Youth-Friendly Services
End of Program Evaluation Report

African Youth Alliance (AYA)

November 2005
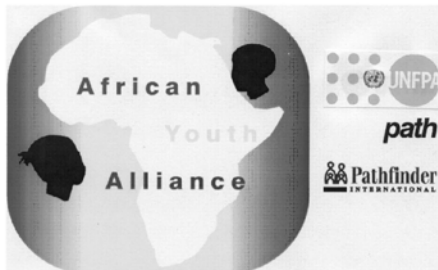
Table of Contents:

List of Acronyms

AYA	**African Youth Alliance**
ASRH	**Adolescent Sexual and Reproductive Health**
BCC	**Behavior Change Communication**
CRHW	**Community Reproductive Health Worker**
CSW	**Commercial Sex Worker**
DISH	**Delivery of Improved Services for Health**
FLEP	**Family Life Education Project**
HC	**Health Center**
HIV/AIDS	**Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome**
KAYA	**Kampala Youth in Action**
KCC	**Kampala City Council**
NGO	**Non-Governmental Organization**
PATH	**Program for Appropriate Technology**
QOC	**Quality of Care**
SRH	**Sexual and Reproductive Health**
SRD	**South Rwenzori Diocese**
STI	**Sexually Transmitted Infection**
UNFPA	**United Nations Population Fund**
UYDEL	**Uganda Youth Development Link**
VCT	**Voluntary Counseling and Testing**
YFS	**Youth-Friendly Services**

EXECUTIVE SUMMARY

The African Youth Alliance (AYA) was launched in the fall of 2000 by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Population Fund (UNFPA). Since its inception, AYA's objective has been 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. Each of the three founding AYA partners brought their own unique expertise to the five-year project. Pathfinder International's contribution in each of the AYA countries was the development and expansion of Youth-Friendly Services (YFS) and institutional capacity building.

This report highlights the results of the YFS work that was implemented by partners[1] in 13 districts in Uganda including: Kasese, Kabarole, Kyenjojo, Kabale, Kapchorwa, Mbale, Soroti, Kaberamaido, Sironko, Iganga and Mayuge. 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 for future scaling-up
- Instituting a minimum package of youth-friendly Sexual and Reproductive Health services (SRH), 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)

Specifically, the AYA/Pathfinder strategy for institutionalizing 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

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[1] The partners included 14 NGOs and districts throughout the country. The NGO partners and the districts they served included: Kampala City Council (Kampala), UYDEL (Kampala), Busoga Diocese (Iganga and Mayuge), South Rwenzori Diocese (Kasese). The district partners included: Mbale, Soroti, Kaberamaido, Kabale, Kabarole, Kamwenge, Kyenjojo, Kapchorwa, and Sironko. An additional partner, Makerere Medical School, was chosen for the pre-service training work done under this project.

- 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 the development of standards and guidelines, YFS tools, and YFS curricula for in-service and pre-service training

AYA/Pathfinder achieved the following results (organized by static facility and outreach results):

Static Facility Results

Facility Reassessment: Reassessments were carried out at the end of the project in selected facilities that showed improvement in the five elements of youth friendliness assessed in the facilities: privacy ensured, competent staff, minimum package of services, peer providers/counselors available, and publicity for YFS. The greatest improvement was seen in the availability of peer providers and counselors, followed by the availability of a trained service provider in the facility to serve young people.

Analysis of Training Data: 202 service providers were trained and all showed increased scores from pre- to post-tests. The comparison of pre- and post-tests from 10 trainings showed an average gain in scores ranging from 9 to 30, with an average gain of 20 points for all.

Analysis of Client Satisfaction Data: Mystery client data were analyzed from three of the five districts that conducted visits. The clients that visited the clinics reported being satisfied with the services provided. They noted that the waiting time was reasonable and privacy was observed. The service providers were youth friendly and demonstrated good communication skills, and overall the services were rated as affordable. The use of Behavior Change Communication (BCC) materials was limited in these cases, but was likely due to shortages of supplies. Overall satisfaction with the services received from the clinics was well demonstrated by the client feeling confident to recommend the service provider to a friend.

Trend analysis: From January 2003 to December 2004, 195,591 clinic visits by youth were recorded. More visits were made by youth 20-24 years of age than other age groups and females made more visits than males. Females 20-24 years made the most visits, followed by females 15-19, males 20-24, and males 15-19. Youth sought counseling more than other available services (family planning services, STI testing and treatment, and pregnancy-related services). Despite increases in the youth-friendliness of clinics, trend analysis shows an overall decrease in visits to the facilities over the project period.[2]

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[2] It should be noted that because reporting was collected by partner (as opposed to by facility), and not all facilities reported each quarter, the numbers of facilities reporting by quarter may not be consistent. Therefore, the number of visits may not have gone down, but rather this could be a reflection of a decrease in the number of facilities reporting.

Findings also revealed that new visits to facilities exceeded revisits and condoms were the most preferred contraceptive method for clinic youth.

Outreach Results

Analysis of Training Data: The national trainers trained over 647 peer providers. The information introduced increased scores from pre- to post-test. In a review of 14 training workshop results, the average marks gained from pre- to post-test for each workshop ranged from 11 to 43, giving an average gain of 23.6 for all the trainings.

Analysis of Client Satisfaction Data: Mystery client visits with peer providers in four districts were analyzed to gauge client satisfaction with peer provider services. There was overall satisfaction with the friendliness and communication skills of the peer providers. The peer providers served the youth well, by distributing supplies, making referrals, and keeping records. Overall satisfaction of the services received from the peer providers was well demonstrated by the client feeling confident to recommend the provider to a friend.

