned and reports were submitted accurately and on time. The institutionalization involved the integration of YFS into the curriculum of nursing and midwifery training institutions in Ghana.

AYA/Pathfinder worked with five implementing partners under the YFS component in Ghana. These were the Ghana Health Service (GHS), Planned Parenthood Association of Ghana (PPAG), Christian Health Association of Ghana (CHAG), Nurses and Midwives' Council for Ghana (NMCG) and the National Youth Council (NYC). The GHS and NYC are public institutions, CHAG is a faith-based organization, and NMCG is a parastatal organization. PPAG was the only nongovernmental organization that participated in the implementation of the YFS component. CHAG and PPAG implemented both the static and outreach strategies. GHS implemented only the static strategy and NYC implemented only outreach. NMCG collaborated with AYA to integrate YFS into its pre-service training curriculum for nurses and midwives.

This report highlights the following results of the YFS work implemented in Ghana. It is organized by static facility, outreach, case study, and overall results.

Static Facility Results

Facility Reassessment: A total of 65 facilities were assessed and 54 action plans developed and implemented. CHAG and PPAG were able to fully implement the action plans of their 14 facilities. GHS, however, was unable to fully implement the action plans in all its 51 facilities as a result of some delays in the implementation of the project and slowness within the government bureaucracy. All the facilities witnessed improvements in their capacity to provide YFS. In addition, their capacity to collect data and report on those services, and to apply and use the facility assessment tool, was increased. Improvement in data collection and the capturing of information on counseling services, which were previously provided at the facilities but not recorded, was also a significant contribution towards sustainable YFS strengthening and implementation. The end of project evaluation revealed marked improvements in the five sampled facilities.

Analysis of Client Satisfaction Data: Client satisfaction of PPAG and CHAG facilities was monitored in part through three mystery client studies. In addition, regular field visits were undertaken by both partner and AYA/Pathfinder staff to all partner facilities as a way of ensuring that standards were met. Feedback from the mystery client studies, facility assessments, and field monitoring visits indicated that clients were generally satisfied with service provision. There remained, however, some reported cases of provider bias, occasional delays in service, and a lack of privacy.

Trend Analysis: The trend analysis showed that the numbers of youth visits to facilities increased from October 2003 to March 2005. It also showed more new visits (60%) than repeat visits (40%), and that more females (61%) than males (39%) made visits to the facilities. Females are more inclined to seek services than their male counterparts, perhaps because reproductive health services are traditionally associated with maternal and child health services. Youth visits to the facilities increased with age: 44% were among 20-24 year olds, 33% were among 15-19 year olds and 23% were among 10-14 year olds. GHS accounted for 74% of all youth visits despite a shorter period of program reporting, and CHAG and PPAG accounting for 20% and 6% respectively. Such large numbers from GHS suggest that it has a strong potential to reach out to greater populations of young people due to the sheer number and coverage of its facilities.

A total of 3,437 visits for testing were recorded. STI testing accounted for 69% of these visits and voluntary counseling and testing for 31%. There were also 3,418 cases of treatment for STIs and sexual abuse and violence. Ninety-six percent of treatment was for STIs and only 4% for sexual abuse and violence.

About half of pregnancy related visits were related to antenatal care. Sixteen percent and 11% were postnatal care and pregnancy testing visits respectively. The remaining visits were for deliveries and post abortion care.

A total of 646,602 male condoms were distributed during the period. Other contraceptive methods, such as the IUD, female condom, pills, and injectables, were not popular among youth. Generally long-term methods are not preferred by youth and provider bias exists around giving hormonal methods to youth.

Outreach Results

Analysis of In-Depth Interviews and Observation of NTCD Implementation: The program showed positive effects on the sexual and reproductive health-seeking behaviors, knowledge, attitudes, and beliefs of the peer educators and youth clients. There was also a positive effect on the community as a whole. Myths surrounding condom use were dispelled, particularly among youth in the communities. NTCDs were observed to provide high-quality services to youth.

Trend Analysis: The outreach program recorded more than one million visits with young people during the project. The number of youth reached fluctuated between quarters, which is likely due to a combination of factors. Unlike the static services, the outreach services reached more males (56%) than females (44%). This may be a result of the fact that males tend to use outreach services more than facility services, as facility services have traditionally been offered and perceived to be for females. In addition, the project used soccer matches to reach youth (via NYC's Challenge Cup project), reaching more males than females.

NYC reached out to more young people (64% of all outreach visits were done by NYC volunteers) than CHAG. CHAG was more oriented toward provision of services at the static facilities and piloted outreach services for the first time through the AYA program. NYC has many years of experience in community outreach and the nature of their Challenge Cup project allowed them to reach more youth, particularly males. PSPs were most effective in reaching out to young people with sexual reproductive health information, while the strength of the NTCDs was in condom distribution. The dropout rate was low (32%) as compared to peer education programs in general, but was slightly higher among the NTCDs (34%) than the PSPs (31%). This may be attributed to the fact that the selection criteria for NTCDs were not strictly adhered to initially, which resulted in a first wave of resignations from some NTCDs.

Case Study Results

Among the notable achievements in the implementation of the YFS component in Ghana, one stands out above the others: the successful collaboration between AYA and the NMCG to integrate adolescent sexual and reproductive health into the pre-service training of nursing and midwifery institutions throughout Ghana. AYA/Pathfinder also partnered with CHAG, a religious organization, to integrate YFS into the service delivery of 10 of their facilities. The collaborations between AYA/Pathfinder and both partners have been identified as success stories and have been documented as separate case studies.

Overall Results

In spite of the advances made in the program, certain limitations hampered implementation, including inadequate behavior change communication materials, some condom shortages, and high employee turnover among the partners. PPAG, for example, lost three project coordinators during project implementation, and CHAG lost their project coordinator who had been integral to the project. The program was also challenged by an initial delay in defining the YFS strategy and

determining indicators for monitoring and evaluation, and the inability of all GHS facilities to fully implement their action plans.

Challenges that remain to be addressed in future activities include the need for further financial and technical support for GHS to fully implement YFS action plans at its facilities and the expansion of YFS into more CHAG facilities, while sustaining YFS where it has already been established.

INTRODUCTION

Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Fund for Population Activities (UNFPA) launched the African Youth Alliance (AYA) in the fall of 2000. In Ghana, AYA was launched in April 2001. AYA was funded with a grant from the Bill and Melinda Gates Foundation and administered through the U.S. Committee for the UNFPA. AYA sought to improve overall Adolescent Sexual and Reproductive Health (ASRH) and reduce the spread of HIV/AIDS and other Sexually Transmitted Infections (STIs) in four African countries – Botswana, Ghana, Tanzania, and Uganda.

The main beneficiaries of the project were young people between the ages of 10 to 24, with an emphasis on those aged 10-19. The secondary targets included teachers, health workers, social workers, and parents. In addition, the tertiary target group included religious leaders, the media, politicians, and policy makers. The latter group was crucial for creating a supportive environment for the project. The project was developed with a focus on six broad areas, including:

1) Advocacy and policy: The creation of supportive community and political environments through policy and advocacy efforts at both the national and community levels, and efforts to improve communication between young people and the adults in their lives.
2) Behavior Change Communication (BCC): The development and expansion of BCC through interpersonal communication; folk and mass media, including drama; life planning skills; programs for youth; peer education and counseling; and social marketing campaigns.
3) Youth-Friendly Services (YFS): The improvement of young people's access to – and the quality of – reproductive health services by developing, expanding, and institutionalizing YFS in a variety of settings.
4) Institutional capacity building: Strengthening the institutional capacity of the country-level partners so they can better plan, implement, manage, and sustain programs and services.
5) Life and livelihood skills development: The integration of sexual and reproductive health into existing livelihood skills development and training programs for youth.
6) Coordination and dissemination: Coordination and information sharing of program activities, lessons learned, and best practices.

Pathfinder International was responsible for the Youth –Friendly Services (YFS) and institutional capacity building components implemented in each country. Through the YFS component, AYA/Pathfinder sought to address the factors that hinder young people from seeking SRH services and to improve the overall quality of services. YFS are services that attract youth, meet a variety of young people's needs comfortably and responsively, and succeed in retaining them for continuous care.

Pathfinder had, through previous work worldwide, developed a list of the key elements of YFS. Under AYA, these have been categorized into essential and supportive elements as presented in table 1.

Table 1: Characteristics of Youth-Friendly Services

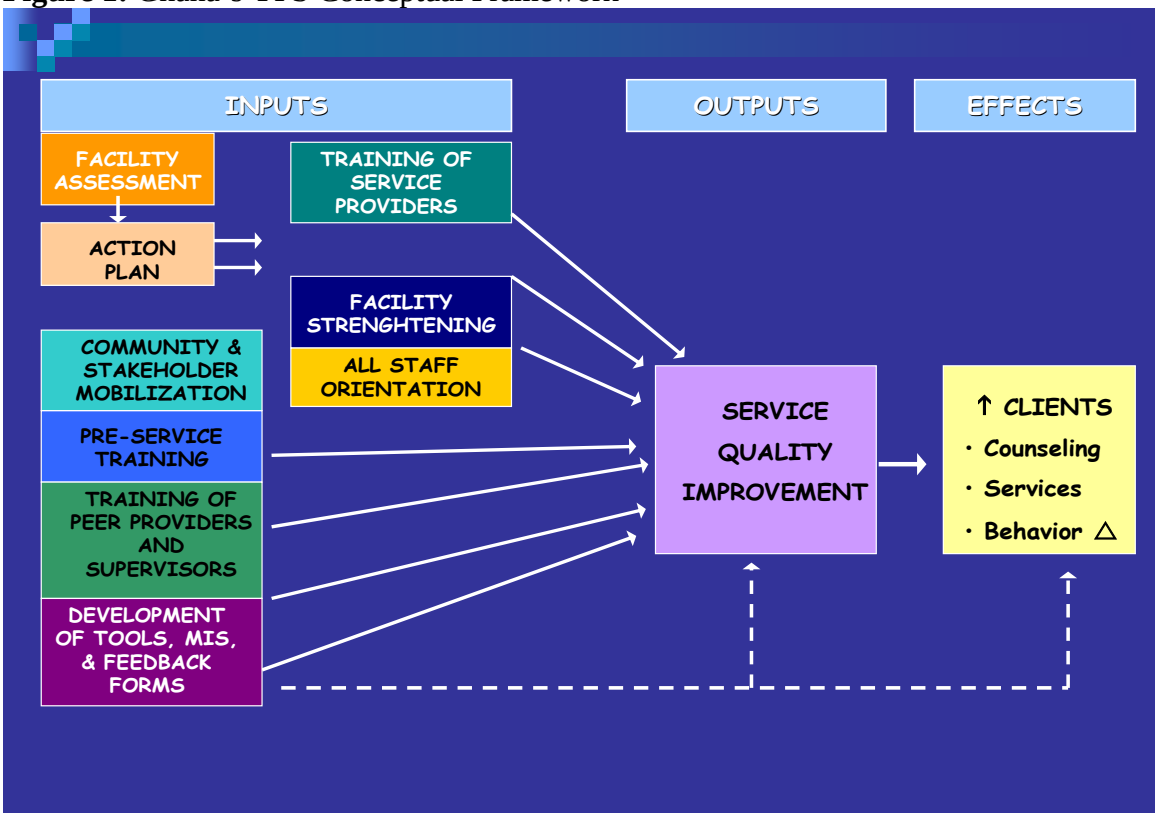
Essential	*Supportive*
• Convenient open hours • Privacy ensured • Competent staff • Respect for youth • Minimum package of services available • Sufficient supply of commodities and drugs • Range of family planning methods offered • Emphasis on dual protection/condoms • Referrals available • Young adolescents (12-15 years-old) are served • Confidentiality ensured • Waiting time not excessive • Affordable fees • Separate space and/or hours for youth	• Youth input/feedback to operations • Accessible location • Publicity for YFS • Comfortable setting • Peer providers/counselors available • Educational materials available • Delay of blood test and pelvic exam, if possible • Partners welcomed and served • Nonmedical staff oriented • Provision of additional educational opportunities • Outreach services available

The AYA/Pathfinder approach to YFS focused on the following:

- Building on existing resources, using available facilities and service providers
- Reaching young people through a variety of channels such as: static clinics, outreach including peer education, and the private and commercial sectors
- Establishing linkages with effective referral sites
- Creating partnerships with other institutions to sustain efforts
- Instituting a minimum package of youth-friendly Sexual and Reproductive Health (SRH) services, including:
  - Information and counseling on sexuality, safe sex, and reproductive health
  - Contraceptive method provision (with an emphasis on dual protection)
  - STI diagnosis and management
  - HIV counseling (and referral for testing and care)
  - Pregnancy testing and antenatal and postnatal care
  - Counseling on sexual violence and abuse (and referral for needed services)
  - Postabortion care counseling and contraception (with referral for treatment of complications when necessary)

AYA/Pathfinder's YFS work is reflected in the conceptual framework presented below (fig. 1).

Figure 1: Ghana's YFS Conceptual Framework



The AYA/Pathfinder strategy for implementing youth-friendly SRH services included the following:

- Facility assessments
- Development and implementation of action plans for quality improvements based on the results of the facility assessments
- Provision of essential technical assistance and monitoring to the institutions, management and clinics as per identified facility strengthening needs
- Training of service providers in ASRH/YFS
- Assistance on data collection and analysis of service statistics
- Implementation of youth input and feedback mechanisms
- Creation and/or expansion of peer education programs
- Community sensitization in SRH and involvement in peer selection for outreach work
- Institutionalization of YFS through development of YFS tools curricula for pre-service training

Implementation began with the selection of AYA intervention sites and implementing partners, as described below.

Selection of AYA Sites and Partners

The selection of AYA intervention sites (regions and districts) in Ghana was done at a strategic planning meeting held in 2001. The approach and processes adopted for the selection included the following:

- Identification of relevant research findings to support the AYA indicators,
- Ranking of the indicators,
- Identification of other factors that affect program implementation in the regions, and
- Weighting of the indicators and factors.

All of the regions were ranked from 1 to 10[1] on the following AYA priority indicators:

- HIV/AIDS prevalence
- STI prevalence
- Pregnancy rates
- Harmful Traditional Practices (HTP) (e.g., Trokosi[2]; female genital mutilation; early marriage)
- Age of sexual onset (ever had sex)
- Unsafe abortion
- Condom use
- Contraceptive Prevalence Rate (CPR)
- Sexual violence/coercion

See Appendix A for the results of this ranking.

The next phase of the selection process involved the identification of facilitating and/or inhibiting factors that affect level of program implementation in the regions. The following factors were identified:

- Ease of working (accessibility to the region and cost of travel within the region)
- Potential for community collaboration
- Potential for quick results/impact (i.e., building on existing high knowledge)
- Exiting donor assisted programs

Each of the regions was then ranked from 1 to 10 according to the facilitating and inhibiting factors; 1 being the least favorable and 10 being the most favorable.

[1] The ranking was done in both ascending and descending orders. Positive indicators such as CPR and condom use, which are the desirable indicators, were ranked in an increasing order (i.e., those with the highest rates were ranked 1 and those with lowest rates were ranked 10). Negative indicators such as prevalence of STIs and HIV/AIDS, which need to be reduced in the programs, were ranked in decreasing order (i.e., those with the highest rates were ranked 10 and those with lowest rates were ranked 1).

[2] Literally "wife of the gods" in the Ewe language. According to the customary practice in Ghana's Volta region, which has lasted approximately 300 years, if someone commits a serious crime or social infraction, traditional leaders order that a young girl from that family be sent to the shrine as a form of atonement. She is expected to serve the priest for three to five years, after which the family might redeem her.

After the regions were ranked, the factors and AYA indicators were weighted by indices of 1 to 5 (with 1 being the lowest rank and 5 being the highest). AYA indicators had the highest weight (5), followed by potential for quick results, potential for community support, ease of working, and donor operations in that order. See Appendix A for the results of the weighting.

At the end of the process, the first five regions were selected. The five regions included: Greater Accra, Central, Ashanti, Eastern, and Upper West. From the five regions, 20 intervention districts were selected using the same process.

Based on a set of criteria arrived at by alliance partners and SRH stakeholders in the country, a number of potential implementing partners applied to participate in the AYA Program. Upon consideration of their capacity, interest in providing YFS, and their roles as reproductive health service providers in Ghana, five partners were selected to participate in the AYA YFS project. The partners included: Ghana Health Service (GHS), National Youth Council (NYC), Christian Health Association of Ghana (CHAG), Nurses and Midwives Council for Ghana (NMCG), and Planned Parenthood Association of Ghana (PPAG).

GHS is a public sector institution mandated for the promotion of health delivery in the country. GHS works in all 10 regions and 128 districts of Ghana and provides more than 60% of the health services in the country. The GHS project was implemented in 20 districts in five regions.

NYC is a statutory public body with the responsibility of implementing and coordinating government policy on youth. Under the Challenge Cup Project, NYC used the passion for soccer in the country to reach out to young people with SRH information and services, particularly condoms. The intervention was implemented in six districts in two regions.

CHAG is an association of 152 faith-based health delivery institutions. CHAG contributes about 35% of health service delivery in Ghana. With AYA funding and support, CHAG implemented the Window of Hope Project, which integrated YFS into member health facilities in eight districts in three regions of Ghana. A detailed report of this work is described in the Pathfinder case study titled *"Building Partnerships with Faith-Based Organizations: Integrating Youth-Friendly Sexual and Reproductive Health Services into the Mainstream Health Delivery of Christian Health Association of Ghana (CHAG)."*

NMCG is a parastatal organization responsible for the training of nurses and midwives in the country. The NMCG sets and maintains the standards for nurse training institutions, develops curricula, and organizes and supervises examinations. AYA/Pathfinder collaborated with the NMCG to successfully integrate ASRH into the curriculum of pre-service nursing training in Ghana. The curriculum is a two-credit hour examinable course for nurse training institutions in the country. The course is part of the licensure examinations conducted by NMCG. A detailed report of this work is described in the Pathfinder case study titled *"Integration of Youth-Friendly Sexual and Reproductive Health into Pre-Service Nursing Training: The Experience of Ghana."*

PPAG is a nongovernmental organization that was established in Ghana in 1967. The association is an affiliate of the International Planned Parenthood Federation (IPPF) and it has a long history of leadership in family planning programs in the country. PPAG has pioneered services including

Family Life Education for youth, community-based services, and male clinics. Since 1999, the association has strengthened their focus on youth because of the reproductive health needs of this segment of the population, which have been neglected in SRH programming. PPAG implemented in four districts in four regions of Ghana.

This report highlights the results of the YFS work implemented in Ghana. It describes the work implemented by AYA/Pathfinder, the process used to evaluate the interventions, and the findings of the evaluation. It also offers recommendations on implementing and evaluating YFS efforts. The report focuses on the two main approaches adopted for the implementation of the program, namely static facility and outreach services.

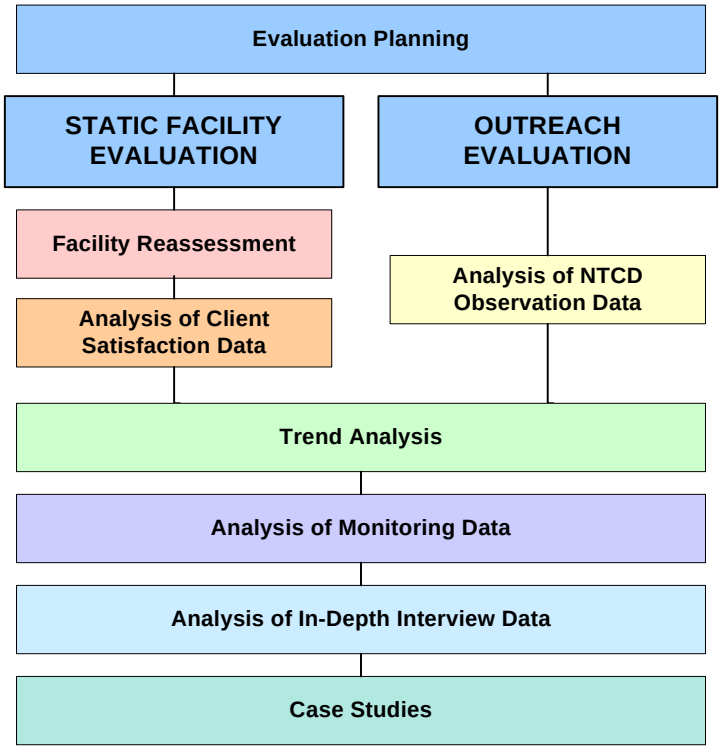
OVERALL METHODOLOGY

The YFS evaluation consisted of activities designed to assess the extent to which the interventions met their objectives (increased use of services), and to capture successes, challenges, and lessons learned of both the facility and outreach efforts. The evaluation process was designed by both Pathfinder headquarters and field staff and implementation was carried out by the field staff, with assistance from Pathfinder headquarters. Key evaluation activities included:

1. Evaluation planning
2. Facility reassessments
3. Analysis of client satisfaction data
4. Analysis of Nontraditional Condom Distributor (NTCD) observation data
5. Trend analysis
6. Analysis of monitoring data
7. In-depth interviews
8. Case studies

The diagram below shows the evaluation activities under both the static facility and outreach efforts, forming the outline for this report.