Trend Analysis: Between January 2003 and December 2004, records reflect 580,771 outreach visits made by youth. More visits were made by youth 20-24 years of age than other age groups and more by males than females. Males 20-24 made the most visits, followed by females 20-24 years, females 15-19 years, and males 15-19 years. Male condoms were the most sought after contraceptive from the peer providers.

Analysis of Monitoring Data: Analysis of monitoring reports found that peer providers faced a number of challenges in their work. Challenges included the use of in-school youth who lived and went to school in different districts, lack of transportation to cover the long distances of their coverage areas, and shortages of male condoms.

Overall, the AYA/Pathfinder program was found to be successful. However, future efforts such as these could be strengthened by the following recommendations: future programs should allocate more staff time and funding for supervision, document program processes more effectively, build evaluation processes into the program at the beginning, and include efforts to improve contraceptive supply.

INTRODUCTION

The African Youth Alliance (AYA) was launched in the fall of 2000 by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Population Fund (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 for the project were young people between the ages of 10 and 24. The secondary targets included teachers, health workers, social workers, and parents. In addition, the tertiary target group included religious leaders, media workers, politicians, and policy makers. The latter group was crucial for creating an enabling 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 behavior change communication 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: The improvement of young people's access to – and the quality of – reproductive health services by developing, expanding, and institutionalizing youth-friendly services 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 services and to make them youth-friendly. Youth-friendly services are those 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 youth-friendly services. 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:
  o Information and counseling on sexuality, safe sex, and reproductive health
  o Contraceptive method provision (with an emphasis on dual protection)
  o STI diagnosis and management
  o HIV counseling (and referral for testing and care)
  o Pregnancy testing and antenatal and postnatal care
  o Counseling on sexual violence and abuse (and referral for needed services)
  o 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: Uganda's YFS Conceptual Framework
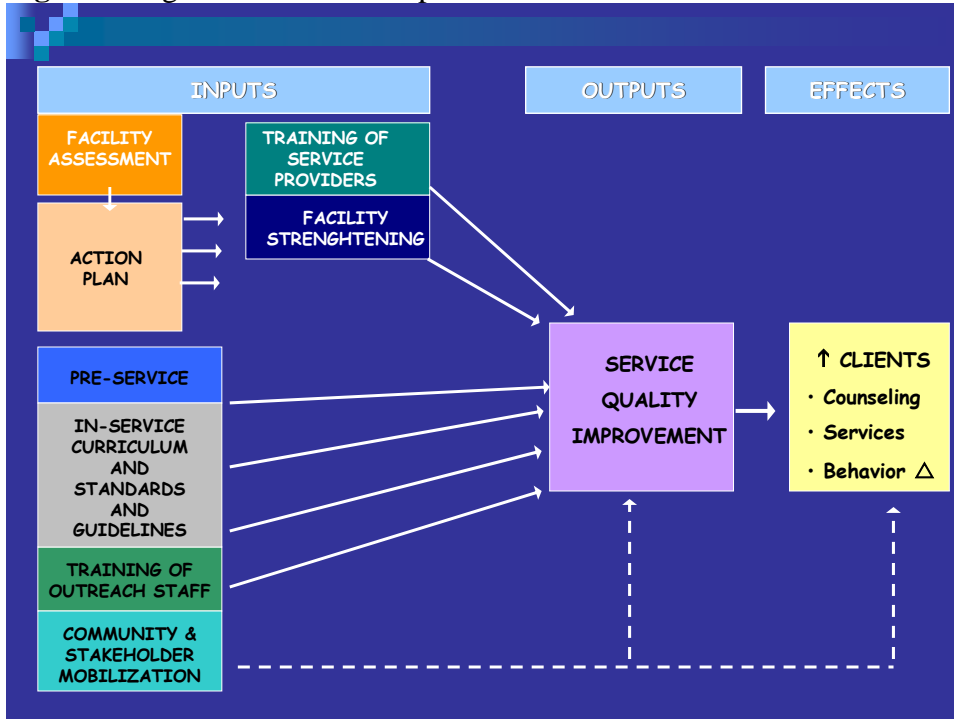
As shown above, the AYA/Pathfinder strategy for institutionalizing youth-friendly SRH services included the following:
- Facility assessments
- Development and implementation of action plans for quality improvements based on the results of the facility assessments
- Provision of essential technical assistance 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 standards and guidelines, YFS tools, and YFS curricula for in-service and pre-service training

AYA/Pathfinder began its work by presenting the AYA project in one-day workshops at several district headquarters. During these workshops the team (with representation from PATH, UNFPA, and Pathfinder International) discussed the criteria for selecting partners to implement youth-friendly services. Partners were selected that:
- already implemented youth development initiatives/programs

- had national or regional coverage and whose technical capacity could be developed and/or strengthened to undertake or replicate national programs
- had experience in managing donor funded programs
- involved youth in programming
- worked with or were linked to government programs
- showed a desire for sustainability of the program
- showed willingness to implement monitoring and other systems to systematically measure progress and impact

In Uganda, the AYA/Pathfinder work was implemented by 14 partners, including non-governmental organizations (NGOs) and districts throughout the country. The NGO partners and the districts they serve included:

- Kampala City Council (KCC) (Kampala)
- Uganda Youth Development Link (UYDEL) (Kampala)
- Busoga Diocese (Iganga and Mayuge)
- South Rwenzori Diocese (SRD) (Kasese)

The district partners included:

- Mbale
- Soroti
- Kaberamaido
- Kabale
- Kabarole
- Kamwenge
- Kyenjojo
- Kapchorwa
- Sironko

An additional partner, Makerere Medical School, was chosen for the pre-service training work.