Figure 2: Ghana Evaluation Framework



Each of the activities and the methodologies is described generally in this section and more specifically as it relates to the facility and outreach evaluations later in the report.

Evaluation planning: An evaluation strategy meeting was conducted in November 2004 with headquarters and field staff from three AYA countries (Ghana, Tanzania, and Uganda). During this meeting, the team inventoried data already available, mapped their respective conceptual frameworks, mapped and prioritized inputs for evaluation, identified methodologies, developed their end of program evaluation plans, and discussed how to manage and monitor the plan. As part of the process, Ghana listed its major intervention areas and then weighted these in relation to the level of effort invested (time, human resources, and money). Based on this information and the resources available for evaluation, staff selected the following key components to evaluate: facility strengthening, client satisfaction, and outreach.

Facility reassessments: AYA/Pathfinder field staff reassessed a sample of five facilities using the facility assessment tool,[3] and applied the certification tool[4] to establish endline results in May 2005. These results were compared against the baseline scores obtained at the outset of the project. It should be noted that the original baseline information obtained through the facility assessment tool was qualitative in nature and was intended first and foremost for planning. In order to quantify the baseline, a retroactive scoring process was used whereby a quantitative scoring tool (i.e., the certification tool) was applied to the facility assessment results to obtain a numerical score.

Essential and supportive elements were scored as follows:
Score 2: If the element meets the criterion fully
Score 1: If the element meets the criterion partially or if actions are underway to comply
Score 0: If the element does not meet the criterion

Analysis of client satisfaction data: Youth served as mystery clients to gauge client satisfaction of service provision at the clinics. A total of 60 mystery client visits were conducted in 14 clinics: 26 visits to 10 CHAG facilities in February 2004, 14 visits to 4 PPAG facilities in July 2004, and 20 visits to 10 CHAG clinics in February 2005.

Analysis of NTCD observation data: Twelve NTCDs were observed by AYA/Pathfinder staff in March 2005 to assess the quality of outreach implementation. The process involved observing the interaction of how the NTCDs demonstrated and explained proper condom use to their clients.

Trend analysis: Service statistics were collected by each facility and peer provider and reported on a quarterly basis. A trend analysis of that data was conducted in July 2005 to reveal changes in the service statistics following the YFS intervention. At the November 2004 evaluation strategy meeting, AYA/Pathfinder staff agreed to examine trends in the following indicators:

[3] The Facility Assessment Tool, *Clinic Assessment of Youth-Friendly Services: A Tool for Improving Reproductive Health Services for Youth,* can be downloaded from Pathfinder International's website at http://www.pathfind.org/site/PageServer?pagename=Publications_Guides_and_Tools_Assessment_Tools.
[4] The *Certification Tool for Youth-Friendly Services* can be downloaded from Pathfinder International's website at http://www.pathfind.org/site/PageServer?pagename=Publications_RH_Resources_ASRH.

- Number of visits (categorized by new and revisits)
- Number of visits by age (10-14, 15-19, 20-24) and sex
- Number of visits by type of service

Analysis of monitoring data: Analysis of monitoring data, including supervision and quarterly reports, was done in May and June 2005 to provide additional information for this report.

In-depth interviews: Interviews were conducted with a variety of stakeholders in the program. For the evaluation of the outreach program, interviews were conducted with 30 PSPs, 30 NTCDs, 10 supervisors and their assistants, 36 community leaders, and 180 youth clients. In addition, interviews were conducted with 39 CHAG council and management members, directors of the Health Directorates of CHAG affiliate institutions, and staff of the facilities for the faith-based organization case study.

Case studies: Three case studies were written and are presented in separate reports. These include:

- *Building Partnerships with Faith-Based Organizations: Integrating Youth-Friendly Sexual and Reproductive Health Services into the Health Delivery System of Christian Association of Ghana (CHAG);*
- *Integration of Youth-Friendly Sexual Reproductive Health into Pre-service Nursing Training: The experience of Ghana; and*
- *Reaching Out to Young People with Sexual and Reproductive Health and HIV/AIDS Information and Services: Case Study of Nontraditional Condom Distribution Strategy in Ghana*

Overall Data Limitations

There were a number of limitations to the data and the evaluation itself, including:

Service statistics: The main difficulties encountered were the different implementation and reporting periods of the partners and the use of different data collection forms. PPAG began the project in 2001, and CHAG, NYC, and GHS began in the last quarter of 2003, however GHS only began reporting in the second quarter of 2004. Although CHAG and PPAG implemented both facility and outreach programs, NYC only implemented outreach, and GHS only facility-based programs. In addition, PPAG and GHS used their own data collection tools before initiating use of the AYA/Pathfinder data collection forms. These forms did not capture a breakdown of the information needed. As a result, the trend analyses only include data from the last quarter of 2003 to March 2005, and do not include data reported by GHS facilities.

Baseline data: As mentioned earlier, the original baseline was qualitative and in order to assign a numerical value, it was necessary to retroactively score the original data. The retroactive scoring process was a limitation to the reassessment data because many baseline assessments were scored after the initial assessment, which was done without the certification tool. This meant that in some cases, related information required to score was missing and could not always be collected retroactively. Because the endline assessments were done after the development and

application of the certification tool to baseline scores, endline assessment information was found to be more complete.

Lack of funding for evaluation activities: As often happens as multi-year projects near an end, funding limitations affected the end of project activities. Because of resource limitations, both human and financial, the evaluation design had to be modified to provide the best information possible.

The following section discusses the static facility evaluation.

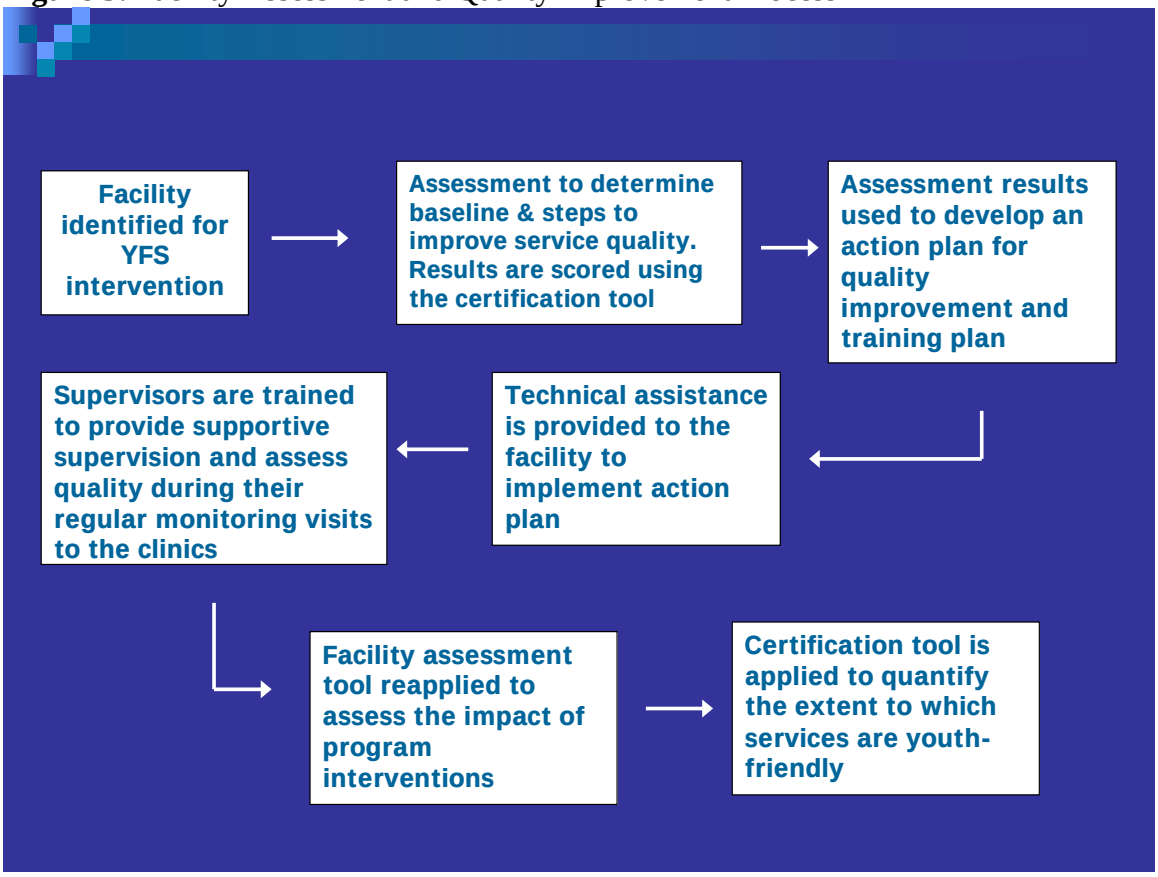
STATIC FACILITY EVALUATION

This section describes the activities done under the static facility component and describes the results of the evaluation of the static facility work, including facility reassessment, analysis of client satisfaction data, and trend analysis. For each section, the methodology for evaluation, data limitations, and results are provided.

Static Facility Activities

AYA/Pathfinder worked to improve the youth friendliness of the partner facilities through the static facility component. The process of integrating YFS into the facilities included the selection of facilities, assessment of those facilities using a facility assessment tool, development of action plans to address gaps in youth friendliness, implementation and monitoring of the action plan, and then reassessment and certification of those facilities. The process is shown in figure 3.

Figure 3: Facility Assessment and Quality Improvement Process



As part of this process, the following activities were conducted in Ghana:

- Selection and training of baseline assessors,
- Conducting baseline assessments and sharing results
- Developing and implementing action plans,

- Monitoring and supervision, and
- Monitoring client satisfaction.

Selection and Training of Baseline Assessors

The selection of the assessors was led by the respective partners with facilitation by AYA/Pathfinder. All assessors then participated in a facility assessment training, which took them through the concepts and processes of the facility assessment, developing action plans and quality improvement methods. It also led them through value clarification exercises to address personal biases in ASRH. The ASRH associate from Pathfinder headquarters led the trainings for all partners. For the PPAG and CHAG trainings, she was supported by two trainers from Uganda. For the GHS training, she was supported by three trainers, one from Uganda and the other two from CHAG. The objective of the inclusion of the Ugandan trainer was to ensure cross-fertilization of knowledge and skills across the African continent. The CHAG trainers were used as a capacity building opportunity and to promote sharing and networking across AYA partners.

The project coordinator of CHAG, in consultation with the health coordinators of the respective participating religious denominations, selected the CHAG assessors: four nurses, two program managers and one administrative officer. For the CHAG team, the facility assessment training was preceded by an abridged training in ASRH and YFS. The objective was to bring the team up-to-date on the concepts and issues of ASRH using data from the Ghana Demographic and Health Surveys and other youth-oriented surveys and studies and build their knowledge of YFS.

To ensure representation from each AYA district, the GHS team was comprised of a district director of health or his or her representative from each district. For PPAG, the director of programs carried out the selection. The assessors included one medical doctor, a nurse, and a youth facilitator.

Conducting Baseline Assessments and Sharing Results

As part of the training practicum, participants were divided into two teams (which included the facilitators) to conduct facility assessments. PPAG facilities in Sogakope and Accra were used as practicum sites. Thereafter, participants were divided into three teams; each of these teams conducted three assessments of different CHAG facilities. The remaining three assessments were conducted in 2003 under the direction of CHAG staff. In the case of PPAG, trained PPAG staff assessed the additional three PPAG facilities.

The GHS team assessed five facilities as part of the practicum, after which AYA facilitated the assessments for five more facilities in the Ashanti region to provide hands-on skill transfer. Thereafter, the team continued the process and conducted assessments of the additional eight GHS facilities in Ashanti. In the other regions, some assessments were delayed due to staff transfers and attrition which led to staffing insufficiency in the regional teams. In some cases, teams had to train more nurses to assist in the assessment process.

The assessments were participatory and involved key facility staff both during information gathering and debriefing sessions. The debriefing sessions allowed clinic management to participate in the identification and formulation of actions to address challenges to making facilities youth friendly. In many cases the debriefing sessions followed immediately after the assessment and actions suggested during these debriefings included minor alterations to service delivery, like partitioning and other arrangements in consulting rooms to foster privacy and confidentiality.

Developing and Implementing Action Plans

Using the results of the assessment and improvements suggested by facility staff, action plans were created for facilities. The table below shows the number of facilities assessed by partner, including the timeframe in which they were assessed, and the numbers of facilities who developed action plans. About 88% (57) of the 65 implementing facilities were assessed and 91% of those assessed developed action plans.

Table 2: Total Number of Facilities Assessed by Partner

Partner	Number of Facilities Assessed	Period Facilities Assessed	Number of Facilities with Action Plans	Comment
CHAG	12	2002-2003	10	Two sites – Manna Mission Hospital & Akim Wenchi (Eastern Region) – were initially assessed but excluded from the project due to disinterest by clinic management (Manna) and incorrect selection (Akim Wenchi).
PPAG	5	2002	4	Sogakope clinic was used as a practicum site during training and was not located within an AYA district.
GHS	51	2003-2004	40	The action plans of 11 facilities were not developed as they were assessed with less than nine months of project implementation remaining.[5]

For a full list of the 65 YFS implementing sites, see Appendix B.

[5]This may be attributed to the later start of the project, as some of the GHS facilities were assessed later in the life of the project thereby affecting the development of action plans and implementation of improvement processes. Though the project was executed by the district health management teams at the district level, AYA had to work through the head office and regional offices in terms of project fund payments. The need to go through these structures inevitably delayed funds reaching the districts on time. Furthermore, the accounting practices required for accountability purposes by AYA/Pathfinder were new to the GHS and took time for GHS administrators to implement. Providing orientation and sensitization sessions for the regional directors of health at the outset might also have increased their understanding of the need to release funds in a more expeditious manner. However, GHS indicated their commitment to YFS beyond AYA funding, including development and implementation of action plans.

Action plans included a range of activities to improve the quality of services delivered to youth. Some activities, such as training and facility refurbishment, required significant financial and human resource investments. Other improvements, such as minimizing interruptions to increase privacy, required little financial resources.

Training

For CHAG and GHS, training was done at two levels: pre-service and in-service.

Pre-service: As provider attitudes and lack of skills in ASRH were identified as contributing factors to youth's low patronage of existing health facilities, there was a need for specialized provider training in ASRH/YFS. As in-service training can be costly and is often not sustainable due to staff attrition and transfer, AYA collaborated with the NMCG to integrate ASRH into the pre-service training curriculum for nurses and midwives. Integration of ASRH into the curricula of training institutions was a key step in institutionalizing YFS in Ghana. The process involved the following activities:

- Identification of an appropriate statutory institution ,
- Dialogue with and sensitization of the Nurses and Midwives Council for Ghana,
- Development of the proposal and signing of the MOU,
- Curriculum review and development,
- Dissemination of the draft curriculum,
- Training of Trainers (TOT) for selected nursing tutors,
- Training of principals and tutors of the training institutions, and
- Teaching and testing students on ASRH.

The partnership between AYA/Pathfinder and NMCG has resulted in a two-credit hour examinable course for all nursing training institutions in the country. The course is part of the licensure examinations conducted by the NMCG.

In-service: To ensure that providers who currently worked in the YFS facilities were well equipped to deliver SRH services to youth, AYA conducted in-service training in collaboration with its partners. In-service training consisted of both TOT and training of service providers. In the first year of implementation, the trainers were trained using the GHS adolescent health training manual complemented by additional activities from the Pathfinder YFS curriculum. For training of CHAG staff, the trained trainers then went to their respective facilities to conduct the step-down training of facility-level staff. In the case of CHAG, a new training using Pathfinder's YFS training manual was conducted for the team of trainers in the second year with the objective of strengthening aspects of youth-friendly service delivery. Because the GHS manual has a broader focus than ASRH and encompasses adolescent health in general, it was felt that further ASRH-specific training would strengthen trainer knowledge and understanding of YFS. But, because of the small size of the PPAG staff, only one training was provided on YFS. In the first year of implementation, PPAG organized an orientation on YFS for all clinical and project-level staff using IPPF training manuals. Staff were then trained using the YFS training manual in the third year of implementation.

The specific numbers of participants for the different training sessions are summarized below:

Table 3: Number of Staff Trained and Oriented by Type of Training and Partner

Type of activity	CHAG	PPAG	GHS	Total
Training of trainers	21	0	165[6]	186
Training of service providers	90	14	581	685
Orientation of facility staff	610	10	2,057	2,667

Refurbishment and Other Quality Improvements

Refurbishment of all facilities – PPAG, CHAG, and GHS – was based on the findings of the various facility assessments. In general, the main gaps identified for refurbishment and addressed by the action plans included:

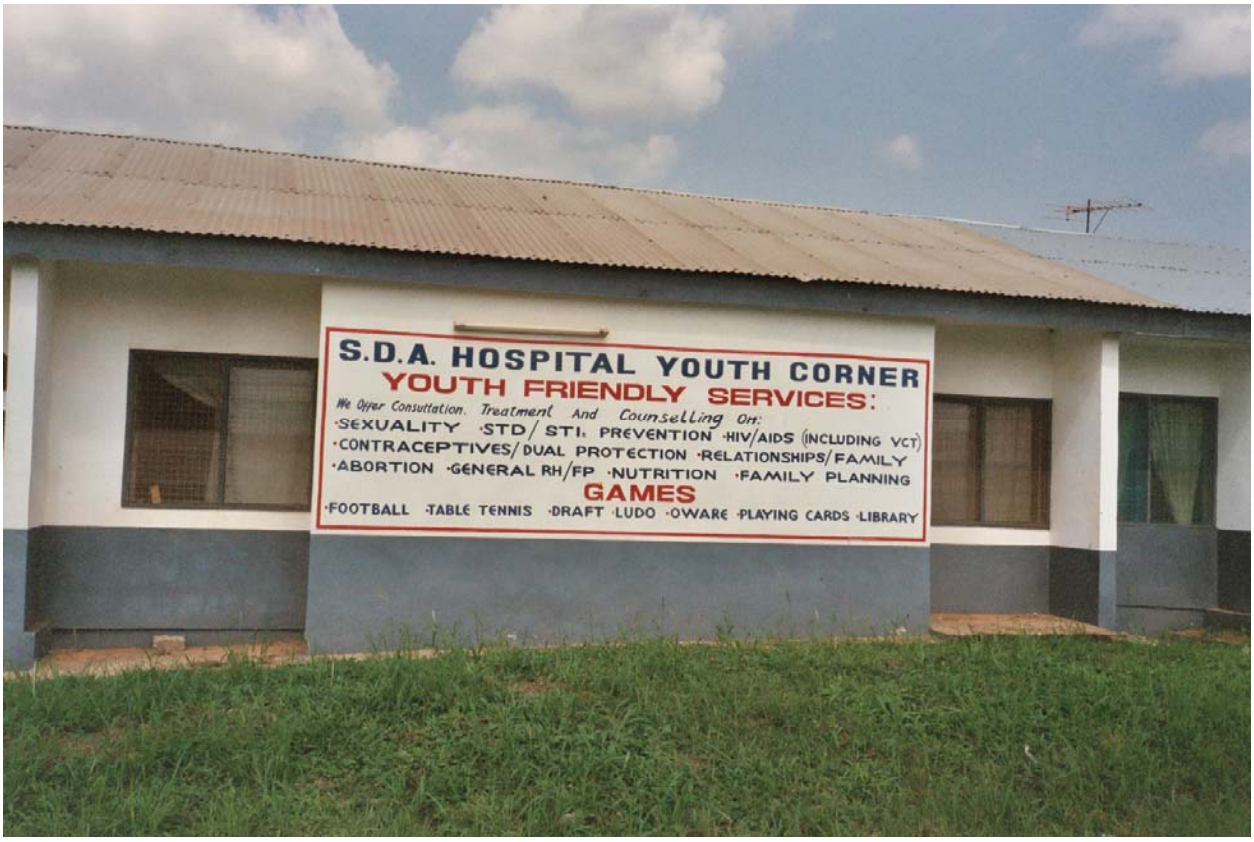
- Partitioning of counseling rooms to increase privacy,
- Painting of facilities,
- Changing of seating arrangements in consulting/counseling rooms,
- Procurement and hanging of SRH posters for youth on walls, and
- Rearrangement of waiting rooms and spaces to ensure privacy for youth and other clients.

Additionally, some CHAG facilities procured and converted metal containers[7] into youth clinics attached to their facilities to address the problem of space. At Assin Praso, Wiamoasi, and Alpha Medical Centre, clinic management renovated or constructed a new set of rooms for use as youth clinics and libraries.

In addition to the refurbishments, the facilities undertook other measures to reduce barriers such as improving client flow, increasing privacy by minimizing interruptions, improving the registration process to increase confidentiality, procuring job aids and BCC materials, and making condoms more accessible by locating them in various places like the dispensary, waiting areas, and registration tables. Facilities also erected signboards and used peers and outreach staff to publicize YFS. As a way of meaningfully engaging young people in the implementation of the program, facility management committees were established at each facility with two youth representatives on each committee. The committees served as a medium through which the views and concerns of young people were channeled for the consideration of management.

[6] About 70 trainers in Greater Accra and Ashanti Regions were trained by the Ministry of Health/Ghana Health Service with funding provided by UNFPA before AYA became operational.

[7] Metal containers are room-like structures constructed with fabricated metals and used as YFS centers in facilities where there is lack of space.



SDA Hospital created this separate space for youth-friendly services and added the accompanying sign to advertise the services available.

Monitoring and Supervision

Monitoring and supervision was carried out to identify weaknesses and make improvements to the facilities and project implementation as needed. Monitoring and supervision included collection and analysis of facility service statistics and regular supervision by trained supervisors and AYA/Pathfinder staff, as described in more detail below.

Collection and analysis of service statistics: Facility service statistics were collected and monitored throughout the project period. Facilities were provided with data collection forms, which disaggregated data by sex, age (10-14, 15-19, 20-24), type of visit (new or revisit[8]), and services provided to each client. The data was compiled and submitted to AYA/Pathfinder on a quarterly basis by the partners. AYA/Pathfinder staff reviewed the statistics to strengthen data collection and implementation, and provided technical assistance in data collection and reporting as needed.

Supervision by partner and AYA/Pathfinder staff: To ensure that quality of services was maintained, partner and AYA staff made site visits to the facilities throughout the project period. During these visits, the supervisors would review planned activities and implementation status,

[8] If the client was new to the facility, the visit was marked as new. If the client had been served at the facility previously, regardless of what they were served for, the visit was marked as revisit.

and discuss new developments with facility staff. They would also discuss personnel issues, staff time, client attendance, and solicit feedback from clients, if available.

Monitoring Client Satisfaction

AYA/Pathfinder promoted the use of mystery clients as a means to monitor client satisfaction and youth-friendliness of clinics. CHAG conducted mystery client visits in 10 of its facilities in February of 2004 and 2005 and PPAG sent mystery clients to its 4 facilities in July 2004. The findings and recommendations for improvement were then shared with the facilities immediately following the exercise. As these studies were reviewed and analyzed as part of the end of project evaluation, the methodologies and results are described in more detail in this section.

In addition, suggestion boxes were placed at facilities to allow youth to provide their opinions more anonymously on the services provided and recommendations for improvement. The suggestions were reviewed regularly by facility staff and managers, gaps were identified, and measures were taken to make improvements. For example, youth at Assin Praso suggested that a separate youth corner be constructed to cater to their needs, and facility staff arranged for internally generated funds (12 million cedis) to be used to support the construction. Youth at the same center also drew the staff's attention to the fact that counseling could be heard in the main hall through air vents. These were sealed as a result. Youth at Alpha Medical Center gave input as to the best location of the youth center.

Regular field monitoring visits were also conducted by both partner and AYA/Pathfinder staff, and included informal interviews with clients, both inside and outside the facility, to gauge their satisfaction with services.

The following section discusses the various evaluation activities carried out (facility reassessment, analysis of client satisfaction data, and trend analysis), including methodologies, data limitations, and results.

Facility Reassessment

Evaluation Methodology

The primary means of evaluating the facility strengthening activities was through a reassessment of facilities using the facility assessment tool and certification tool to receive an endline score. In addition, quarterly monitoring and training reports were reviewed to supplement the information.

The sample frame was defined as facilities that had been assessed at baseline and had implemented their action plans for at least nine months to show the effect of the strengthening efforts. Two facilities each of GHS and CHAG and one PPAG facility were then selected, taking into account the rural-urban divide. The facilities selected are shown in the table below.

Table 4: Facilities Selected for Reassessment

Partner	Number of Facilities	Name of Selected Facility	Location/Region
GHS	2	Tema Polyclinic	Greater Accra
		Kuntanase District Hospital	Ashanti
PPAG	1	Young & Wise Centre	Greater Accra
CHAG	2	Alpha Medical Centre	Greater Accra
		Presbyterian Clinic, Assin Praso	Central

Reassessment teams consisted of three members, including one youth. In conducting the reassessments with the facility assessment and certification tools, the methods below were applied.

Review of clinic records: This involved looking critically at the daily, monthly, and quarterly statistic forms to see how many youth were served, with what services, and what age groups and sex were served to uncover issues like younger youth not being served or youth being counseled but not really given FP. In addition, the team would note if data was collected by age groupings and if there were problems with data recording.

Observations/ examination: This involved observing the general layout of the clinic and client flow as well as availability of equipment, commodities, and educational materials. Client-provider interaction was also observed to determine provider attitudes toward serving youth clients and technical competency in ASRH.

Interviews with clinic managers, staff and clients: Questions were posed to managers, clients and providers to elicit their opinions on the youth-friendliness of the clinic and to determine their attitudes and practices in serving youth. During the reassessment, questions were asked to find out more detail about clinic improvements.

Review of policy and procedures: At each facility, managers were asked if they had any policy documents that were in support of ASRH, YFS, or both. If they did, these documents were reviewed, but in absence of the documents, providers or mangers were only asked whether such documents existed and whether they were aware of the policies mentioned in the documents. Different scenarios were presented to the managers and staff related to the appropriate age group for ASRH services, especially on eligibility of contraceptives to explore barriers such as minimum age or parental consent.

Data Limitations

The primary limitation of the evaluation of the facility assessment process was that the certification tool (developed to complement the facility assessment tool) was introduced later in the project. Consequently, the scoring of the initial assessment of facilities was not done at the time of the baseline assessments.

Results

As can be seen in the table below, the CHAG facilities improved their scores greatly from baseline to endline, particularly the Assin Praso Centre. PPAG's Young and Wise Centre began with a high baseline score and ended with an endline score of 49, one point shy of the highest possible score of 50. The GHS facilities showed less or no improvement from baseline to endline. All facilities but Tema Polyclinic showed increases in both essential and supportive elements.

Table 5: Baseline and Endline Scores of Selected YFS Sites

Facility	**Essent**	**Support**	**Baseline Score**	**Essent**	**Support**	**Endline Score**
PPAG						
Young & Wise Centre Youth Clinic, Accra	21	21	42	27	22	49
CHAG						
Alpha Medical Centre, Madina	16	8	24	22	20	42
Assin Praso Presbyterian Health Centre	17	7	24	26	21	47
GHS						
Kuntanase Government Hospital	14	8	22	24	9	35
Tema Polyclinic	19	11	30	18	12	30

As table 5 shows, PPAG and CHAG facilities fully implemented their action plans and CHAG facilities made significant improvements between the first and second assessments. They achieved improvements in all areas except availability of BCC materials. The facilities of the two partners recorded improvements in the facility environment, special hours, or separate space allocated for youth clients, staff preparedness and attitudes, increased publicity and involvement

of young people in the planning, monitoring, and evaluation of activities. The range of services provided to young people at the health facilities increased in most of the facilities. In addition, all the facilities witnessed improvements in data collection. For instance, conscious efforts had been made to capture services that were previously provided at the facilities, but not recorded (including counseling on sexual violence and rape, general counseling, etc.). It is recommended that the two partners be encouraged to sustain their achievements and also expand to other non-AYA facilities.

Youth-specific educational posters were visibly displayed at most clinics.

Though GHS facilities also made improvements to SRH service delivery for youth, they did not achieve results of the same level of significance as CHAG and PPAG facilities, most likely due to the delays noted earlier. However, GHS facility staff has noted their commitment to continuing with the facility strengthening efforts beyond AYA funding, particularly in developing and implementing their action plans.

Analysis of Client Satisfaction Data

Evaluation Methodology

The three mystery client study reports have been further reviewed and analyzed for this evaluation in July 2005. Each study included the creation of reports for each facility which had been previously shared with the facility and local implementing partner staff. The findings were organized into the following categories:

- Location
- Facility environment
- Staff preparedness
- Services provided
- Peer education and counseling programs
- Educational activities
- Youth involvement
- Administrative procedures
- Cost of service

The reports offered recommendations to the clinic on how staff can further improve their skills relating to youth. It should be noted that confidentiality and privacy, key quality issues for youth service provision, were examined through the "services provided" category.

In order to conduct the mystery client evaluations, youth were selected from and around the clinic catchment areas. They included:

- CHAG (2004): Nine youth (seven male and two female) 18 to 24 years of age;
- PPAG: Three youth (two males and one female) 18 to 24 years of age; and
- CHAG (2005): Ten youth (six males and four females) between 15 and 20 years of age.

Each youth participated in a one or two day training workshop. PPAG staff conducted the trainings for both PPAG and CHAG mystery clients. The training oriented the participants on the following topics:

- An overview of the mystery client methodology,
- The concept of youth friendliness,
- Standards or indicators of youth friendliness,
- Adolescent reproductive health rights,
- Essential service package for YFS,
- Techniques in conducting a mystery client study, and
- How to compile a mystery client report.

The training included a combination of brainstorming, lectures, question and answer periods, and role play exercises to prepare the mystery clients for the mystery client exercise. Following the training, mystery clients were given instructions and schedules on which clinics to attend, what scenario to present, and when to report back on their findings. See Appendix C for the checklist that mystery clients completed after their

visits, Appendix D for detailed information on numbers of visits to each facility and the scenarios presented, and Appendix E for a description of each scenario.

After the visits, the mystery clients produced reports on their individual observations and experiences for each facility. The reports were compared to examine similarities and differences. Clarifications were sought from the mystery clients as needed and the three reports were merged into one report for each facility. Key findings were extracted from these individual reports and appropriate recommendations made.

Data Limitations

A major limitation of the mystery client data is that the PPAG study was done only one time in early 2004 without follow-up at the end of the project. Because project implementation lasted an additional year, later improvements to services in the facilities are not reflected in the data. In addition, GHS was unable to conduct any mystery client studies.

Results

The mystery client findings are summarized in the table on the following page, followed by a discussion of those results.

Table 6: Mystery Client Visit Findings

Element	CHAG (2004)	PPAG (2004)	CHAG (2005)
Location	Most facilities easy to locate, though some lacked directional signs and signposts did not indicate that they provided YFS.	All but Suame were easy to locate, but more directional signs could be added. Signposts did not indicate that they provided YFS.	Most facilities easy to locate, especially with new directional signs and signposts.
Facility Environment	Clean environment both inside and out, comfortable and attractive to youth, services not always clearly labeled. Where youth centers and corners exist, they appear to have heavy presence of young people.	Clean environment both inside and out, comfortable and attractive to youth, services clearly labeled. Where youth centers and corners exist, they appear to have heavy presence of young people.	Clean environment both inside and out, most newly painted, comfortable and attractive to youth. All facilities now have youth centers and corners, but youth were often not directed there from emergency or other services.
Staff Preparedness	Some exhibited biases against youth.	Apart from Cape Coast, all providers were reported to be youth friendly.	Apart from Kwadaso SDA Hospital, biases remain among some providers however others were generally respectful.
Services Provided	Most not counseled on STIs, HIV/AIDS or family planning, STIs treated prior to testing (as referred elsewhere) and without partner treatment, focused on curative rather than preventive services, and no availability of hotline/helpline or e-counseling.	Most not counseled on STI, HIV/AIDS, or condom use. However, youth who indicated they had unprotected sex were counseled on family planning methods.	Many not counseled on STIs or HIV/AIDS, those referred for voluntary counseling and testing were not always given pre- and post-counseling. Although some providers advised on condom use, this was not 100%.
Educational Activities	Most lacked brochures and audio-visual equipment; majority had posters, but focused on non-ASRH issues.	Two facilities had brochures, but only one clinic had materials to take away and only one client was given materials by the service provider; all had posters, but only one had AV equipment focusing on ASRH issues.	The majority had put up posters on ASRH material. However, since most lacked brochures, materials couldn't be given away. Audio-visual equipment was lacking.

Element	CHAG (2004)	PPAG (2004)	CHAG (2005)
Peer Education and Counseling/ Youth Involvement	Minimal if not nonexistent at the facility, and most did not have comment boxes.	All but Suame have youth in counseling and other staff positions.	Two facilities (Assin Praso and Bomso) have added facility-based peer to peer education and counseling programs.
Administrative Procedures	Most clients waited less than 10 minutes to be seen, though in a few cases waiting exceeded 1 hour. Interaction time was noted as acceptable in every case.	Waiting time was less than 10 minutes to see a provider for all, and most felt they had enough time with the provider. No appointments were needed, but some had to return to see a specific doctor.	N/A – information not collected.
Cost of Service	Lack of coordination among some service providers regarding service payment.	Most found services affordable.	Cost was dependent on the facility and the nature of the cases presented, but in youth corners, some services were free of charge.

Through the mystery client studies, both strengths and weaknesses of the facilities can be identified. Clients found that the clinics were easy to find, clean and comfortable, had informative posters on the walls, and youth corners and centers were utilized. Areas where further progress is needed to improve the youth-friendliness of SRH services include: having sufficient supply of BCC materials in the clinics for distribution; service providers removing biases against providing services to youth;[9] and counseling on STIs and HIV/AIDS and condom demonstrations.

Some experiences of the clients are described below.

Some clients were given thorough information and were counseled in a way that was considered truly helpful. "*The service provider gave me a lot of education on the problem I presented. Her education included the problems, probable causes, the signs and symptoms. During the education process measures were taken by the service provider to stop me from panicking, realizing my reaction and mood*," one young man explained. "*I went to the facility to find out whether or not I was pregnant, but I received more than that. The way and manner the service provider took time to counsel me was very heart warming*," another client reported.

Nevertheless, experiences did vary across the mystery clients and the different service providers. In one instance, a client described the counseling she received as, "*not satisfying at all. It lasted just a minute. The service provider mentioned condoms, but did not go into educating me about it. He said, 'Do you know what a condom is? Do you know how to use it?' He did not use any educational material. It looked as if there were a lot of people he had to attend to*." Clearly the issue of the service provider's available time can drastically affect the quality of care.

Some clients described interactions with service providers as negative, in terms of bias or lack of privacy. "*The counselor was surprised about the case I presented and she therefore became judgmental and started condemning me,*" said a client that sought contraceptive counseling. The client noted that he was not counseled on contraceptives during the visit and the provider did not want to talk to him about this topic. A client explained her experience with the following scenario: "*There was no privacy. The door was not closed and I thought the people in the waiting room could hear us.*"

Despite the challenges of the physical structure of certain facilities, some providers made elaborate efforts to ensure privacy during visits. "T*he first provider assured me of confidentiality. A man inside the room checking blood pressure was asked to excuse us. We were in an enclosed place with only two windows where nobody could see or hear us,*" one client explained. Other clients reported, "T*here was interruption by one of the facility staff, so he asked me to wait. This assured me of confidentiality,*" and "*the provider showed me a back door to pass through so as not to be seen.*"

[9] Facilities reported migration of their staff to other countries over the course of the project. Therefore, many of the service providers and nurses currently in the facilities were those who had not received ASRH and YFS training. The migration of health staff has been documented in a number of articles, including, *The health service brain drain – what are the options for change?* (GAVI Quarterly, October 2003); *The Brain Drain and Retention of Health Professionals in Africa* (a case study prepared by Delanyo Dovlo, September 2003); *Efforts under way to stem 'brain drain' of doctors and nurses* (Bulletin of the World Health Organization, February 2005); and *A Golden Chance to Solve the Health Worker Crisis in Africa* (Global AIDSLink, November 2005).

It should be noted that many of the mystery clients were very pleased with their interactions. *"When I was telling the provider the reason why I visited the facility, he told me to feel comfortable and not to feel shy to tell him everything bothering me,"* one explained. *"There were no harsh attitudes toward me and the doctor showed a sense of respect and dignity toward me. He listened attentively to me when I was telling him my problem. He was not judgmental and appeared ready to help,"* another said. "T*he conduct of the nurse was remarkable. She was friendly, occasionally sharing little jokes here and there to make me feel at home,"* another explained.

Some clients also described the importance of youth involvement in the clinics, particularly as youth counselors. "*Some of the service providers I met during the service delivery process were* [peers] *and as such, I had the opportunity to talk with them without any fear*," explained one.

Although the positive results of many of the mystery clients are encouraging, more work needs to be done to ensure consistency in all YFS facilities for young people.

Trend Analysis

Evaluation Methodology

Service data spanning the fourth quarter of 2001 to the first quarter of 2005 were reviewed and collated for the trend analysis. However, it should be noted that the four partners (GHS, PPAG, CHAG and NYC) started implementation and reporting at different times. PPAG started implementation and reporting in 2001, ahead of the other three partners. CHAG and NYC began submitting reports in the fourth quarter of 2003, and GHS first reported their activities in the second quarter of 2004. In addition, whereas CHAG and PPAG implemented static and outreach strategies, GHS and NYC implemented only one strategy each. Table 12 shows the timeframes of data availability and strategies used for each partner.

Table 7: Data Available by Partner

Partner	Number of Reporting Facilities/Sites	Time Frame for Reporting	Type of Strategy	Period with Standard Data[10]
CHAG	10	Qtr. 4 2003- Qtr. 1 2005	Static and Outreach	Qtr. 4 2003- Qtr. 1 2005
NYC	6	Qtr. 4 2003- Qtr. 1 2005	Outreach	Qtr. 4 2003- Qtr. 1 2005
PPAG	4	Qtr. 4 2001- Qtr. 1 2005	Static and Outreach	Qtr. 4 2003- Qtr. 1 2005
GHS	20	Qtr. 2 2004 – Qtr. 1 2005	Static	Qtr. 2 2004 – Qtr. 1 2005

Due to the different reporting periods, the trend analysis is covers the fourth quarter of 2003 through first quarter of 2005. However, total youth visits and condoms distributed during the entire period are also presented, to give a broader picture of the true reach of the project.

Data Limitations

The main limitation encountered was that the partners' implementation and reporting periods differed, as described above. As a result, analysis of some of the partners work had to be done separately.

Otherwise, PPAG and GHS initially used their own data collection tools before reverting to the use of the AYA/Pathfinder data collection forms. Thus, the data collected by PPAG from first quarter of 2001 to third quarter of 2003 does not conform to the AYA/Pathfinder summary data collection formats (i.e., lack disaggregation of data into the three age groups (10-14, 15-19, 20-24)). This has presented challenges in comparing data to over the entire implementation period.

[10] Data conforming to AYA/Pathfinder requirements (i.e. data disaggregated by age (age groups included 10-14, 15-19, 20-24), sex and services)

Results

Youth Visits

A total of 281,296 youth visits were made to PPAG, CHAG, and GHS facilities from the third quarter of 2001 to the first quarter of 2005. However, when the data is limited to the fourth quarter of 2003 through first quarter of 2005 (when data conformed to the AYA/Pathfinder requirements), a total of 252,186 youth visits were reported. From the fourth quarter of 2003 to first quarter of 2005, CHAG and PPAG reported 81,857 youth visits.