This report highlights the results of the YFS work implemented in Uganda. It describes the work implemented by AYA/Pathfinder staff in the country, the process used to evaluate the interventions, and the findings of the evaluation. It also offers recommendations on implementing and evaluating YFS efforts.

OVERALL METHODOLOGY

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

- evaluation planning
- facility reassessments
- analysis of training data
- analysis of client satisfaction data
- trend analysis
- analysis of monitoring data

The diagram below shows the evaluation activities under the static facility and outreach efforts, forming the outline for this report. Each of the activities is described generally in this section and then more specifically as it relates to the facility and outreach evaluations later in the report.

Figure 2: Uganda Evaluation Framework
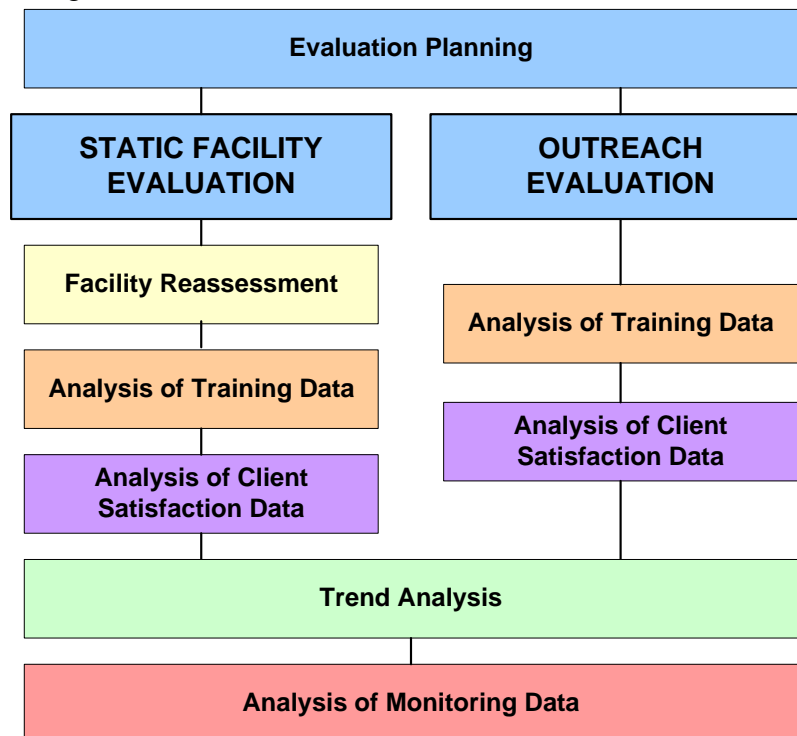
Evaluation Planning: An evaluation strategy meeting was conducted in November 2004 with headquarters and field staff. As part of the design process, Uganda listed its major intervention areas and then weighted these in relation to the level of effort invested (time, human resources, and money).

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Based on this information, staff selected the following key activities to evaluate based on available resources: facility strengthening, training, and client satisfaction.

Facility reassessments: AYA/Pathfinder field staff reassessed a sample of facilities using the facility assessment tool,[3] and applied the certification tool[4] to establish endline results in January 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 primarily for planning purposes. 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 training data: Trainings were evaluated using a combination of pre- and post-test assessments and an end of training evaluation. Pre- and post-test data were analyzed in January 2005. The average scores gained per training were calculated and comparisons were made across the different types of trainings. A review of training evaluation summaries and discussions with national and district trainers provided additional information.

Analysis of client satisfaction data: Youth served as mystery clients in order to gauge client satisfaction with service provision at the clinics and from peer providers. Interview results of 99 mystery client visits to clinics and 101 visits with peer providers between April and November 2004 were analyzed in July 2005.

Trend analysis: Each facility and peer provider collected and reported service statistics on a quarterly basis. A trend analysis of those data was conducted in April 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:
- Number of visits (new and revisit)
- Number of visits by age (10-14, 15-19, 20-24) and sex
- Voluntary Counseling and Testing (VCT)

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[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.

Analysis of monitoring data: An analysis of monitoring data, including peer provider and supervisor reports, was done to provide additional information for this report.

Overall Data Limitations

There were a number of limitations to the data and the evaluation itself, including lack of service statistics, lack of analysis of data, retroactive scoring, staff turnover at the end of the project, and lack of funding.

Service statistics: AYA/Pathfinder was unable to obtain monitoring data from all of its partners, including facility and peer provider service statistics. For example, Busoga Diocese, a partner who implemented YFS in January of 2003, including a large outreach component, did not provide statistics of its work after March 2004 (despite numerous attempts on the part of AYA staff). In addition, the district partners began in late 2003, so their reported statistics only covered one year. Finally, despite attempts to work with the implementing partners to collect and clean the data, some data were not able to be fixed and could not be analyzed, thereby decreasing numbers reported.

Lack of analysis of data: Another limitation was the lack of analysis and explanation of improvements seen throughout the project and reported in the results, caused by a lack of resources. For example, specific information was not captured on why facilities made improvements or why increases or decreases in services occurred at particular times throughout the project. Despite attempts to obtain this information from project staff throughout implementation, this information is missing.