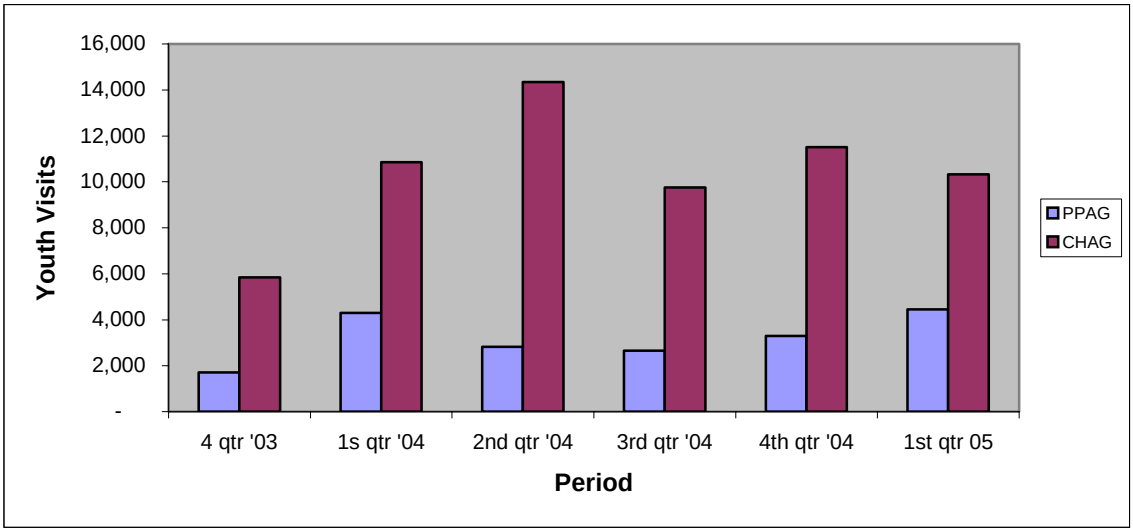
Youth Visits by Partner

As shown by the graph below, youth visits to CHAG facilities increased for the first three quarters but declined in the third quarter of 2004 and again in the first quarter of 2005. The decrease in CHAG youth visits during the third quarter may be due in part to the resignation of the project coordinator at the end of the second quarter. Following the appointment of a new coordinator, implementation was slowed as the new coordinator familiarized himself with the project. However, in the next quarter visits increased again.

For PPAG, there was a slight increase in visits between fourth quarter of 2003 and first quarter of 2004. The decrease in the second quarter of 2004 could be attributed to reduced funding from other donors, such as USAID, due to the restrictions of the Mexico City Policy. The initial project activities of PPAG focused more on BCC.

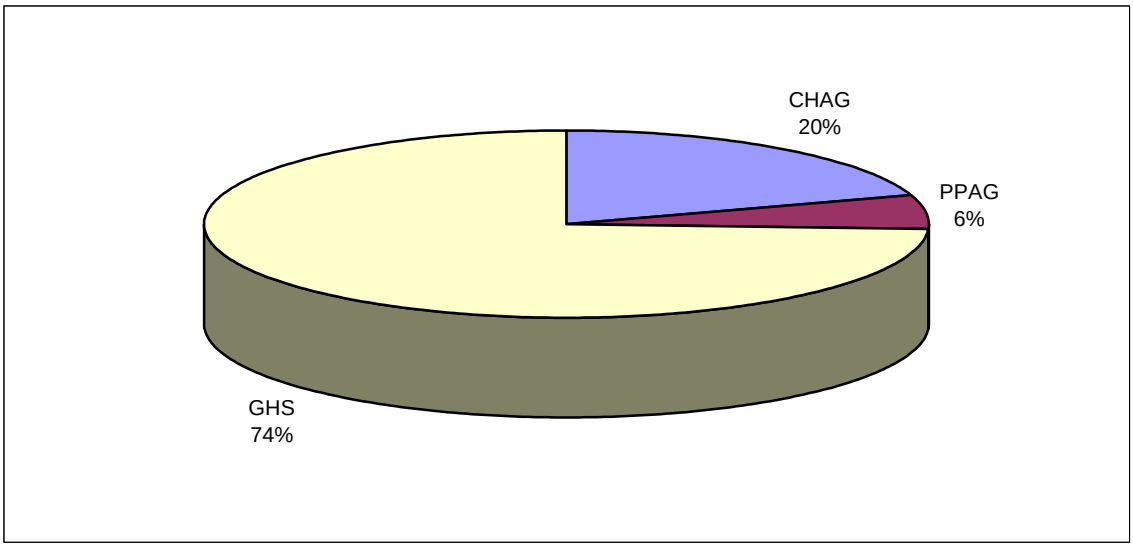
The general decrease in volume of youth visits during the first quarter of 2005 could be explained by the fact that it was the last quarter of implementation of the project. In addition, project staff were busy preparing reports and four public holidays fell during this period.

Figure 4: Youth Visits by Partner (CHAG and PPAG), Quarter 4 2003 – Quarter 1 2005



For comparing the contribution of each of the partners to total youth reached, data for the analysis was limited to the period between the second quarter of 2004 and the first quarter of 2005 because GHS reports only cover this period. Visits to GHS facilities account for 74% of the 252,186 visits. This suggests that public sector health facilities have great reach and potential in addressing the many reproductive health problems of young people. A number of factors may account for this trend. The sheer number, size, and coverage of GHS facilities are likely to account for a large number of GHS visits. Twenty of the 51 implementing GHS facilities reported during this timeframe. Ten CHAG and four PPAG facilities reported. CHAG reported more youth visits than PPAG, which may be attributed to the fact that CHAG has more and bigger facilities than PPAG. Also, due to cost recovery, PPAG fees are sometimes higher than CHAG fees for some services.

Figure 5: Partner Share in Total Youth Reached



Youth Visits by Sex

As seen in the following figures (6a and 6b), there were more visits by young females than males; almost three-fifths of the visits for SRH services were by females (61%). The trend analysis reveals that female visits consistently outpaced male visits in all quarters. This is probably because reproductive health services have traditionally been perceived to be only for females. This attitude may also be attributed to the location of most of these services in maternal and child health wards. Also, young men have not traditionally been encouraged to seek out SRH services and usually rely on pharmacies or chemical shops and peer providers for these services. However, the fact that young men still constituted about 40% of youth reached by the project is commendable and an accomplishment given the social context.

Figure 6a: Youth Visits by Sex

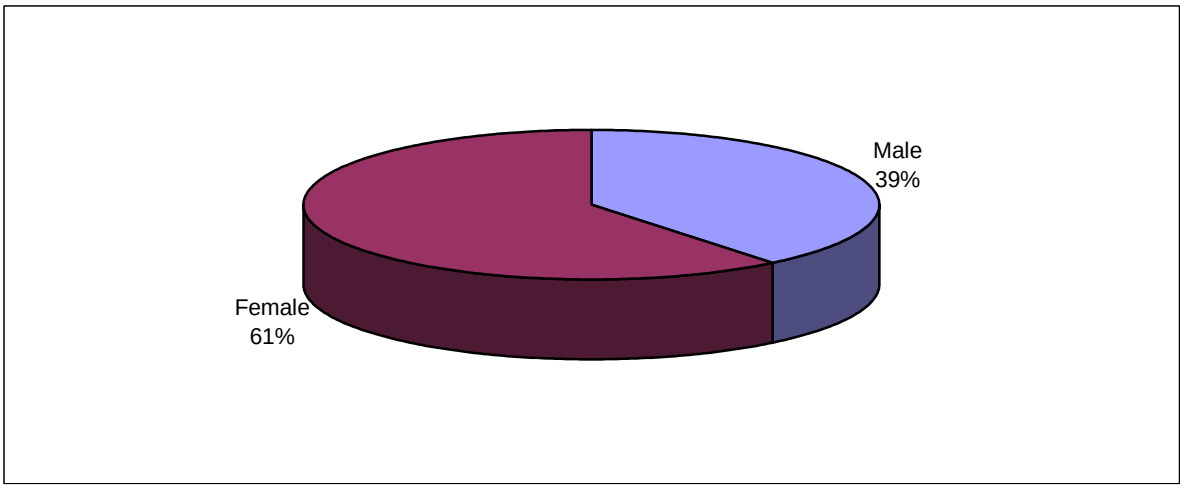
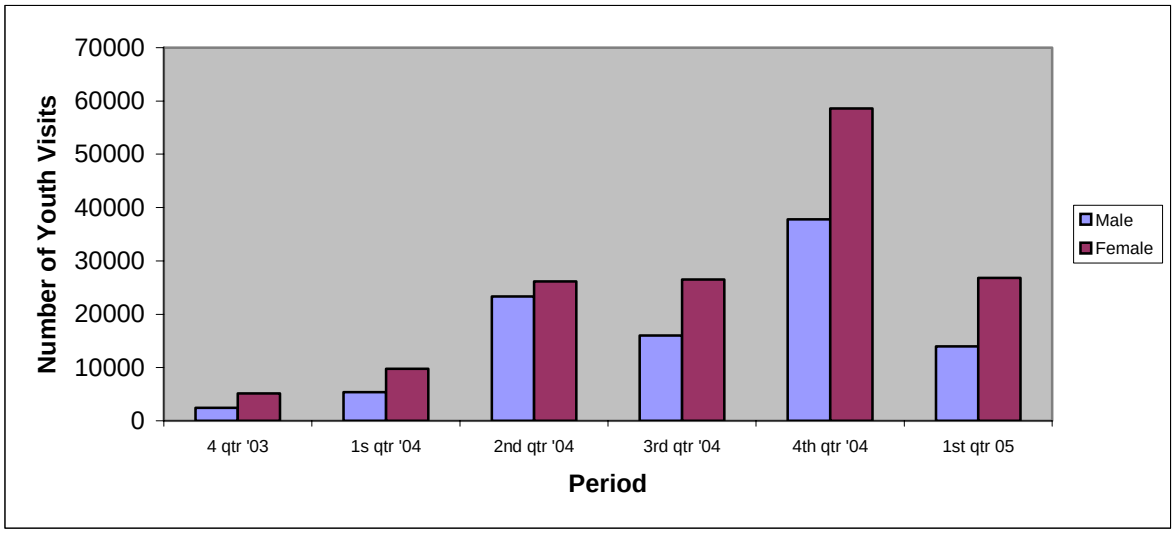


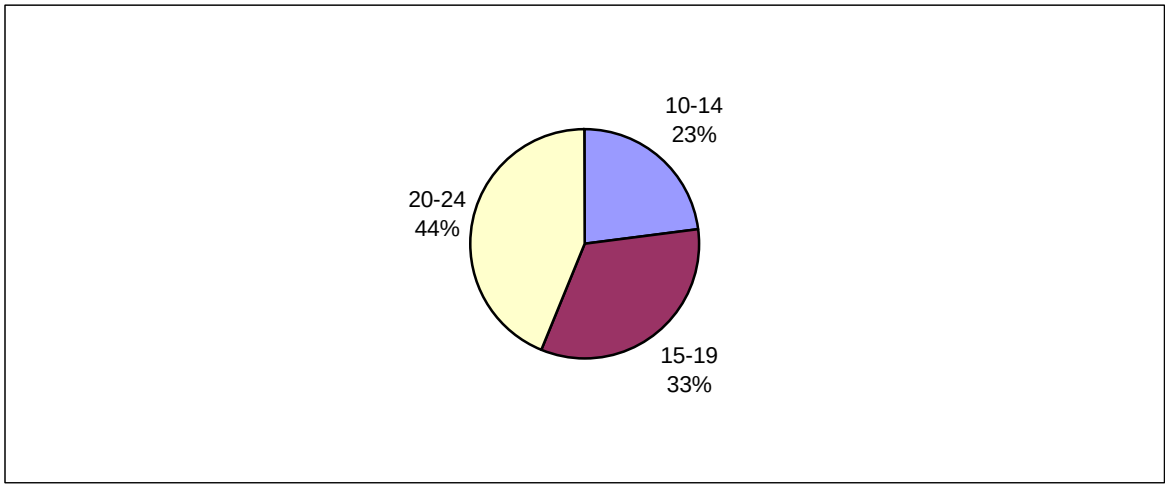
Figure 6b: Youth Visits by Sex



Youth Visits by Age

Analysis of the age distribution of youth visits (figure 7a) shows that youth visits increased with age. About 44% of youth visits were from people aged 20-24 years. Visits by 15-19 year olds and 10-14 year olds were 33% and 23% respectively. This trend does not reflect the youth population percentages reported in the 2000 Population and Housing Census Report where the reverse is true – 10-14 year olds account for 35% of the population, 15-19 year olds for 33%, and 20-24 year olds for 31% of the total population between 10-24 years. This could be because most of the youth who visited the facilities did so with SRH problems and since most young people between 10-14 years are not sexually active they may not have the same need to visit the facilities. Furthermore, as revealed during the outreach assessment described in the next section of this report, most people still feel that the focus of SRH education for young people between 10 and 14 should be on abstinence. Consequently, this group of young people may still feel shy and afraid to approach a health service provider if they fear stigma and negative treatment. It should be noted that the average age of sexual debut in Ghana is 18.2 years.[11]

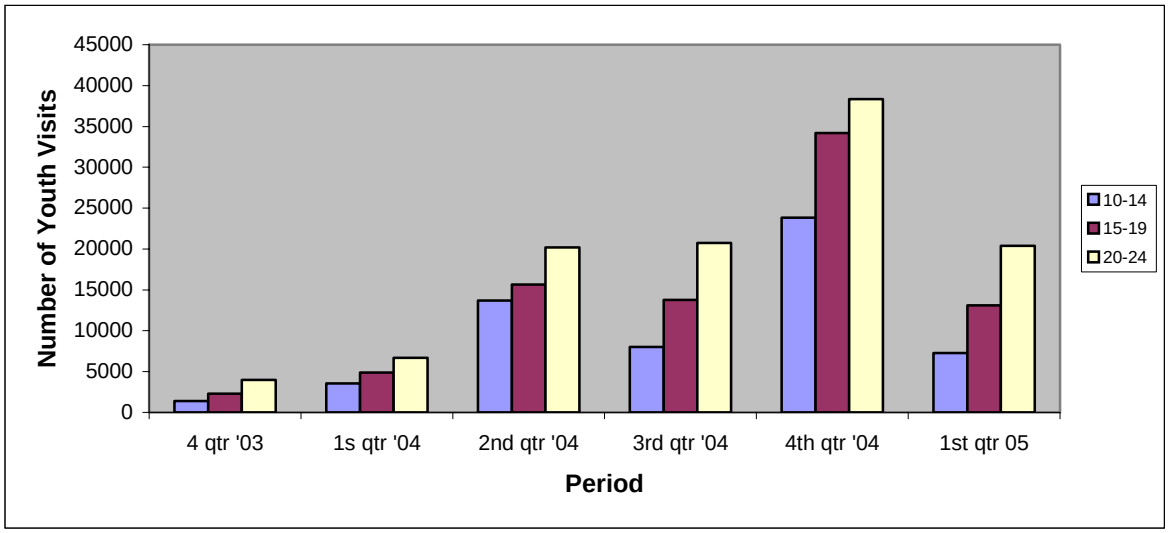
Figure 7a: Youth Visits by Age



[11] 2003 Ghana Demographic and Health Survey.

Figure 7b shows that youth visits by age group 10-14 and 15-19 increased over the period of the study, but declined in the third quarter of 2004 and first quarter of 2005. However, the only decline experienced by the 20-24 year group during the period under review is the first quarter of 2005.

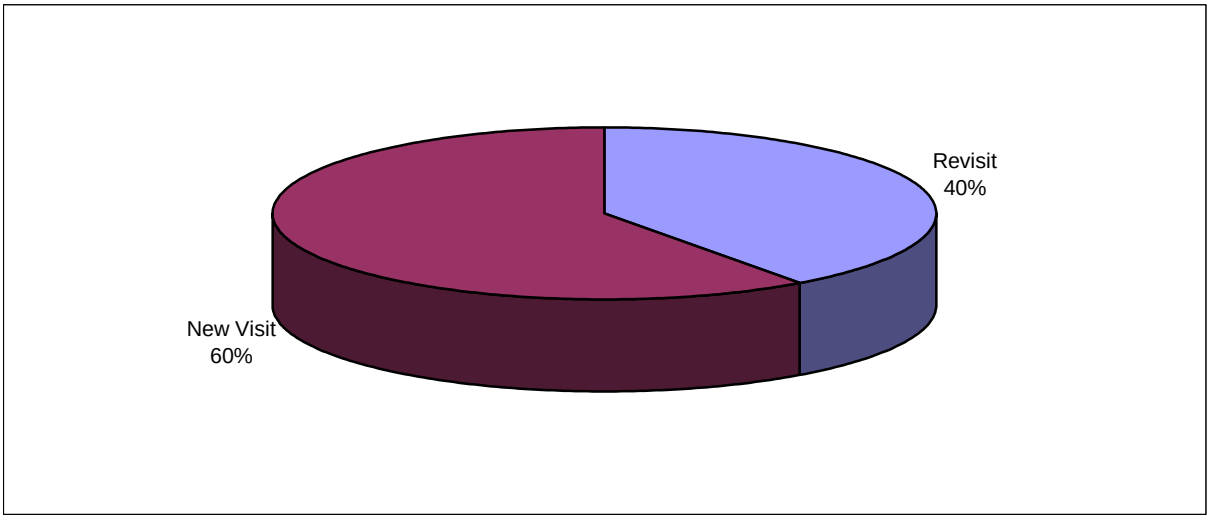
Figure 7b: Youth Visits by Age



Youth Visit by Type of Visit (New or Repeat)

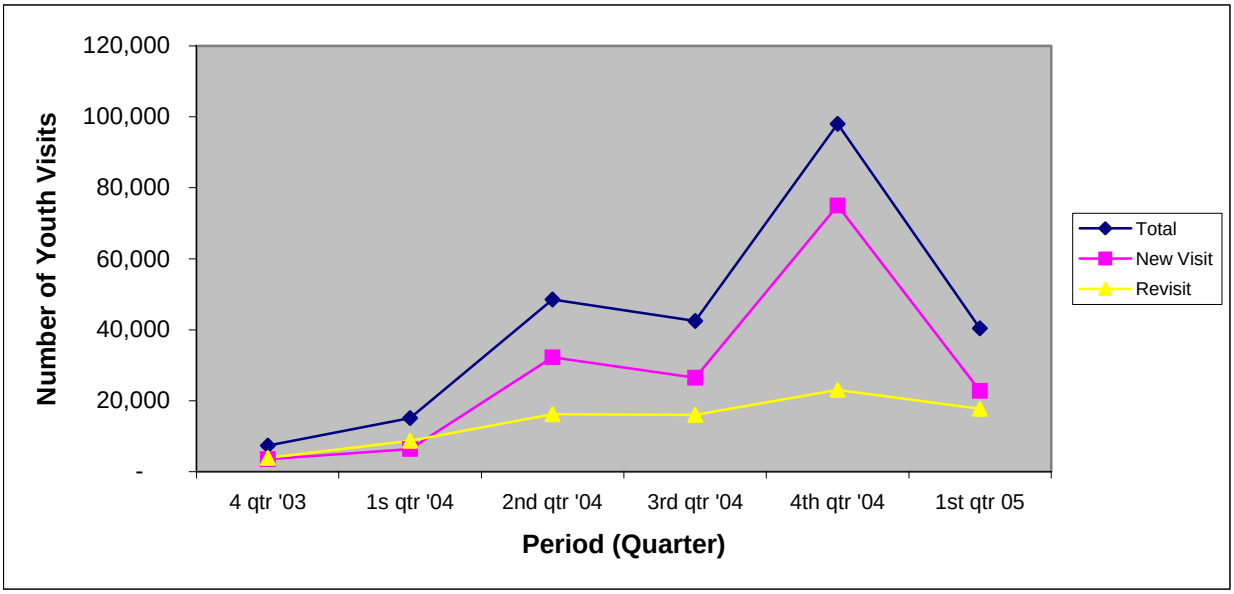
Figure 8a reveals that facilities did not receive as many repeat visits as new clients. Sixty percent of youth visits were new clients. Forty percent were repeat clients. It is not known whether this is attributable to client satisfaction issues or whether the first visit sufficiently met clients' needs. The high percentage of new visits could also be a reflection of the large number of new clients seeking services across the period of project implementation. According to one youth, another reason for the lower percentage of revisits is that "*reproductive health concerns and needs are not as frequent as other general health problems, such as headaches and stomach aches, which necessitate return visits."* There is a need for the facilities to either follow up with individual clients or conduct a study to determine the reasons why young people who visited their facilities did not revisit.

Figure 8a: Youth Visit by Type



The trend analysis of youth visits by type of visit (figure 8b) shows an increase in youth visits of all types between the first three quarters of implementation of the project. However, as in the previous graphs, there was a decline in youth visits during the third quarter of 2004 and again in the first quarter of 2005. It must be noted, however, that whereas there was a sharp increase and decline of new visits between the first quarter 2004 and first quarter 2005, the number of repeat visitors remained relatively constant.

Figure 8b: Youth visit by Type

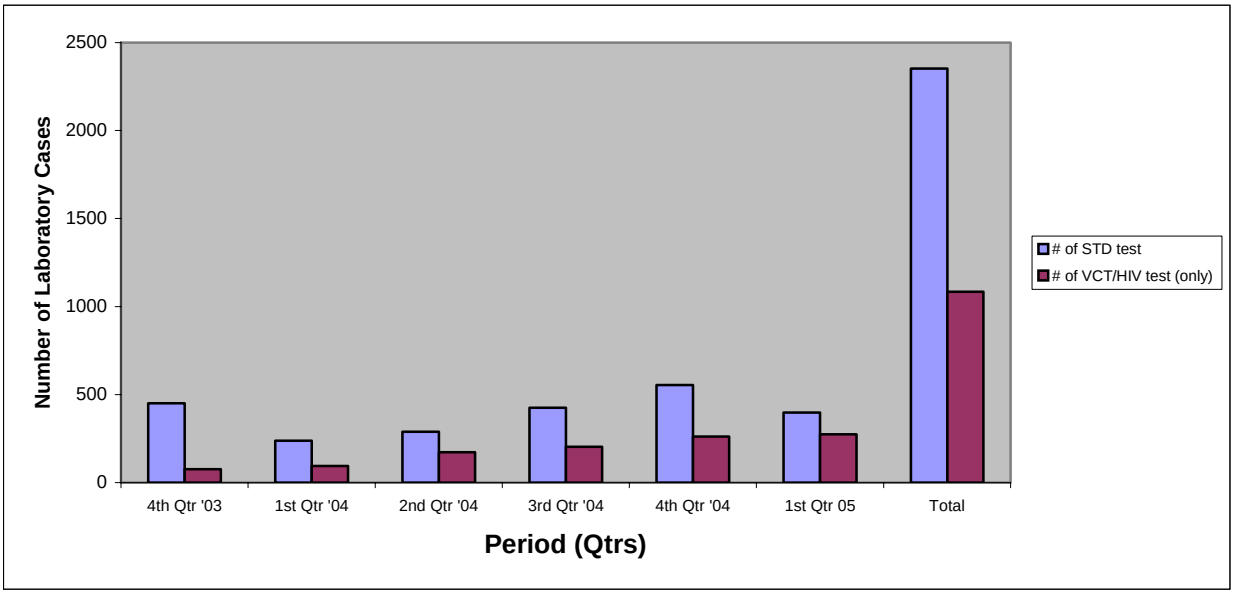


Testing and Treatment

Testing: A total of 3,437 STI and HIV tests were conducted for youth. A greater proportion of the tests conducted were for STIs (69%). The proportion of Voluntary Counseling and Testing (VCT) was 31%. The low proportion of VCT may be explained in part by the fact that not every facility offered VCT.

Figure 9 shows that reported STI testing dropped, increased steadily, and dropped again. On the other hand, VCT increased steadily from 76 tests in the fourth quarter of 2003 to 275 recorded tests in the first quarter of 2005. Though the number of young people who visited the facilities for VCT for HIV testing was low, the trend analysis shows that there is an increase in testing visits, which may be attributed to the awareness that has been created in the communities.

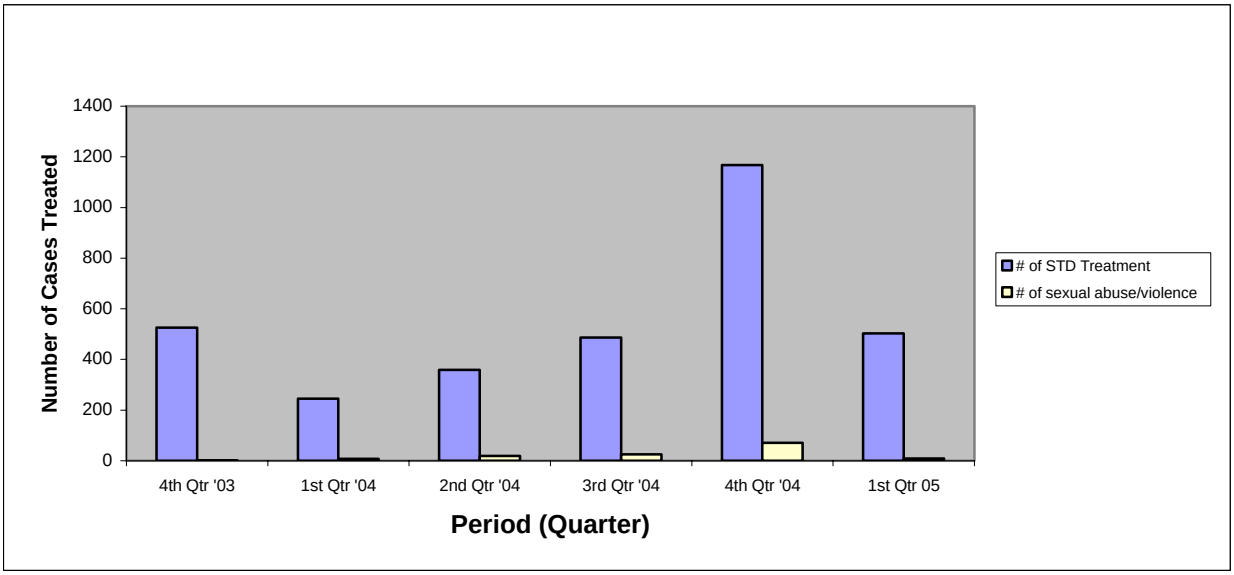
Figure 9: Testing Conducted by Type and Quarter



Treatment: Two types of visits were reported during the period under consideration – STI and sexual abuse or violence treatment. In all, 3,418 young people were treated. Most of the cases treated were for STIs (96%). Sexual abuse or violence cases treated accounted for only 4% of the total visits. This may be attributed to the fact that women, particularly young women, may feel shy or are afraid to report for treatment of sexual abuse or violence.

STI visits declined in the first quarter of 2004 after the initial spike in the fourth quarter of 2003 (figure 10). However, in subsequent quarters, STI treatment visits increased consistently until the first quarter of 2005 when they declined by about 50%. The increase could be due to increased awareness of these issues in the communities, particularly as a result of outreach efforts. Treatment for sexual abuse or violence increased during the first five quarters but fell in the first quarter of 2005.

Figure 10: Treatment of Cases by Type and Quarter

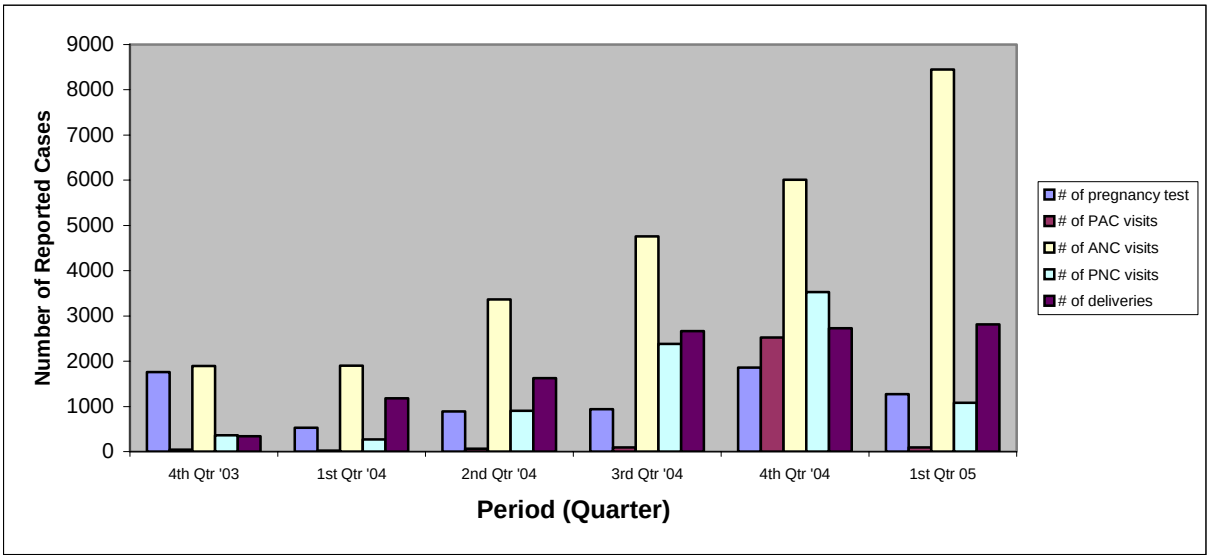


Pregnancy-Related Issues

A total of 53,154 pregnancy-related visits were recorded, including PAC, antenatal care and postnatal care visits, deliveries, and pregnancy testing. Half of all reported cases were related to antenatal care. Deliveries accounted for a little over a fifth of all reported cases. The proportion of postnatal care visits and pregnancy testing were 16% and 11%, respectively. Fewer young people (2%) visited the facilities with PAC cases. In part this may be due to the fact that not all the facilities chosen for YFS offer PAC. Even facilities that offer PAC are often not able to consistently provide PAC on a 24 hour basis due to lack of trained providers and lack of MVA equipment. In addition, young people may not be aware of available PAC services, which could be addressed through further community sensitization and awareness.

Antenatal care visits increased consistently over all reporting quarters, but other pregnancy related visits did not follow particular patterns (figure 11). Postnatal care visits decreased from the fourth quarter of 2003 to the first quarter of 2004, but increased steadily over the subsequent quarters, and only declined again in the last reporting quarter (first quarter, 2005). The consistent increase in deliveries over the entire period may be attributed to increasing awareness of the new government policy of free deliveries at all public health facilities and private maternity homes in the country.

Figure 11: Pregnancy-Related Cases by Type and Quarter

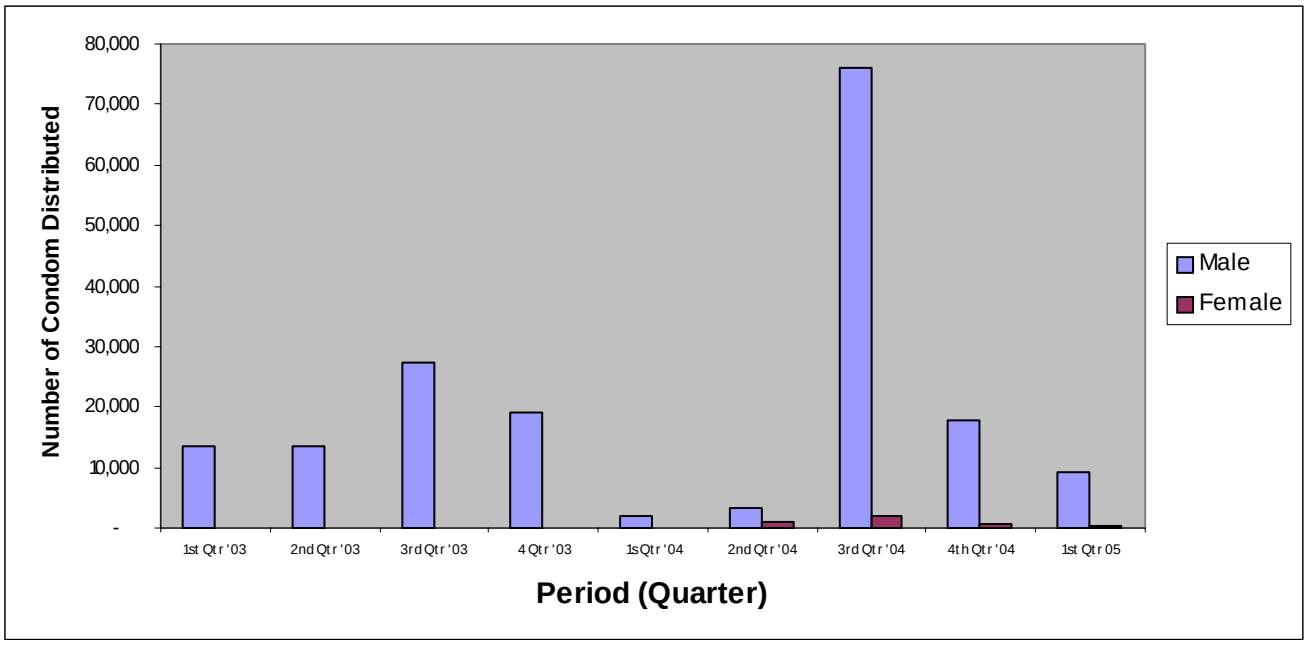


Contraceptive Distribution

Analysis of contraceptive distribution has been divided into two aspects – condom distribution and the distribution of other contraceptives because the high number of male condoms distributed renders distribution of the other contraceptives insignificant in the analysis if kept together.

Condoms: A total of 646,602 male condoms and 3,784 female condoms were distributed through clinics between 2002 and the first quarter of 2005. The year 2002 accounted for 72% of all male condoms distributed and came from PPAG alone. Because data for 2002 is not disaggregated by quarter, the trend analysis is based on data from first quarter 2003 to first quarter 2005 (figure 12a).

Figure 12a: Condoms Distributed by Type and Quarter



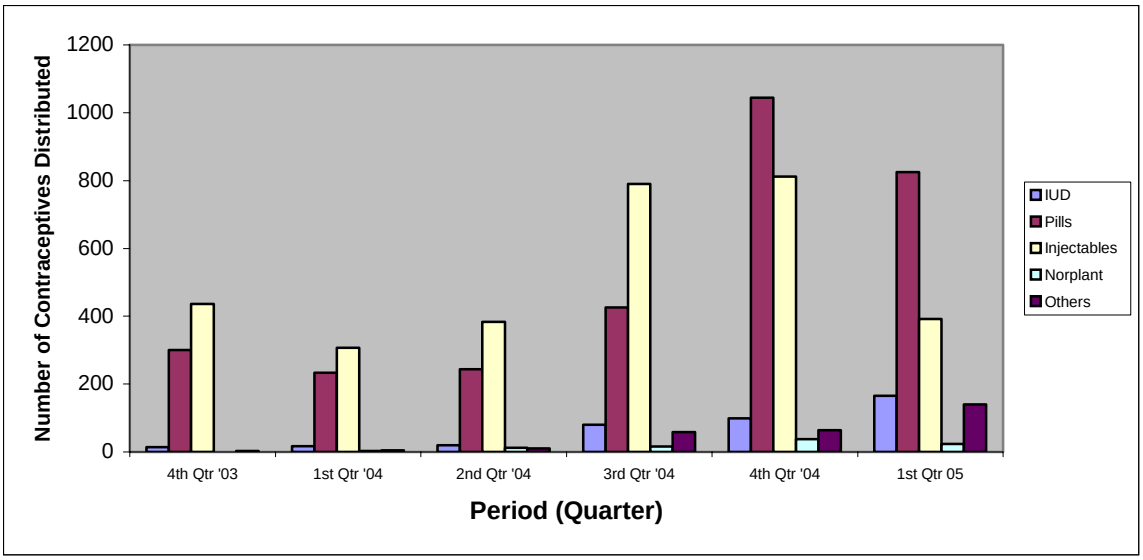
As seen above, male condom distribution held steady in the first two quarters and increased in the third quarter of 2003. In the next three quarters distribution of male condoms declined until the third quarter of 2004 when condom distribution increased significantly. Condom distribution declined in the next two quarters.

No female condoms were distributed until the fourth quarter of 2003. This may be attributed to low publicity of the method and the fact that the commodity was very new in the Ghanaian health system. From the fourth quarter of 2003 to the third quarter of 2004, the number of female condoms distributed increased from 16 to 1,892. Distribution decreased, however, in the subsequent quarters. Reasons for the spike and decline could be explained by initial curiosity about the method and consumer unhappiness, as suggested by anecdotal evidence from women who have tried it.

Other Contraceptives: A total of 6,960 other contraceptive methods, including IUDs, pills, injectables, Norplant, and others including emergency contraceptive pills, foaming tablets, Neo Shampoon and Conceptrol, and jelly, were distributed. Injectables (45%) and pills (44%) were more popular among the young people and together accounted for about 89% of all noncondom contraceptives distributed. The share of IUD and Norplant of the total noncondom contraceptives distributed is only 5% and 1% respectively. The popularity of injectables and pills may be attributed to the fact that most young people feel secure using these two methods because they are temporary methods that offer high protection, while being easy to use. Injectables are also popular because it is a method that is not visible. Condoms remain more popular than either injectables or the pill, perhaps because there is a perception among young people that the two methods (pills and injectables), particularly pills, cause weight gain.

The use of IUDs, injectables, and Norplant increased steadily over the six quarters. On the other hand, the number of pills distributed decreased from 300 in the fourth quarter of 2003 to 233 in the first quarter of 2004. However, it then increased consistently over the subsequent three quarters until declining in the first quarter of 2005. The distribution of other contraceptives, such as the emergency contraceptive pill, also increased during the first five quarters and only decreased in the first quarter of 2005 (figure 12b).

Figure 12b: Other Contraceptives Distributed by Type and Quarter



Age Distribution

As presented in figures 13a-13d, testing and treatment visits, pregnancy-related visits, and contraceptive distribution of all types increased with age. However, more 15-19 year olds visited the clinics for VCT and sexual abuse or violence treatment than any other age group.
There were no recorded cases of 10-14 year olds receiving contraception (other than condoms), but members of this age group did receive VCT and pregnancy-related care.
Further investigation is needed to determine the reasons for this trend.