Retroactive scoring: The retroactive scoring process was a significant limitation to the reassessment data because many baseline assessments were scored months after the initial assessment, which was done without the certification tool in mind. This meant that in some cases, related information required to score appropriately was missing. Though efforts were made to find missing information, these were not always successful. 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.

Staff turnover: Unfortunately, due to the upcoming project end date, two key Pathfinder staff left the AYA project in November and December 2004, and were not able to complete the evaluation activities as planned. As a result, much of the work had to be done by consultants that had some familiarity with the project and by new staff. These circumstances have limited some detail and information in the report.

Lack of funding: As often happens as multiyear projects near an end, funding limitations affect end of project activities and particularly evaluation work. The evaluation design was scaled back in this case to provide the best information possible given the resources available.

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 training data, analysis of client satisfaction data, and trend analysis. For each section the methodology for evaluation, data limitations, and results are provided.

Static Facility Activities

The Uganda static facility component consisted of the following activities:
- Development of a national ASRH training team
- Development of a national training curriculum
- Training of district trainers
- Selection and training of assessment teams
- Facility assessments
- Selection of clinics for facility strengthening
- Development of quality improvement action plans
- Implementation of action plans
- Monitoring and supervision
- Use of mystery client visits and exit interviews

Development of a national ASRH training team

AYA/Pathfinder supported the development of a national ASRH training team to conduct trainings for the health workers in the 13 AYA districts. A consultant from Pathfinder trained the team of 20 national trainers in May 2001. The training was designed to improve the participants' capacity to plan, conduct, and evaluate trainings, and addressed various aspects of training management.

The training of trainers was followed by a seven-day training in ASRH/YFS in July and August. Several previously trained trainers from Botswana participated in the ASRH/YFS training, which provided an opportunity for skills sharing among AYA countries.

Development of a national training curriculum

The national trainers were involved in the review of the national training curriculum. The objectives of the review were to:
- Identify issues and suggestions for improving curriculum;
- Solicit suggestions and recommendations from participants on how to improve the document;
- Enable participants to apply knowledge and skills acquired during the master trainer training;
- Familiarize national trainers with the ASRH training materials.

Training of district trainers

Twenty-eight people (eight male and 20 female) from 10 AYA districts participated in a seven-day training on ASRH. They included three clinic officers, two public health nurses, three youth, seven nurse midwives, three service delivery coordinators, one youth officer, six staff of the Department of Gender and Community Development, one from the Department of Education, a district health provider, and a health visitor.

Selection and training of assessment teams

The national trainers also supported the facility assessment exercise. The team participated in a one-day training on assessing and planning for youth-friendly services; this prepared them to take part in the exercise as facilitators, assessors, and supervisors of data collection and report writing. The training covered characteristics of YFS, assessment methodologies, challenges to the assessment process, and a review of the YFS tool.

The national trainers conducted facility assessment trainings for the district teams. The first district training was a one-day training in the Kasese district. The trainers noted that one day was not enough for the facility assessment training, so later trainings were increased to two days in the other districts. The additional day allowed sufficient time for the teams to effectively cover topics such as assessment challenges and how to conduct a participatory debriefing session.

Facility assessments

After the trainings, district teams were divided into groups of four to six people (one national trainer, two to three district officers and one to two young people) to conduct baseline facility assessments. Each assessment took one day. The numbers of facilities assessed varied from district to district.

At the conclusion of each facility assessment, the team prepared a debriefing note, which was used to facilitate discussion of the findings with the facility staff. This exercise enabled the team to highlight both positive points as well as areas where improvement was required. This also allowed facility staff to provide feedback and their own recommendations for improvement. The facility report summaries were shared with the partners.

Baseline assessments were conducted in 154 facilities between August 2002 and March 2003 in the districts of Kasese, Kabarole, Kabale, Iganga, Mayuge, Mbale, Soroti, Kaberamaido, Kampala, Kamwenge, Kyenjojo, Kapchorwa, and Siroko from August 2002 to April 2003.

Producing quality improvement action plans

Although the assessment teams planned to create action plans on the last day of the assessment, almost none had sufficient time to do so. In the Kasese district, a team of national trainers shared facility assessment reports with facility managers in a two-day workshop and came up with draft facility action plans. These action plans were later refined by the South Rwenzori Diocese staff of the Young and Powerful Initiative. For other partners, action planning at the facility level was not done as a result of changes in management and delays. Instead, plans were produced at the district level for all of the facilities in that district in a systems-wide means using summaries of the actions required for improvement in each facility.

Selection of clinics

Although 154 clinics were assessed, clinics had to then be selected for implementation of YFS. In the first districts where assessments were conducted (Kasese, Iganga and Mayuge), the district assessment teams assessed all the facilities that were presented by the partners. However, the assessment teams realized that implementation would not be possible in all the clinics being selected by the partners due to a shortage of resources, and that clinics would need to meet additional criteria in order to be assessed. Thus, in the remaining districts, the national teams first interviewed the district officials about the facilities to establish if they were located in the AYA selected health subdistricts, if they were in subcounties where BCC activities were taking place, and if they were located near places where young people congregate. For example, Kasese had 22 facilities assessed, but only nine were selected for implementation based on facility selection criteria. In the remaining districts, the number of facilities assessed ranged from 5 to 12 facilities and almost all were selected for implementation. In the end, 96 facilities were selected for implementation. In 20 of those facilities, implementation was limited to training (see Appendix A).

Implementation of quality improvement action plans

Facility action plans focused on making physical improvements (such as painting and partitioning to increase privacy and make clinics more youth friendly), creating linkages (between facilities of different levels[5] and between facilities and outreach/community

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[5] Uganda has several facility levels: **Health Centre I** is a community level facility, which does not usually contain physical infrastructure, but is for planning purposes. It includes community health workers of all types (i.e., outreach workers). *Health Centre II* contains curative and preventive services (i.e., immunizations, treatment of minor ailments) with no surgical interventions and can provide simple family planning services and syndromic treatment of STIs (no laboratory facilities). It is usually staffed with only a nurse and a nursing assistant, but in cases where there is a midwife, it can provide ANC and normal delivery services. *HC III* is at the sub-county administrative level and provides both curative and preventive services, including minor surgery under local anesthesia. HC111 are staffed by nurses, nursing assistants, midwives, clinical officers, and there are provisions for simple lab tests, family planning, ANC, normal deliveries, STI prevention and treatment, ASRH services, assisted delivery (with vacuum

providers and activities), and training of service providers. Service provider training was the primary activity implemented in Uganda, and was done at two levels: in-service and pre-service.

In-service training

Districts selected a minimum of six service providers – at least one from each of the YFS facilities – to be trained and subsequently provide YFS in their facilities. The participants included clinical officers, registered nurses/midwives, enrolled nurses/midwives and a few nursing assistants. Participants were selected that had a minimum education level of O-level (four years of secondary school) and who had previous training in reproductive health. A total of 202 service providers were trained throughout the project period.

The trainings focused on equipping service providers with knowledge, skills, and positive attitudes on adolescent, sexual, and reproductive health. Training of clinical service providers was conducted using the Ministry of Health's "*National Training Curriculum for Health Workers on Adolescent Health and Development*."

During the two-week trainings, the service providers were taken through six modules covering:
- Introduction to training
- Communication and counseling for adolescents
- Life skills, gender and culture
- Adolescent sexual and reproductive health
- Providing youth-friendly health services
- Drug and substance abuse
- Behavior change communication

An overview of AYA and adolescent health issues in Uganda were also included in the trainings.

Pre-service training

AYA/Pathfinder also integrated YFS training in the pre-service training for medical professionals in collaboration with the Makerere Medical School. A total of 18 tutors (at least two from each of the participating schools and eight from Mulago) were trained. In addition, 48 health workers (nurses and doctors) and 17 preceptors were trained, equipping them with knowledge and skills to support students in service provision to youth during their practical rotations.

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extraction), PNC, and basic emergency services. Ideally should also be able to provide IUD insertion, Norplant, MVA for PAC and I/V fluids, but that is often dependent on the skills on the midwife available. *HCIV* is the first referral level and has all of the services outlined for HCIII, but also has a resident medical officer and an anesthetic assistant, so should also be able to provide emergency surgery (i.e., Ceaserian section), surgical contraception and blood transfusions.

Through several sessions, the tutors collectively developed the curriculum with similar content for the different training programs. They designed a module-based curriculum, a curriculum guide, and a student manual. Modules 1-3 of the curriculum were piloted in all schools in August and September 2004, however, modules 4-6 could not be covered during the school's calendar year.

Monitoring and Supervision

Monitoring and supervision was carried out throughout the project in order to identify weak areas and make improvements to the facilities and project implementation as necessary. Monitoring and supervision included collection and analysis of facility service statistics and regular supervision by district and partner staff, as well as 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[6]), and services provided to each client. The data were compiled and submitted to AYA/Pathfinder on a quarterly basis by the partners. AYA staff reviewed the statistics on an ongoing basis for purposes of strengthening of data collection and of implementation.

Supervision by AYA/Pathfinder and district and partner staff: Supervision of AYA/Pathfinder staff included visits to facilities to review progress on planned activities, assess linkages with other AYA activities in the area, and inspect the conditions of the facility environment. The district supervision teams from the office of the director of District Health Services conducted monthly supervision visits in which they looked at the services being provided, availability of supplies and procurement plans, the records prepared by the service providers, and progress on other planned activities. All partners shared their experiences and reviewed progress made under AYA during annual meetings.

Use of mystery client visits and exit interviews

Exit interviews and mystery clients[7] were used to assess client satisfaction at Mbale, Kabale, UYDEL, KCC, and SRD facilities. In order to gather information on the quality of service provision, exit interviews were conducted with youth as they left the facilities. Mystery clients were chosen by partner and district officers, with the help of peer providers. They could be male or female but in order to be representative of the majority of young people in the community, could not be working with the AYA program.

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[6] 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.
[7] Mystery clients are trained people (usually community members) who visit program facilities in the assumed role of clients, and then report (by completing a survey or through an interview) on their experience.

Training was carried out for the selected mystery clients. The content of the training included introducing the participants to the overall purpose of the exercise, the steps involved, and what they would be looking for. The mystery clients were also given the scenarios they would use during the visit, which they discussed and role-played, including responses to questions the service provider or other facility staff might ask. The following scenarios were presented during the mystery client visits:

- Unwanted pregnancy
- Information regarding contraceptives
- Information regarding STIs
- Counseling regarding premarital intercourse

Mystery clients were instructed to assess and report on communication skills, waiting time, length of service provided, use of BCC materials, provider attitudes/barriers, cost of service, and their overall satisfaction with the service. Youth were interviewed following their clinic visits using an interview guide (see Appendix B). Results were reviewed by the facilities and partners, and actions were taken to improve any areas that were identified as needing improvement.