Figure 13a: Testing by Type and Age

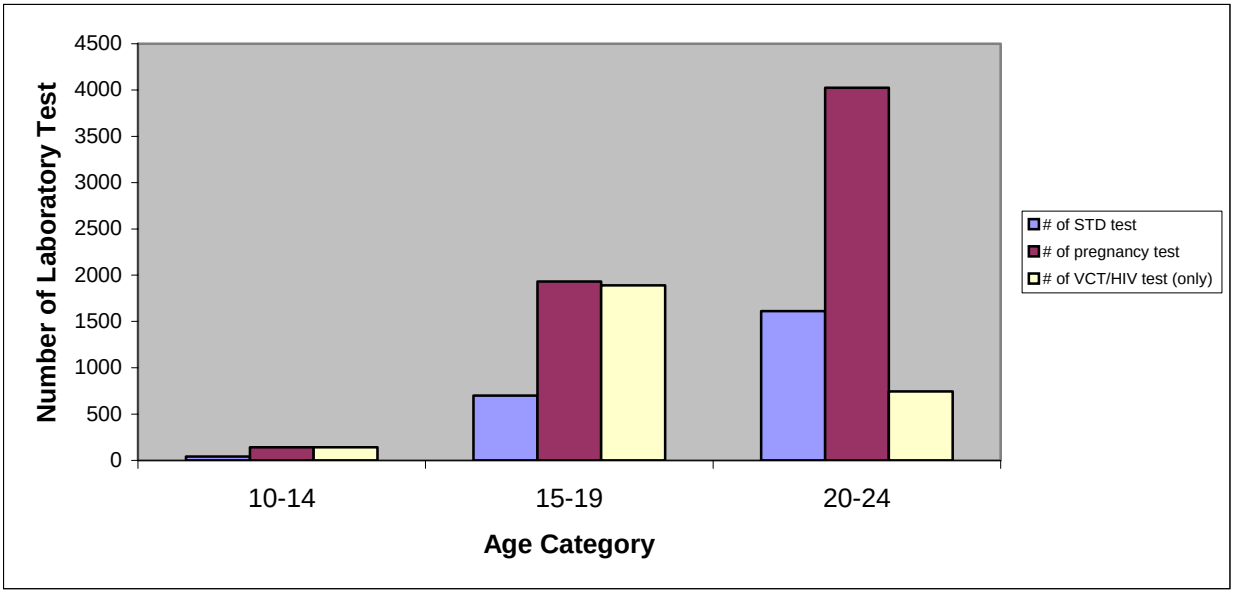


Figure 13b: Treatment by Type and Age

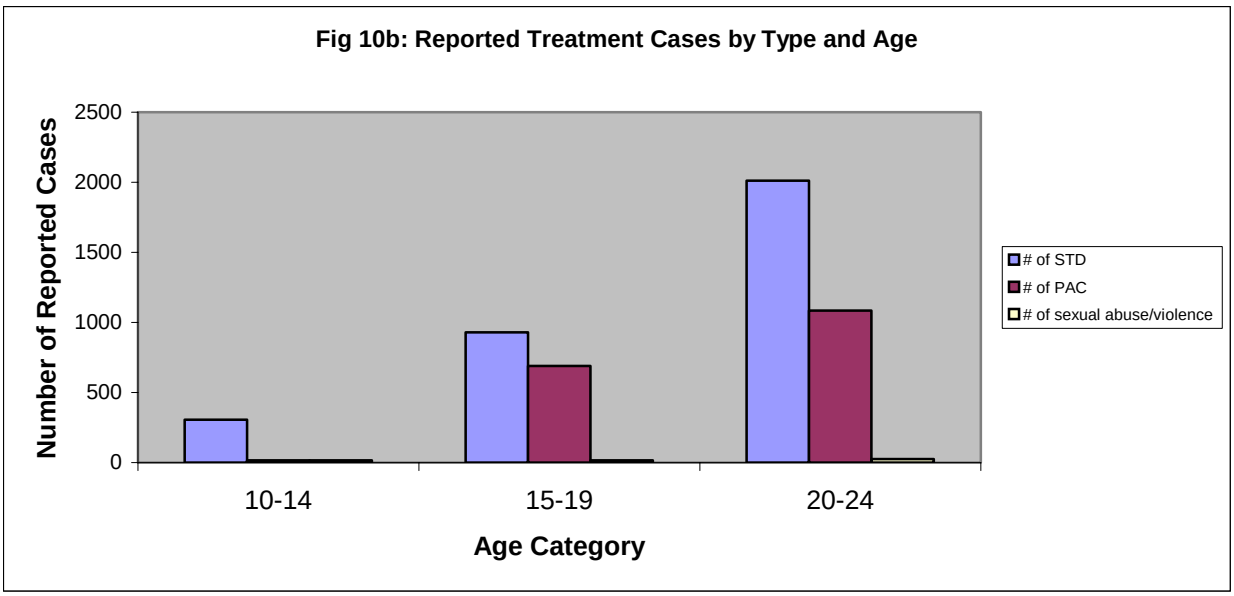


Figure 13c: Pregnancy-Related Cases by Type and Age

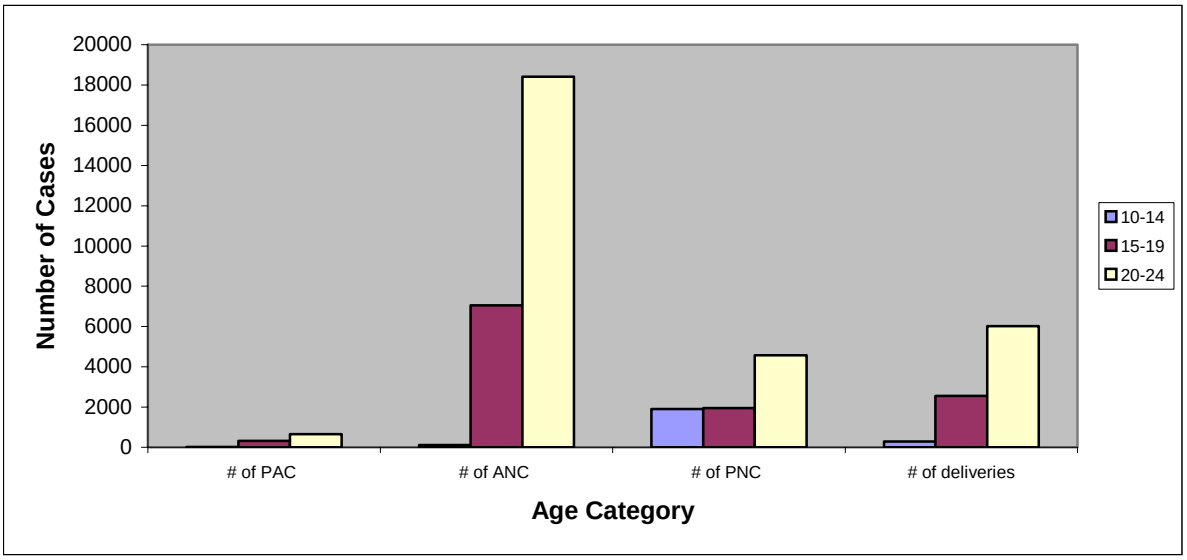
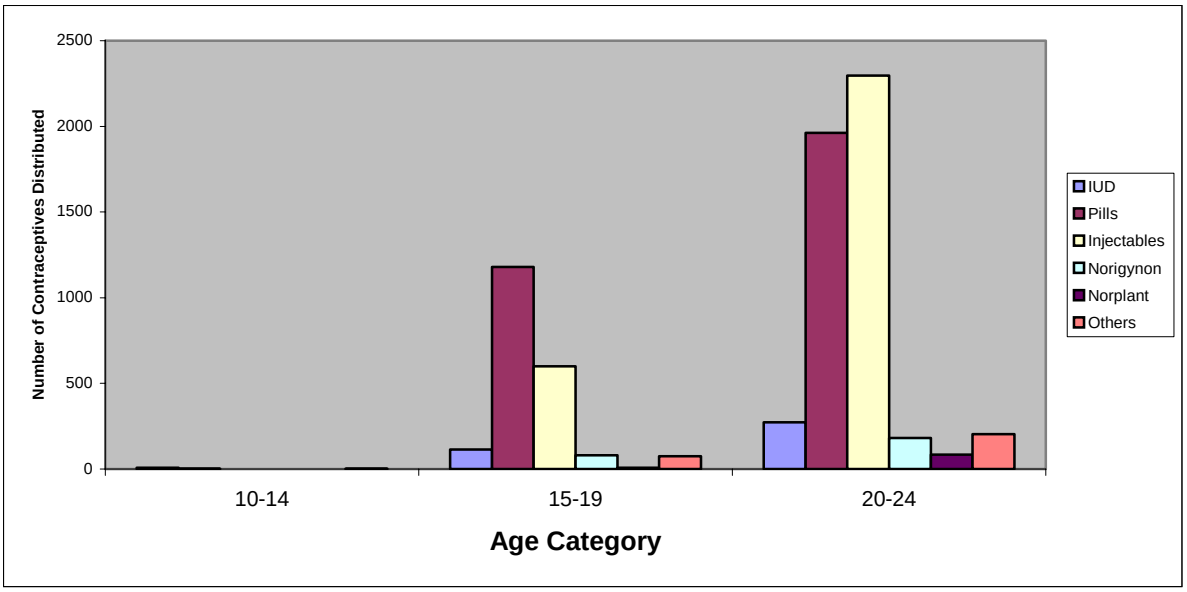


Figure 13d: Contraceptives Distributed by Type and Age



OUTREACH EVALUATION

This section describes the activities done under the outreach component and describes the results of the outreach evaluation, including analysis of client satisfaction data, trend analysis, and analysis of in-depth interview and focus group discussion data. For each section, the methodology for evaluation, data limitations, and results is provided.

Outreach Activities

The outreach program in Ghana used two strategies, peer service provision and nontraditional condom distribution. The use of Peer Service Providers (PSPs) has been extensively used and tested in terms of its effectiveness in Ghana and elsewhere, but the use of Nontraditional Condom Distributors (NTCDs) is a new strategy being implemented in Ghana for possible replication within and outside the country. The concept of nontraditional condom distribution is based on the fact that traditional sources and strategies for promoting SRH services among young people have been too formal and do not reach large enough numbers of youth. Consequently, taking into consideration the socio-economic environment, youth-oriented SRH studies and programs have underscored the importance of widening the channels for reaching youth with SRH information and services, using nonformal channels which have a wider appeal in Ghana.

Therefore, nontraditional condom distribution is designed to promote SRH information and services for youth in places where young people tend to congregate daily, such as barber and dressmaking shops. Such places are often operated by or managed mainly by young people and reach out more to the youth than conventional outlets for SRH services. The use of NTCDs, therefore, involved the selection of youth barbers, dressmakers, and hairdressers (both males and females), equipping them with SRH information and social marketing skills to promote SRH information and YFS.

Selection and Training

Since the inception of the program, a total of 497 youth (200 NTCDs and 297 PSPs) implemented activities in 12 of the 20 AYA districts, covering three regions. As noted earlier, outreach activities were conducted by PPAG, CHAG, and NYC, but not by GHS. The selection of the youth as NTCDs and PSPs was based on criteria developed by AYA/Pathfinder in collaboration with the partners. The basic requirements for qualification included the following:

- Be between 15 and 24 years of age[12];
- Be able to read and write well enough to record activities on the data collection forms and transfer them onto the monthly summary forms;
- Be respected in the community (i.e., be a role model);
- Be interested in reproductive health issues;
- Have a willingness to listen to others;
- Be morally upright by other people's estimation;

[12] In some cases, NTCDs were above 24 years of age.

- Willing to learn and teach others;
- Willing to talk about sexuality issues and provide contraceptive services to others;
- Willing and able to serve free of charge;
- Nominated by the target group;
- Known history of community participation;
- Available for the next two to three years.

In addition to the above, for a youth to qualify as an NTCD, he or she had to be involved in a trade as either an apprentice or a master trainer.

Candidates who fulfilled at least the minimum criteria were selected. The project coordinators of the three partners used the list of criteria and discussed them thoroughly with the project supervisors in the field for their input in the selection. Community leaders such as chiefs, assembly members, queen mothers, unit committee members, religious leaders, teachers and other opinion leaders in the various intervention sites were consulted in the selection. Other key stakeholders, i.e., youth and church groups, also played key roles in the selection of the youth as PSPs and NTCDs. The identification and selection took a period of three weeks.

A *group of peer service providers under CHAG's Window of Hope Project.*

Each PSP was trained for five days using the PPAG training manual. The NTCDs were trained for three days with an abridged version of the same training manual. An additional supplementary training on social marketing was provided to the NTCDs, using the training

manual from the Ghana Social Marketing Foundation International. Both PSPs and NTCDs were trained on the proper completion of the data collection forms. The training unit of PPAG facilitated the training workshops. Annual refresher courses were organized to update their knowledge and skills.

Implementation

After the training, 10 PSPs and 10 NTCDs implemented outreach activities in each of the 20 sites. Each trained PSP and NTCD was provided with the necessary supporting materials such as a bag, flip chart, demonstration kit (e.g. penis models), contraceptives, and BCC materials to enable them to provide the following services:

- Distribution of condoms and other non-clinical contraceptives,
- Referral of youth to counselors and health centers, and
- Provision of SRH information and education, with an emphasis on HIV prevention.

Key strategies used by the PSPs to reach out to youth clients were one-on-one and group discussions. They achieved these through home visits, attendance at soccer matches, athletic activities, funerals and parties, and invitations to church and other group activities. NYC, for example used the Challenge Cup project to reach out to young people with SRH information and services at soccer matches. A large number of youth attend such matches, so before matches and during intermission, the PSPs talked about SRH issues and sold condoms.

For the majority of the PSPs, the group discussions were more effective because they were able to reach out to more young people at the same time. On the other hand, a smaller proportion of the PSPs thought that the one-on-one was effective and contended that it provided a conducive and relaxing atmosphere for clients to discuss their problems. Explained one PSP, *"Sometimes a youth client would approach you after group discussions that he or she has other issues that are personal to discuss with us. It is not everybody who can discuss his or her problems in public."* For the NTCDs, one-on-one contact was their main strategy and they depended on young people who patronized their services (i.e., barbering, tailoring). On a few occasions, some NTCDs also collaborated with the PSPs to organize programs in the communities.

Monitoring and Supervision

The activities of the PSPs and NTCDs were coordinated and supervised by field supervisors, who were selected by the partners themselves. In all, 18 NYC and CHAG supervisors were trained. PPAG already had a pool of trained supervisors, so they did not train additional supervisors until the final year of project implementation.

To ensure the quality of implementation of outreach activities, the field supervisors maintained regular contact with the PSPs and NTCDs in order to support and supervise their activities. Follow-up activities undertaken by the supervisors after the deployment of the PSPs and NTCDs included the following:

- Facilitating contact between the PSPs and NTCDs and members of official agencies, public health personnel, and church and youth groups;
- Preparing them for the role they have been assigned;

- Supplying them with additional knowledge, which was included in the basic course;
- Providing them with BCC and other materials; and
- Ensuring prompt payment of transportation allowances.

The follow-up activities were supplemented with weekly field supervisors' visits, quarterly visits of AYA program technical officers, annual review meetings, and bimonthly meetings and reporting. During the bimonthly meetings, the field supervisors resupplied contraceptives to the PSPs and NTCDs, mentored them, answered questions that had arisen, and strengthened their communication and outreach skills. In addition, the field supervisors participated in community activities organized by PSPs.

The reporting of the PSPs and NTCDs was facilitated by the development of daily and summary data collection formats. The summary formats captured data disaggregated by three age categories (10-14, 15-19, and 20-24), sex, and type of volunteer (PSP and NTCD). In general, the tools facilitated timely and accurate reporting by the partners.

Analysis of In-Depth Interviews and Observation Data

Evaluation Methodology

In-depth interviews and direct observation were used to solicit information from PSPs, NTCDs, supervisors, and community leaders such as, religious and traditional leaders, assembly members and other opinion leaders. Direct observation, which was used to assess the quality of outreach implementation, involved observing how the NTCDs demonstrated and explained proper condom use to their clients. Guidelines were designed to record the interactions between the NTCDs and youth clients.

The in-depth interviews gathered information related to the possible effect of the outreach activities on the health-seeking behaviors of young people in particular, and the intervention communities as a whole. They also solicited information from the PSPs and NTCDs on the effect that their involvement in the outreach activities has had on their own reproductive and sexual health behaviors and other aspects of their lives. In addition, the barriers and facilitating factors of the outreach activities were examined through discussions with the PSPs and NTCDs, youth clients, community leaders, and supervisors.

Selection of Sites[13]

The intervention sites were therefore sub-grouped by partners and locality (i.e., rural, urban and peri-urban). CHAG had 10 intervention sites in 6 districts; PPAG had 4 intervention sites in 4 districts; and NYC had 6 intervention sites in 6 districts. The sampling technique adopted ensured that all the different categories of sites were well represented in the sample.

A proportional sampling technique was used to allocate six sites (about a third of the total intervention sites) to the three participating partners. On the basis of this criterion, two NYC sites were randomly selected, three CHAG sites, and one PPAG site.

Using the criteria described above, the following sites were selected for the assessment:

- NYC: Akwapim North and Atwima Districts
- CHAG: Assin Praso - Assin District, Wiamoasi - Afigya Sekyere District, and Kwadaso – Kumasi Metropolitan Authority (KMA)
- PPAG: Laterbiokoshie – Accra Metropolitan Authority (AMA)

Selection of Respondents

In each intervention site, 10 PSPs and 10 NTCDs had been conducting activities under the project. For the observations, two NTCDs were chosen per site. For the interviews, 50% of both the PSPs and NTCDs at each site were randomly selected for the interview - 30 PSPs and 30 NTCDs from the six sites. The sampling procedure ensured that both young women and young

[13] For CHAG and PPAG, a site is defined around a facility and the catchment communities it serves. NYC sites are defined as the five communities in a district where the outreach program is implemented.

men were proportionally represented. About 37% of PSPs interviewed were between 15-19 years old and 63% were between 20-24 years. The majority of NTCDs (70%) were between 20-24 years, followed by those aged 25 years and above (20%), and those aged 15-19 years (10%). Finally, 63% of PSPs and 53% of NTCDs were males.

A total of 180 youth clients, 30 from each of the selected sites, were randomly selected for interviews. The PSPs, NTCDs, and supervisors assisted in the recruiting of youth interviewees. In each site, the supervisors, PSPs, and NTCDs provided a list of youth they had reached in the intervention site, which provided the basis for follow up and interview.

In addition, ten field supervisors and their assistants and at least six community leaders (comprising religious and traditional leaders, assembly members, and other opinion leaders) per site were randomly selected from each site and interviewed.

Data Limitations

The interviews did not benefit from baseline survey data at the various study sites. A baseline survey would have provided benchmark information on the knowledge and sexual health behaviors of the PSPs, NTCDs, and youth clients and the attitudes of the community towards the provision of SRH information and services to youth before the AYA intervention. The current situation could have been compared to this baseline data. The study therefore relied on respondents' ability to accurately recollect the past situations.

Results

The following section discusses both programmatic and implementation results, as found through the in-depth interviews and observations.

Programmatic Results

NTCDs Provided High-Quality Services to Youth

Observations showed that most NTCDs provided high-quality services to youth. NTCDs exhibited skills in creating the necessary rapport for discussion of clients' concerns and assured the clients of confidentially. Good communication skills were exhibited by the NTCDs in discussing teen pregnancy, contraceptives, HIV/AIDS, and high risk behaviors. NTCDs exhibited high levels of knowledge regarding condoms, including dual protection, and appropriate use. All NTCDs demonstrated the correct steps using the model penis. In the absence of a pelvic model, about half of the NTCDs effectively explained the use of the female condom. All the NTCDs had condom stocks that could last for at least two weeks, and all ended their interactions with their clients by referring them (filling in the referral forms) to health care centers, providing directions to the health centre, and giving the name of at least one service provider in case of difficulties. Of those observed, two made follow-up visits to the service delivery points to check on their clients.

Observations requiring further investigation and improvement:

- One NTCD was judgmental in providing information to his client. This underscores the importance of conducting value clarification exercises during bimonthly meetings and supportive supervision.
- Forty percent of the NTCDs did not have female condoms. Of those who had them, less than half were willing to use it for demonstration, as there was no pelvic model.
- In three cases where the youth client's discussions indicated potential postabortion complications, the NTCDs provided information beyond their instruction and scope of knowledge, although they eventually referred the cases.

Increased Knowledge of SRH

Through in-depth interviews, most PSPs and NTCDs indicated that they had heard about HIV/AIDS before becoming a part of the AYA program, but knew little about the symptoms of the disease and modes of transmission and held several misconceptions (e.g., they thought that one can contract AIDS if he or she shakes hands with an HIV-infected person). With the exception of gonorrhea, knowledge of other STIs was also limited before their participation in AYA. However, all the PSPs and NTCDs indicate that they now know about the symptoms and mode of transmission of HIV/AIDS and other STIs.

Ninety-seven percent of youth client respondents reported having heard about HIV/AIDS, or STIs, or a combination of both before their contact with peer educators, but they said they knew little regarding the symptoms of infections and modes of transmission of HIV/AIDS. Young people reported that their knowledge of the mode of transmission and symptoms increased after meeting with the PSPs and NTCDs.

Improved Community Attitude toward Discussing SRH

Many community members originally believed that discussing SRH with young people would promote promiscuity. But community members now indicate a greater understanding and acceptance of the provision of SRH information and services in their communities. Parents have requested that PSPs and NTCDs talk to their children about SRH. Explained a PSP, "*Some mothers approach us at times to talk to their children who they think need more information on SRH. They will tell us that they have discussed some of the issues with them, but because we are more knowledgeable, they want us to hold further discussions with them. In most cases, a parent will ask the child to come and see us.*"

A PSP reported that her aunt made a confession to her that if she had known, she would have allowed her daughter to participate in the project, *"The daughter of my aunt got pregnant, but my aunt had been very strict on her. She would not allow anybody to talk to her about sex, including my aunt herself. She would also not allow her to play with boys and also to go out after school. She thought that by so doing, the girl would be spoiled. The girl got pregnant anyway and this surprised my aunt because she thought that she was strict enough to deter the girl. Now my aunt says that she has regrets and that she appreciates the need for young people to know everything about sex and its implications. According to her, she now discusses sexuality issues with her younger daughter."*

Community leaders were also found to be supportive of PSPs and NTCDs. One stated, "*They have conducted themselves very well and have put all of us to shame because we thought that their involvement in the project would spoil them. We also thought that they were going to teach our young people to be promiscuous by teaching them how to use condoms and also to chase young girls. We are witnesses to some changes that have taken place in the PSPs and NTCDs themselves. Some of the young people who used to be 'very bad' have changed completely."*

Some community leaders believe the PSPs and NTCDs have become role models in the communities and have encouraged other young people to join the outreach activities. "*We did not understand them (referring to the PSPs and NTCDs) at first. We thought they were spoilt* [promiscuous] *and were going to spoil the kids in the community. But now we know that they are helping the community. However, we think that the 10-17 years olds are too young to be introduced to condoms, so the focus for this group should be abstinence. Condoms should not be mentioned to them at all*," a community leader noted.