The following section discusses the various evaluation activities used (facility reassessment, analysis of training data, 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. It should be noted that a subset of questions were selected from the facility assessment tool, specifically those that had data available and were considered the important to achieving YFS. These were: privacy ensured, competent staff, minimum package of services, peer providers/counselors available, and publicity for YFS.

Due to limitations in time and resources, a sample of five facilities was selected for reassessments, including both NGO and district partner facilities. The facilities reassessed were:
- Komamboga Health Center in Kampala
- Kinyamaseke Health Center in Kasese
- Bubuto Health Center in Mbale
- Kasheregenyi Health Center in Kabale
- Bufulubi Health Center in Mayuge

Endline assessments were conducted in January 2005 and the certification tool was applied to those results in February 2005.

Data Limitations

One limitation to the evaluation of the facility assessment and strengthening was that due to funding limitations, a small sample (five out of the 76 facilities) of facilities were reassessed. The results found may not be representative of results across all facilities.

Another significant limitation was that in reviewing the baseline assessment results, district staff focused on areas that they believed were most important or on areas which they could have a significant impact. Therefore, each district focused on different areas. However, all assessed the following five out of 14 areas: privacy ensured, competent staff, minimum package of services, peer providers/counselors available, and publicity for YFS. As a result of this, the evaluation only examined the above-listed five areas in the sampled facilities (as opposed to reassessing all elements of the facility assessment tool).

Finally, despite requests from program staff for more information on the facilities, including reasons for their improvement in particular areas, this information was not collected and could not be included in this report. Therefore, analysis of the results is limited.

Results

Improvements were seen in each of the five elements, as seen in figure 3. The "peer provider/counselors available" component had the greatest score increase over baseline, due to the program's peer provider training and program implementation. Another big increase was seen in the "privacy assured" element. Privacy was an area that was found to be very weak during the baseline assessments and was strongly emphasized during the trainings of service providers and improved through the partitioning work done in many clinics. Figure three provides a comparison of the baseline and endline scores (with 10 being the highest score possible):

Figure 3: Total Component Scores
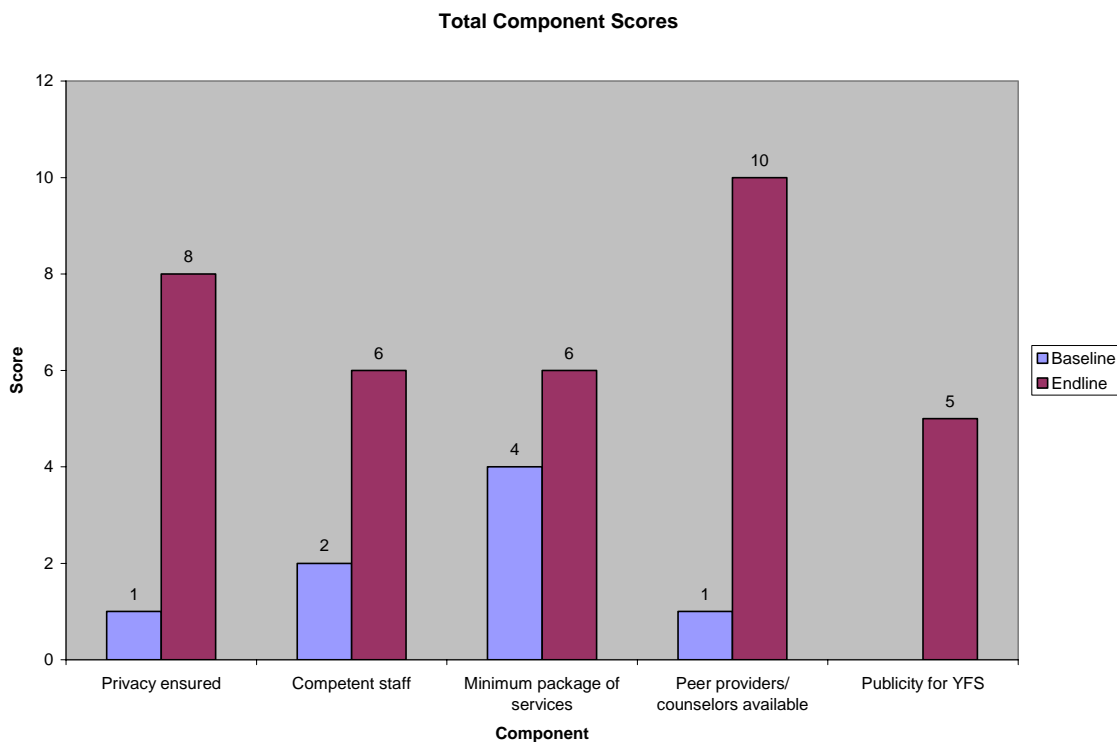
As can be seen in table 2, each facility also saw overall improvement from baseline to endline; scores for each element either improved or remained the same. Komamboga saw the greatest improvement, with an increase in scores from one at baseline to an endline score of nine. Bufulubi, scoring the lowest of the sampled facilities with a baseline score of zero, made the next greatest gain of the facilities with an endline score of seven. Kinyamaseke, though scoring the highest of the sampled facilities at baseline, saw the smallest gain of three points. The results for each facility are as follows (see Appendix B for complete scores):

Table 2: Facility Baseline/Endline Scores

FACILITY	BASELINE SCORE	ENDLINE SCORE	IMPROVEMENT
Bubuto	1	6	5
Kinyamaseke	4	7	3
Komamboga	1	9	8
Kasheregenyi	2	7	5
Bufulubi	0	7	7

During the assessments, staff noted that one strength of the assessment process was the production of facility-based reports, which allowed for monitoring of the facilities using the specific findings of the assessment. This helped focus the activities on the facilities' needs to increase availability of quality YFS services. However, staff also noted that the process of developing action plans in some cases created expectations that were not able to be met through AYA, occasionally causing frustration to some facility staff.