Increased Use of Condoms and of Youth Practicing Abstinence

Most of the PSPs and NTCDs noted that they were sexually active prior to participating in the program. Though a majority had heard about the condom, they had not "bothered" to use it during sexual intercourse because, they believed, "*toffees taken with the plastic on are not tasty*," in other words, having sex with a condom takes away all the pleasure. "*The women complain of pains and it is also believed that condom use can make a woman barren*," explained another. Some of them posed a question, "*who goes to bathe wearing a cloth?"* Consequently, whenever they had sexual intercourse, they did it "raw" (i.e., without a condom). However, after their participation in the program, they reported either abstaining or using a condom to protect themselves any time they had sex. The respondents indicated that they are now well informed about condom use to prevent unwanted pregnancy and also HIV/AIDS and other STIs.

Eighty-four percent of young clients indicated that contact with a PSP positively changed their attitudes regarding condom use. Among youth clients who used a condom, 56% mentioned that it was used to prevent HIV/AIDS transmission and 44% stated that condom was used to prevent pregnancies. Youth clients who did not use a condom during sex gave a number of reasons, including: having no idea at all about condoms (33%), not being prepared for the sexual encounter when it happened (21%), partners did not approve of the use of a condom (18%), indifference about condom use (12%), fear that the condom might break (6%), and belief that they would not have maximum sexual pleasure by using a condom (6%). Twenty percent of young clients stated they were abstaining from sex following their contact with a PSP or NTCD.

Reduction in the Number of Partners

Some PSPs and NTCDs, both male and female, indicated that prior to AYA they often had multiple partners. The males noted that having girlfriends was a sign of one's manhood. For the females, it was an indication that one is pretty. They describe the situation of having multiple partners as "atodwe,"[14] which connotes having sex with many people.

[14] Atodwe in Akan means cultivation of rice, maize, or groundnuts

Through their participation in AYA/Pathfinder outreach activities, the PSPs and NTCDs have overcome the misconceptions they had about having multiple partners, realizing that they increase their risks for contracting deadly diseases. They now report having fewer partners. As some of them put it "*we are now advocates for safer sex and we have to live by example – to live exemplary lives"* and "*In case of contracting STIs or making a woman pregnant, we now know the appropriate place to go for services."*

More than half (59%) of youth clients interviewed had had sex, and almost all of them (96%) had their first sexual encounter before coming into contact with a PSP or NTCD. After contact with a PSP or NTCD, 80% of youth clients reported having a single partner and 20% were in no relationship at all.

Improved Leadership and Public Speaking Skills of PSPs and NTCDs

Some of the PSPs and NTCDs contended that until they became involved in the outreach program, they were shy and had trouble speaking in public. However, the majority have built up their self-confidence and can speak with authority to a big crowd in public forums and to church groups without feeling shy. They can also speak about SRH issues and use reproductive health language and terms. Previously, it was taboo to talk about such issues or use such language in public. They also noted they have increased their interview and teaching, communication, and leadership skills.

Increased Ability to Negotiate Condom Use

PSPs and NTCDs acquired skills in negotiating condom use and in properly using condoms. Several mentioned that they are now more assertive than before; they insist that their partners use a condom because they do not want to either become pregnant or contract STIs, and they refuse to have sex if their partner insists on having it "raw."

Increased Respect for PSPs and NTCDs in their Communities

The PSPs and NTCDs have also earned respect in their communities and with religious leaders. For example, some of the young people are referred to as "*doctor ketewa,*" meaning, "junior doctor" and they are approached by youth seeking SRH information and contraceptives. PSPs and NTCDs have been invited to various programs to give presentations on SRH, including to church groups. Some parents have invited them to talk to their children on SRH issues.

Increased Client Volume for NTCDs

Most of the NTCDs indicated that their involvement in the outreach program has made a positive impact on their business, as most people who come to have their haircut now also buy condoms. Furthermore, a client volume increase was seen because many young people would have a haircut in order to buy condoms. The increase in client volume and the commission they receive on the sale of condoms have increased their overall income.

A few NTCDs indicated that their participation in the program had some negative effects on business because it conflicted with their main activities to generate income. They noted that sometimes they had to close their shops when they needed to attend or organize youth programs.

Implementation Results

The in-depth interviews also identified the barriers and enabling factors of outreach implementation, as well as factors that motivated or disengaged youth from serving as PSPs or NTCDs. These are described in the following section.

Barriers to Outreach Service Provision

The PSPs and NTCDs had a number of hurdles to overcome during the implementation of the program. Because of the sensitive nature of SRH issues in the communities, opposition came from several segments of society, including young people, community leaders, parents, and other family members. The myths about condom promotion among young people and deep-rooted socio-cultural norms made it more difficult for people to discuss issues about sex openly. The PSPs and NTCDs were sometimes taunted and teased by their peers and would be referred to as "AIDS people," "condom people," "madam condom," "Michael condom," etc. In some communities, areas were declared as "no go areas" for the PSPs and NTCDs because these areas were predominantly inhabited by residents who were strongly opposed to their activities. These people contended that their activities would promote promiscuity among the youth. Some females were teased more frequently than their male counterparts or received suggestions that they, themselves, were promiscuous. These situations sometimes affected the morale of the PSPs and NTCDs, but their supervisors and some of the elderly residents who supported their activities provided them with additional encouragement to promote their persistence.

Inadequate supply of BCC materials, delays in payment of transportation allowances to the PSPs, the inaccessible nature of some of the communities, and shortage of condoms were some of the challenges that worked against the smooth operation of the activities of the PSPs and NTCDs. Additionally, migration of some PSPs and NTCDs who went on to pursue studies or seek employment was another barrier to the program.

Enabling Factors of Outreach Service Provision

Other factors in the communities worked in favor of the activities of the PSPs and NTCDs. These factors include the cooperation of some elders and religious leaders, support of some parents and family members, and the support of field supervisors. In some of the AYA communities, PPAG, through the Policy and Advocacy Project, established the Traditional Advocacy Network and the Policy Advocacy Network. These are advocacy groups of community leaders such as chiefs, queen mothers, teachers, religious leaders, assembly members and unit committee members who advocate for ASRH activities in their communities. In communities where these networks have been established, the assessment found that it strengthened implementation of outreach activities. It is recommended that the establishment of advocacy groups be integrated into future programs since it is a good way of changing the socio-cultural norms inherent in the communities.

All the PSPs and NTCDs interviewed indicated that the support they received from the field supervisors facilitated their work. The support was in the form of encouragement to continue working in the face of provocation, technical support, meeting organization, and participation in PSP and NTCD meetings. Some of the field supervisors also had discussions with some of the PSPs and NTCDs who had problems with their parents about their involvement in the program.

Motivating Factors for Serving as Peer Providers

The PSPs and NTCDs were motivated to offer their services for the outreach program for various reasons, but the underlying factor was the desire to help the young people in the communities understand SRH issues and to enable them to make informed decisions about their health. PSPs and NTCDs explain their willingness to work voluntarily despite many difficulties with an Akan proverb, which translates as *"Good name is better than riches."*

Reasons for Drop Out

The drop out rates among the PSPs (31%) and NTCDs (34%) were low compared with other peer provision programs. Some of the reasons given by those who left the program include lack of motivation and loss of interest. The majority of those who resigned did so to continue their education or to transfer to another community outside the intervention sites. PSPs tended to leave the program for these reasons more than NTCDs. For the NTCDs, some of the reasons for leaving the program included conflict with their work and difficulty in writing reports. Some of the PSPs and NTCDs also reported that they either could not cope with the teasing by their peers or thought that they would be paid salaries but later understood that the work was voluntary. One female gave birth and was compelled to leave the program, another died, and a few others left because they had exceeded the upper age limit of 24 years.

Trend Analysis

Evaluation Methodology

Outreach service statistics were analyzed, as were project proposals, partner quarterly reports, workshop reports, field-monitoring reports, supervisors' notes, and studies and assessments conducted throughout the life cycle of the project. Information gathered through these additional sources provided supplementary information for analysis.

Data Limitations

While PPAG did report on numbers of condoms distributed by you, it did not report on youth reached through NTCDs. Therefore, the data analyzed for youth reached through the outreach does not include the performance of NTCDs by PPAG. PPAG also utilized its own data collection forms from 2001 to 2003, which did not disaggregate data by the AYA age categories.

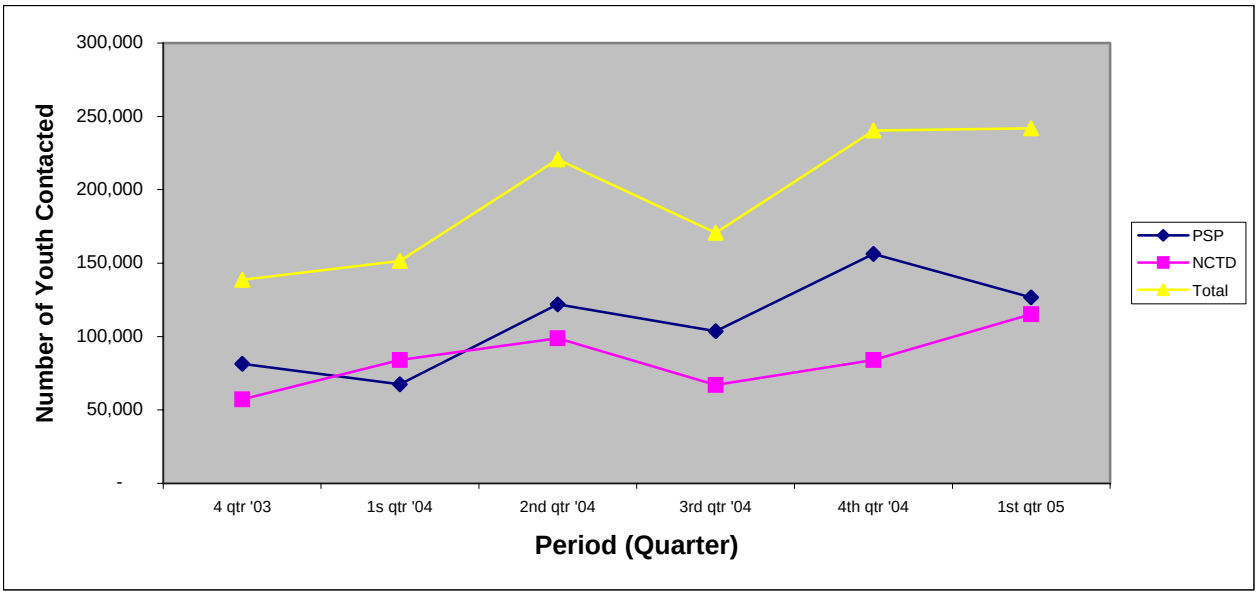
Results

Youth Reached

A total of 1,150,915 youth contacts were made through outreach, including 68,187 by PPAG PSPs. However, when the data is limited to the fourth quarter of 2003 through first quarter of 2005, a total of 1,082,728 youth contacts were made by CHAG and NYC PSPs and NTCDs (data for this analysis is limited to CHAG and NYC because PPAG did not report on NTCD reached). Figure 14 presents information on youth contacts made during this period.

The PSP share of youth contacts was 60%, an indication that PSPs were more effective than NTCDs in reaching large numbers of young people with information. The data trends were similar for PSPs and NTCDs. Youth contacts made by the two types of outreach workers increased in the fourth quarter of 2003, declined slightly in the first quarter of 2004, but increased again in the second quarter of 2004. Youth contacts dipped again in the third quarter, increased in the fourth quarter, but then decreased again. There does not seem to be a specific trend in the number of youth contacts made by either the NTCDs or PSPs. Every other quarter, youth contacts increased and declined.

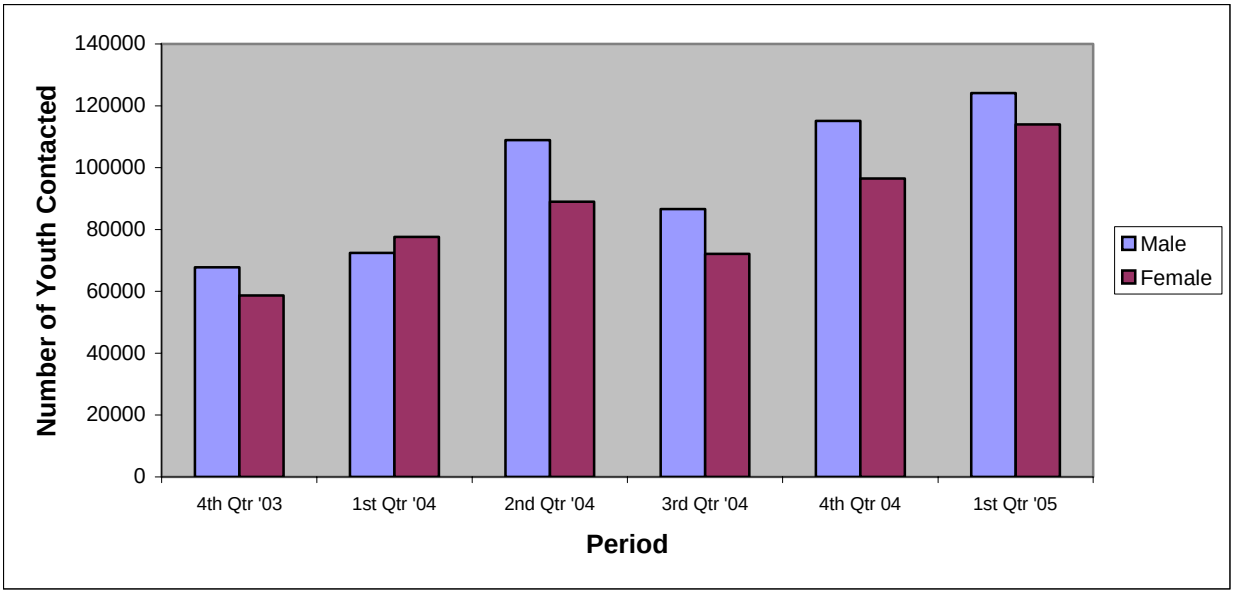
Figure 14: Youth Contacts by Type of Outreach Provider and Quarter



Unlike the static facilities, more males (56%) than females (44%) were reached by the PSPs and NTCDs. This trend is likely due to the fact that males typically favor outreach services over facility services, as facility services have traditionally been offered and perceived to be for females. In addition, NYC's Challenge Cup project reached youth, particularly males, through soccer matches.

Figure 15 shows a steady increase in both males and females reached from one quarter to the next, except in the third quarter when there was a decline. The number of males and the number of females reached both increased from the fourth quarter of 2003 to the second quarter 2004, declined in the third quarter of 2004, and increased again during the last two quarters.

Figure 15: Youth Contacts by PSPs and NTCDs by Sex



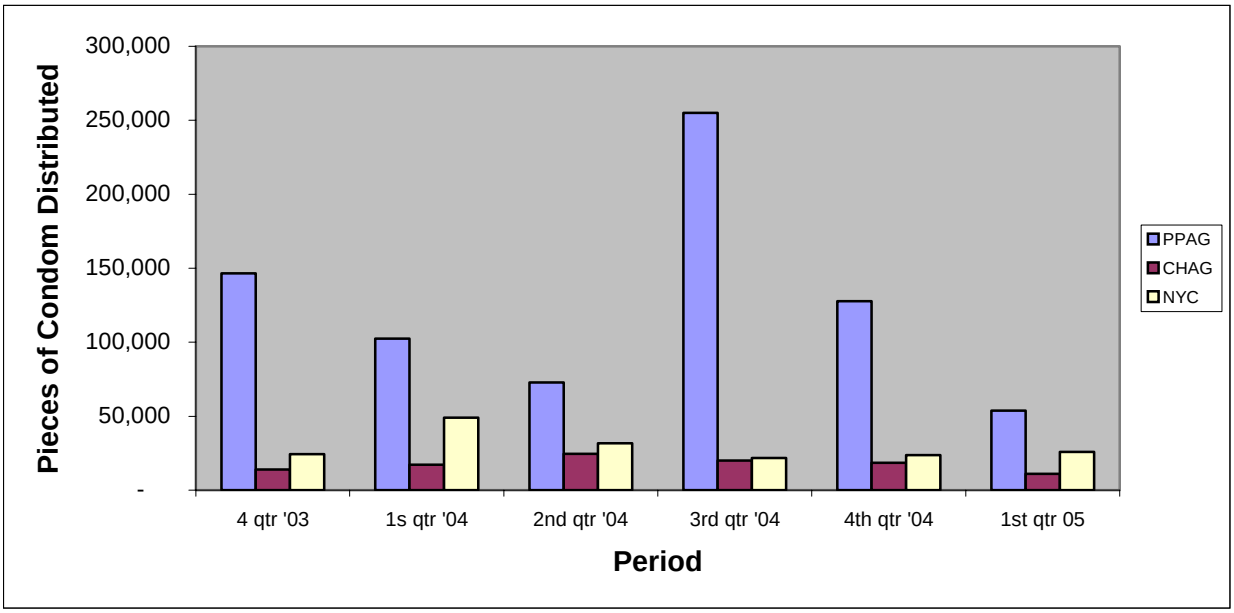
Partner share

NYC reached out to more young people (64%) than CHAG; this may be attributed to the community mobilization skills of NYC and also the fact that CHAG is more focused on health facilities and tried the peer outreach activities for the first time with this project.

Condoms distributed

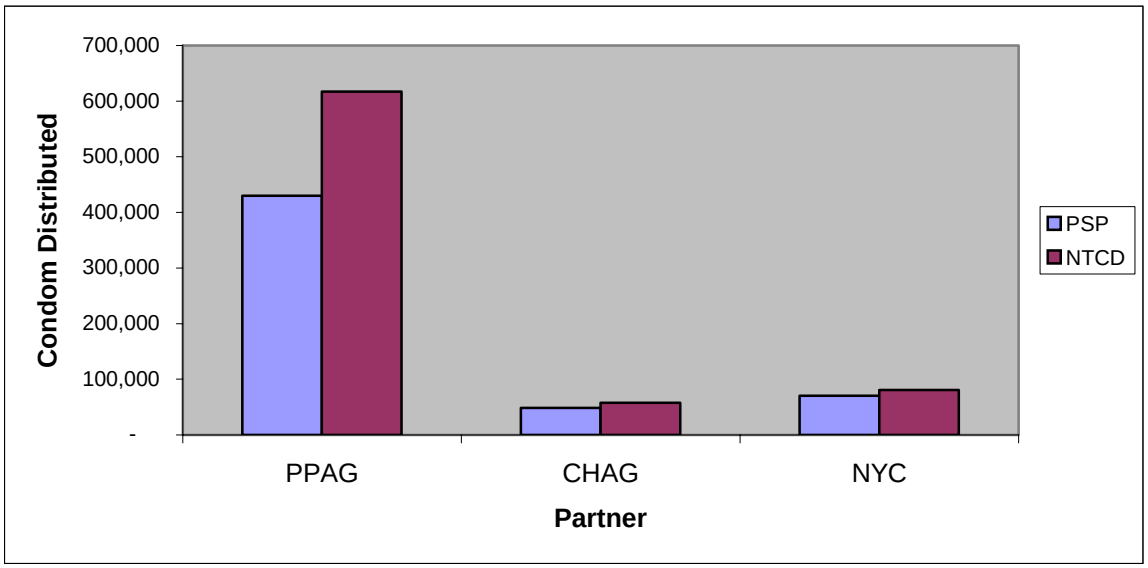
Since 2001, CHAG, NYC, and PPAG distributed a total of 1,303,808 condoms. However, if the period is limited to the fourth quarter of 2003 and first quarter of 2005 (figure 16a) when all the partners reported, a total of 1,041,155 condoms were distributed. Of the 1,041,155 condoms distributed, PPAG accounted for 73%, NYC 17%, and CHAG 10%. The larger contribution of PPAG could be attributed to their experience and long-time involvement in outreach, whereas NYC and CHAG implemented this strategy for the first time.