<u>**Analysis of Training Data**</u>

Evaluation Methodology

The end of project evaluation concentrated on the in-service, rather than pre-service training for providers conducted by the national training team. All of these trainings were evaluated using a combination of pre- and post-test assessments and an end of training evaluation. In analyzing the pre- and post-test assessments, average scores gained per training were calculated, and comparisons were made across the different types of trainings. A review of training evaluation summaries and discussions with national and district trainers provided additional information.

Data Limitations

Training reports mentioned the use of daily reviews and observation to monitor participants' learning, but since the trainers did not report the outcomes of either of these, these data were unable to be included in the analysis.

Results

The following table shows the total participants of both the in- and pre-service work.

Table 3: Total Number of Participants Trained

Training and Participant Type		Number Trained
In-service	National Trainers	20
	District Trainers	28
	Service Providers	202
Pre-service	Tutors	18
	Health workers	48
	Preceptors	17

Analysis of pre- and post-tests showed gains in all service provider trainings, as seen in the table below.

Table 4: Pre- and post-test analysis –Service Provider Trainings for 2003 to 2004

District	Average Score		
	Pre-test	Post-test	Gain
Kasese	45	61	16
Kampala	33	63	30
Kabarole, Kasese	47	66	19
Kyenjojo, Kamwenge	44	68	24
Kampala	46	73	27
Kabarole	57	81	24
Mbale, Sironko, Soroti, Kaberamaido, Kapchorwa	54	67	13
Kabale, Kamwenge, Kyenjojo, Kabarole	53	72	19
Mbale, Sironko, Soroti, Kapchorwa	55	64	9
Iganga, Mayuge	58	84	26
TOTAL	50	70	20

The range of score increase for the 10 service provider trainings was from 9 to 30, with an average increase of 20.

Those trained felt that they gained valuable knowledge and skills as a result of the AYA/Pathfinder trainings. One national trainer described her observations of how the training transformed the service providers, "At the beginning, providers were asking questions like 'Why the youth? Are they not served? Where are they?' But by the end of the training, they were excited that now they knew what they were going to do to serve young people."

A weakness of the training, according to training evaluations, was that many of the service providers would have preferred more time for practical training to further develop their confidence in serving young people in their facilities.

<u>**Analysis of Client Satisfaction Data**</u>

Evaluation Methodology

The primary means of assessing client satisfaction was through analysis of mystery client interview forms from three of the districts that conducted mystery client visits: Mbale, Kasese, and Kabale. In the three districts, a total of 99 mystery client visits were conducted at 22 facilities between April and November 2004. The number of visits conducted[8] and the communities within each district in which the visits occurred are included below:

- Kasese (59): Kiteso, Kahokya, Kuyateka, Malisa, Muhokya, Kinyamaseke, Kitsutsu, and Nyakatunzi
- Kabale (8): Rubaga, Katenga, Muko, Bufundi, Kasheregyenji, and Kakoomo
- Mbale (28): Buwundu, Bukokho, Bunatsimi, Bumushikho, Bunamubi, Bumatanda, Bunabutiti and Buchida

The table below shows the mystery clients by district, age, and gender.

Table 5: Mystery clients by district, age group and sex

Age (years)	Kabale			Kasese			Mbale			Unknown		
	M	*F*	*UK*	*M*	*F*	*UK*	*M*	*F*	*UK*	*M*	*F*	*UK*
10-14	0	1	0	0	0	0	0	1	1	0	0	0
15-19	1	1	1	9	19	0	1	3	11	0	1	1
20-24	0	4	0	9	12	3	1	3	7	0	1	1
Unknown	0	0	0	5	2	0	0	0	0	0	0	0
Totals	*1*	*6*	*1*	23	33	3	2	7	19	0	2	2
		8			*59*			*28*			*4*	

Interview data were received from the partners and entered into Excel for analysis. The data were analyzed by question and are reported below.

Data Limitations

The primary limitations were the lack of response by mystery clients to a number of questions[9] and the lack of staff time and funding to follow-up more intensely with mystery clients to complete interview forms. Another limitation was the difficulty of measuring quality of care, given the emphasis on mystery clients as the sole source of data. Additional data gathering could assist in determining whether services provided are of acceptable quality.

A number of limitations of the interview guide were also identified, including:
- Questions were not grouped together thematically to enable the clients to reflect and respond in a logical fashion that clearly presents information. The recommendation

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[8] It is unclear from the forms in which districts four of the visits were conducted.
[9] Because of this limitation, the percentages in the graphs do not equal 100 percent; the percentage of nonresponse for each element has not been included.

would be to group all "communication" questions together as well as the "attitude/barrier" questions.