Figure 16a: Condoms Distributed by Partner and Quarter



The NTCDs distributed more condoms than the PSPs during the project. Of the total of 1,303,808 condoms distributed, the share of the NTCD distribution was about 58%, while PSPs distributed 42%. The trend prevails in all the partners that used both PSPs and NTCDs. The use of NTCDs is a promising practice for reaching youth with condoms and should be replicated within and outside Ghana to measure its efficacy in other settings.

Figure 16b: Condoms Distributed by Partner and PSPs and NTCDs



CONCLUSIONS AND RECOMMENDATIONS

The program achieved significant successes, despite initial delays in program implementation. It successfully assessed 88% of the targeted intervention facilities at baseline and developed action plans for 91% of assessed facilities. YFS have been established in all the intervention facilities as reflected in the findings of the endline assessments and monitoring data.

CHAG, and to some extent PPAG, made significant improvements in their facilities. Client satisfaction of services increased, as confirmed by mystery client studies, facility reassessments, and field monitoring visits. Other facility improvements observed in the facility environment included expanded hours of operation, staff preparedness, and positive attitudes of service providers. There were also improvements in privacy in all CHAG and PPAG facilities, though there were occasional reported cases where facility staff came in and out of consulting rooms when consultations with young clients were in progress. Other improvements are needed, including attention to the cost of services and attitudes of select service providers.

GHS has begun work to make services youth-friendly and has great potential to reach a large number of youth. Though many improvements in service quality have been made, there is still a need to continue this work beyond the end of AYA/Pathfinder's program.

Youth reached with services by both the static and outreach strategies increased over the period and exceeded the target of 990,000 by 16%. About 1,303,808 male condoms were distributed, and increases were recorded for all other services. Improved data collection and reporting, and improvement in the attractiveness of the facilities to young people, are believed to have accounted for at least part of the increased number of young people reached with information and services.

The creation of a platform for young people to be actively involved in the planning and management of the project was also crucial to ensuring its success. The project provided an opportunity for the youth, through the use of project management committees and youth advisory boards, to bring their input to bear on the smooth implementation of the project. They were also involved in the mystery client studies, facility assessments and reassessments, and the outreach assessment. Their involvement helped improved the quality of project implementation. For example, their suggestion concerning the extension of the clinic operating hours to cover evenings and weekends has proved extremely useful.

The use of PSPs and NTCDs proved to be an appropriate and effective means of distributing contraceptives to young people in these communities. The presence of the PSPs and NTCDs provided youth with easy access to affordable contraceptives, particularly condoms. Previously, young people who needed these services had to deal with unfriendly service providers or travel long distances for these services. However, experience from the project has shown that to sustain the enthusiasm and commitment of PSPs and NTCDs, it is critical to provide allowances promptly and ensure a sufficient supply of BCC materials and condoms.

Through the outreach activities, awareness has been created about youth SRH issues in the intervention communities. This created a positive impact on people's perceptions and has broken through the myths surrounding SRH issues, particularly condom use among youth. The involvement of community and church leaders and the establishment of the Traditional Advocacy Network and the Policy Advocacy Network facilitated project implementation.

The YFS program in Ghana made two major breakthroughs of great significance. These are the successful integration of SRH into the pre-service curricula for nurses and midwives (in collaboration with the Nurses and Midwives' Council for Ghana) and into the health delivery systems of faith-based organizations (in collaboration with CHAG). In addition to the partnership with GHS, the AYA/Pathfinder work has widened the coverage of services to a larger population of young people throughout Ghana.

There were many successes in the implementation of the YFS component in Ghana even though some difficulties were encountered, including:

- The groundwork necessary for the development of the overall YFS strategy and the collaborative relationships took longer than anticipated so that actual implementation took place over three of the project's five years.
- There were delays in the development and acceptance of a standard reporting format, resulting in data collected during the initial quarters of the program not conforming to eventual data requirements.
- Supplies of certain materials at the health facilities and for outreach activities were sometimes unavailable.
- The socio-cultural norms in the communities are strong and sometimes worked against SRH education activities for young people. Some of the challenges encountered by the peer service providers, NTCDs, and their supervisors discouraged some prospective PSPs and NTCDs from participating in the program.
- Logistical bottlenecks, such as delays in allowance payments to PSPs and NTCDs and intermittent shortage of condoms at times affected program implementation.
- High staff turnover of some partners affected implementation of the program.
- Heavy bureaucracy at GHS caused delays in the transferring of funds from the project office to the GHS head office and on to the regional and district offices, leading to drop outs.

Some of the lessons learned from the program implementation include the following:

- Programs are better integrated and sustained if processes are clearly outlined to obtain leadership commitment (e.g., the partnerships between AYA and CHAG and NMCG).
- Exploring alternative channels such as informal places where the youth congregate to provide SRH information, referrals, and condoms, increases access. Using channels such as NTCDs increases program reach and sustainability.
- The active involvement of youth in advocacy, implementation, management, and monitoring and evaluation ensures opportunities for young people to make meaningful contributions to various phases of the project cycle.
- Integrating YFS into pre-service education for health care providers reduces the need for in-service training and helps ensure that providers are better able to reach out to young

people. By institutionalizing YFS, there is greater acknowledgement of youth issues and greater acceptance of the need to provide SRH services to young people.

In view of the challenges that confronted the implementation of the project, the following recommendations are made to help guide future programs:

- All program indicators should be clearly defined and outlined in the early stages of program implementation.
- Bottlenecks should be identified and addressed early on to reduce the drag on program implementation and to ensure that projects make maximum use of the entire duration of the project to ensure optimum benefit.
- In view of the potential for GHS's impact on SRH programs for young people, all efforts should be made to address the barriers to implementation of YFS by the public sector. It would be helpful if funds could be given directly to the districts in the future.
- Given the successful collaboration with CHAG, the association should be encouraged to expand YFS to more facilities.
- Inclusion of outreach as a part of YFS increases program reach and should be carefully factored into future programs. Furthermore, the NTCD strategy was effective and should be replicated in other reproductive health programs.
- Efforts should be made to address the recruitment problems of NTCDs, to reduce the drop out rate, and also to ensure that the full potential of the strategy in distributing condoms is realized.
- The Challenge Cup project concept is innovative and has the potential of reaching out to many young people with information and services and should be sustained.

Given the positive results that AYA/Pathfinder achieved in Ghana in increasing access of youth to SRH information and services, it is hoped that efforts will continue beyond the project. In particular it is hoped that support will continue for GHS in the implementation of its action plans, YFS will expand into more CHAG facilities, and YFS will be sustained where it has already been established. Facility staff and managers have all shown commitment to sustaining the program. Facility management contributed towards the construction of the youth centers and promised to continue supporting youth-friendly activities with internally generated funds. In some cases, district assemblies committed funds to the program. It is recommended that all district assemblies should be encouraged to contribute financially to support future activities.

Appendix A: AYA Region Selection Tables

AYA Priority Indicators

Regions	HIV/ AIDS[15]	Prostitution[16]	Pregnancy[17]	HTP	Age of sexual onset/ Ever had sex[18]	Unsafe Abortion[19]	Condom Use[20]	CPR[21]	Sexual Violence/ Coercing	Rating
Greater Accra	(1.9) 6	(771) 10	(2.9) 1	5	(41.1) 4	(11.2) 5	(18.9) 6	(22.4) 5	9	41
Western	(3.1) 8	(290) 8	(9.3) 3	4	(39.6) 7	(12.8) 7	(20.5) 4	(25) 2	8	43
Central	(0.1) 2	(-) 1	(18.7) 10	2	(42.1) 5	(1.7) 2	(8.5) 8	(11.2) 8	7	44
Ashanti	(1) 4	(383) 9	(17.8) 8	3	(33.6) 9	(12) 6	(5.6) 9	(10) 10	6	55
Eastern	(9) 10	(33) 2	(17.9) 9	1	(39.9) 6	(20.4) 9	(21.8) 2	(23.4) 4	4	45
Volta	(4.7) 9	(46) 4	(9.5) 4	7	(48.4) 1	(13) 8	(30.7) 1	(34.8) 1	10	41
BA	(0.7) 3	(83) 7	(13.8) 7	6	(43.6) 2	(22) 10	(21.3) 3	(23.5) 3	5	39
Northern	(0.1) 2	(81) 6	(10.4) 6	8	(34.3) 8	(0.6) 1	(3.2) 10	(10.6) 9	1	45
Upper West	(2.6) 7	(38) 3	(10.4) 6	9	(22.4) 10	(2.5) 3	(17.8) 7	(17.8) 7	2	51
Upper East	(1.4) 5	(50) 5	(5.4) 2	10	(41.1) 4	(3.8) 4	(19.7) 5	(20.7) 6	3	39

Other Criteria for the Selection of Regions

Regions	AYA Outcomes (x 5)	Ease of Working (access/cost) (x 2)	Potential for community collaboration (x 3)	Potential for Quick Results/Impacts (high awareness) (x 4)	Donor operational activities (not donor HQ/ proxy for political priorities) (x 1)	Rating
Greater Accra	41 (205)	10 (20)	5 (15)	9 (36)	4 (4)	280 (4)
Western	43 (215)	1 (2)	3 (9)	2 (8)	2 (2)	236 (10)
Central	44 (220)	9 (18)	2 (6)	6 (24)	3 (3)	271 (5)
Ashanti	55 (275)	8 (16)	10 (30)	10 (40)	7 (7)	368 (1)
Eastern	45 (225)	4 (8)	9 (27)	5 (20)	5 (5)	285 (3)
Volta	41 (205)	5 (10)	7 (21)	8 (32)	1 (1)	269 (6)
BA	39 (195)	7 (14)	4 (12)	7 (28)	6 (6)	255 (7)
Northern	45 (225)	2 (4)	1 (3)	1 (4)	8 (8)	244 (9)
Upper West	51 (255)	3 (6)	8 (24)	3 (12)	9 (9)	306 (2)
Upper East	39 (195)	6 (12)	6 (18)	4 (16)	10 (10)	251(8)

[15] Briefing Book, Arkutu (15 – 19)
[16] Organization of Female Prostitution in Ghana, SIDA/AIDS, Feb 2000 (Home based sex workers as well as street/bar/hotel)
[17] DHS, 1998 (15 – 19)
[18] Ghana Youth RH Survey Report – JHU (12 – 24)
[19] Ghana Youth RH Survey Report – JHU (12 – 24)
[20] Ghana Youth RH Survey Report – JHU (12 – 24)
[21] Ghana Youth RH Survey Report – JHU (12 – 24)

Appendix B: 65 YFS Implementing Facilities (By Region, District, and Partner)

Region	Districts	Partner	Facilities
Greater Accra	Accra Metropolitan Assembly	GHS	1. La Polyclinic 2. Achimota Hospital 3. Mamprobi Polyclinic 4. Kaneshie Polyclinic 5. Ussher Fort Clinic
		CHAG	1. Maamobi Salvation Army
		PPAG	1. Laterbiokorshie Young and Wise Center
	Ga District Assembly	GHS	1. Amasaman HC 2. Madina HC 3. Weija HC
		CHAG	1. Alpha Medical Centre
	Tema Municipal	GHS	1. Tema Polyclinic 2. Ashaiman HC 3. Tema General Hospital
	Dangme East	GHS	1. Ada HC 2. Kasseh HC
	Dangbe West	GHS	1. Dodowa HC 2. Asutuare HC
Ashanti	Kumasi Metro	GHS	1. Manhyia Hospital 2. Suntreso Hospital 3. Maternal and Child Health Hospital 4. Kumasi South Hospital
		CHAG	1. Bomso Church of Christ Clinic
		PPAG	1. Suame PPAG Clinic
	Afigya Sekyere	GHS	1. Agona Hospital 2. Jamasi HC
		CHAG	1. Wiamoase Salvation Army 2. SDA Hospital
	Bosomtwe-Atwima-Kwanwoma (BAK)	GHS	1. Kuntanase Government Hospital 2. Foase HC
		CHAG	1. Amakom Lake Bosomtwe Methodist Clinic

HC = Health Centre, RCH = Reprocare Health, SDA = Seventh Day Adventist

Region	Districts	Partner	Facilities
	Atwima	GHS	1. Nkawie-Toase Hospital 2. Nyinahin Hospital 3. Abuakwa HC
		CHAG	1. Kwadaso SDA Church
	Ejisu-Juabeng	GHS	1. Ejisu HC 2. Juabeng Hospital
		CHAG	1. Onwe SDA Hospital
Upper West	Wa	GHS	1. Wa Hospital 2. Ponyentanga HC
	Nadowli	GHS	1. Daffiama HC 2. Nadowli HC
Central	Gomoa	GHS	1. Apam RCH Centre 2. Gomoa Oguaa HC 3. Obuasi Community Clinic
	Assin	GHS	1. Fanti Nyankumasi HC 2. Assin Foso RCH Centre 3. Bereku HC
		CHAG	1. Assin Praso Presbyterian Clinic 2. Assin Nsuta Presbyterian Clinic
	Cape Coast	GHS	1. Ewim Urban Health Centre 2. Cape Coast District Hospital
		PPAG	1. Cape Coast Youth Center
	KEEA	GHS	1. Elimina Urban HC 2. Abrem Agona HC
	Awutu-Efutu-Senya	GHS	1. Kasoa HC 2. Bawjiase HC 3. Winneba Hospital
Eastern	Akwapin North	GHS	1. Tetteh Quarshie Memorial Hospital 2. Mampong RCH Centre
		PPAG	1. Abriw Youth Center
	East Akim	GHS	1. Kibi Government Hospital 2. Anyinam HC
	Kwahu South	GHS	1. Atibie HC 2. Kwahu Government Hospital

HC = Health Centre, RCH = Reprocare Health, SDA = Seventh Day Adventist

Appendix C: CHECKLIST FOR MYSTERY CLIENT (PPAG & CHAG 2004)

QUESTIONS	Response	REMARKS
A. LOCATION AND ENVIRONMENT		
Did you find the facility easily?	Yes No	
Were there any directional signs outside the facility?	Yes No	
Were there any directional signs within the facility?	Yes No	
How did you find the welcoming?	Friendly Not friendly	
Was the outside of the facility clean?	Very clean Somewhat clean Unclean	
Was the inside of the facility clean?	Very clean Somewhat clean Unclean	
Was there a separate waiting room for adolescents?	Yes No	
Are there posters on STIs and other SRH issues in the facility?	Yes No	
Did you find any poster stating the rights of the client?	Yes No	
How many adolescents did you find waiting to see the provider at the facility?	Number: ……..	
How long did you have to wait before being attended to?	…… ……	…… …… ……
How did you feel about the waiting time?	Just OK Too long	
B. INSTRUCTION/EDUCATION		
How many providers attended to you during the service delivery process?	Number:……..	
How would you adjudge the attitude of each provider?	Security	a. friendly b. not friendly
	Registration	a. friendly b. not friendly
	History	a. friendly b. not friendly
	Consultation/ examination	a. friendly b. not friendly
	Laboratory	a. friendly b. not friendly
	Dispensary	a. friendly b. not friendly
Was your medical history taken?	Yes No	
Was your social record taken?	Yes No	
Was your sexual history taken?	Yes No	
Were you assured of confidentiality?	Yes No	

QUESTIONS	Response	REMARKS
Were you counseled in a place where visual privacy was guaranteed?	Yes No	
Were you counseled in a place where auditory privacy was guaranteed/	Yes No	
Were you counseled on any contraceptive methods	Yes No	
Did the provider physically examine you?	Yes No	
Were you examined in a place where visual privacy was guaranteed	Yes No	
Did the provider give you any treatment?	Yes No	
Did he/she give you instructions on how to use the treatment?	Yes No	
Did you feel the provider had adequate time for you during consultation?	Yes No	
Did the provider talk about HIV/AIDS with you?	Yes No	
If yes, what did he/she say?		
If you reported an STI case did the provider ask you to bring your partner for treatment?	Yes No	
Did the provider give you an opportunity to ask questions?	Yes No	
Were you given any educational materials to read?	Yes No	
Did you pay for the service you received?	Yes No	
What did you think about the cost?	Expensive Affordable Cheap	
How much time did you spend with each provider?	Registration	
	History	
	1st Consultation	
	Laboratory	
	2nd Consultation	
	Injection	
	Dispensary	
In general, how did you find the counseling?	Satisfactory Not Satisfactory	
Did the provider ask you to return?	Yes No	
If yes, did he/she give you a specific date to return?	Yes No	
Will you recommend this facility to any of your colleague youth?	Yes No	
If no, what are your reasons?		

Appendix D: Mystery Client Visits and Scenarios Presented

CHAG 2004 Mystery Client Visits

Region	**Facility**	**Visits/ Scenarios Presented**
Greater Accra	Alpha Medical Center	2 – ECP, STI
	Urban Aid Salvation Army Clinic	2 – Pregnancy test, Contraception
Central	Assin Praso Presbyterian Health Center	2 – STI, STI
	Assin Nsuta Presbyterian Clinic	2 – STI, Contraception
Ashanti	Wiamoase Salvation Army Clinic	3 – Contraception, ECP, STI
	Assamang SDA Hospital	3 – STI, Pregnancy test, ECP
	Bomso Church of Christ Clinic	3 – ECP, STI, STI
	Amakom Methodist Clinic	3 – STI, Contraception, STI
	Onwe	3 – STI, Contraception, Contraception
	Kwadaso SDA Hospital	3 – VCT, Contraception, STI

PPAG Mystery Client Visits

Region	**Facility**	**Visits/ Scenarios Presented**
Greater Accra	Young and Wise Centre	5 – ECP, Pregnancy test, STI, ECP, ECP
Ashanti	Suame Clinic	3 – STI, ECP, ECP
Eastern	Abiriw Young and Wise Centre	3 – Pregnancy test, STI, VCT
Central	Cape Coast Clinic	3 – ECP, VCT, STI

CHAG 2005 Mystery Client Visits

Region	**Facility**	**Visits/Scenarios Presented**
Greater Accra	Alpha Medical Center	2 – VCT, Pregnancy test
	Urban Aid Salvation Army Clinic	2 – VCT, Pregnancy test
Central	Assin Praso Presbyterian Health Center	2 – STI, ECP
	Assin Nsuta Presbyterian Clinic	2 – ECP, STI
Ashanti	Wiamoase Salvation Army Clinic	2 – ECP, STI
	Assamang SDA Hospital	2 – STI, ECP
	Bomso Church of Christ Clinic	2 – VCT, Contraception
	Amakom Methodist Clinic	2 – STI, ECP
	Onwe	2 – ECP, STI
	Kwadaso SDA Hospital	2 – Contraception, VCT

Appendix E: Mystery Client Scenarios

Pregnancy test: A female adolescent has had unprotected sex with her boyfriend. She was to have had her menses a week prior to her visit to the clinic but missed it. The adolescent goes to the provider to help her determine whether or not she is pregnant.

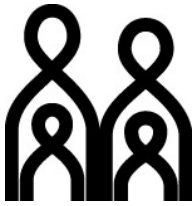
ECP for male: A male adolescent had unprotected sex with his partner the previous night. The partner fears she may get pregnant as she is in her dangerous time. She is also afraid to go to the health provider for help. Her partner decides to go to the provider on her behalf to request ECP.

ECP for female: A female adolescent has had unprotected sex with her boyfriend. She was to have had her menses a week prior to her visit to the clinics but missed it. The adolescent goes to the provider to help her determine whether or not she is pregnant.

STI: An adolescent had unprotected sex a week ago. Now the adolescent is experiencing some itching/burning sensations/pain around an in the genital. The adolescent is feeling uncomfortable and the situation is getting worse with each day. The adolescent is also feeling shy to tell his/her parents. He/she told a friend who advised him to seek treatment at the health facility. He goes to the provider for help.

Contraception: An adolescent wants to know more about ways to prevent pregnancy and if possible protection against STIs as his/her girl/boyfriend has been demanding sex of late but he/she does not want to have unprotected sex with his/her partner.

VCT: An adolescent wants to know his/her HIV status. He/she walks to a health facility to get in-depth information about he processes and procedures he/she has to go through.



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