- The use of a majority of close-ended questions limited the data analysis. For example, it would have been more useful to follow up clients who described services as "cheap", "affordable," or "expensive" with a question about how much they paid. Clients who said they would recommend the service to a friend, should have been asked, "why?" However, even when probing follow up questions were included in the guide, no responses were recorded. It is unclear whether this is because the interviewers did not probe.
- The rankings and terms used in some questions might also have limited the data. For example, in question 36, "cheap", "affordable," and "free service" could mean the same thing to respondents.
- Finally, the exercise did not address several key issues of youth-friendly services, including confidentiality, hours of operation, and comfortable environment.

Results

The mystery client visits showed positive results in most of the elements under observation, including the communication skills of the service providers, the waiting and counseling time of the visits, privacy, use of visual aids, cost of service, and overall satisfaction of the visit. The individual results are shown in the following graphs.

As figure 4 illustrates, all clients were able to speak to a service provider. Ninety-four percent of mystery clients believed they received a friendly greeting from the provider, 97 percent were asked the reason for their visit, and 84 percent of service providers asked clients if they had questions and answered the questions that were asked of them. Seventy-four percent of clients felt their concerns were taken seriously. In addition, 70 percent felt nothing was done or said by the service provider to make them feel uncomfortable.

**Figure 4:** Communication of Service Provider
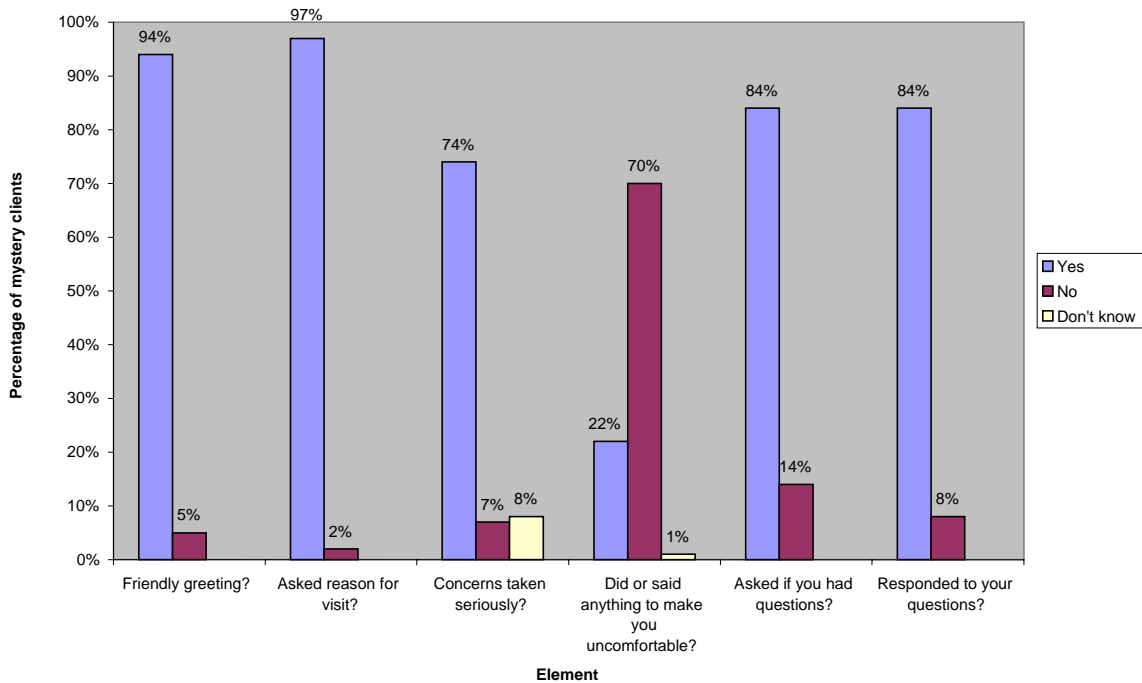
Results showed that waiting time was less than 30 minutes for almost half (46 percent) of the clients in all districts (fig. 5). There was no waiting time for some clients (32 percent) and 17 percent expressed that the time was too long.

Figure 5: Waiting Time for Visit
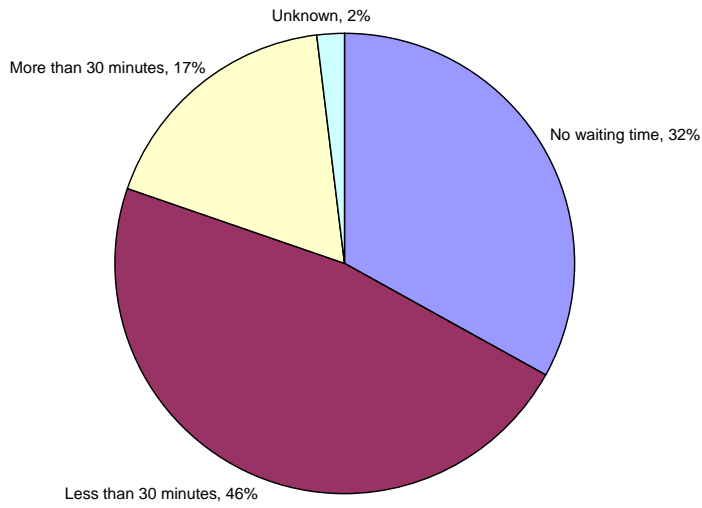
As shown in the figure below, counseling time varied for mystery clients: 10 percent were counseled for less than 10 minutes, 46 percent for 15 to 59 minutes, while 19 percent were counseled for an hour or more. The majority of clients (81 percent) reported feeling that they had enough time with the service provider.

Figure 6: Counseling Time
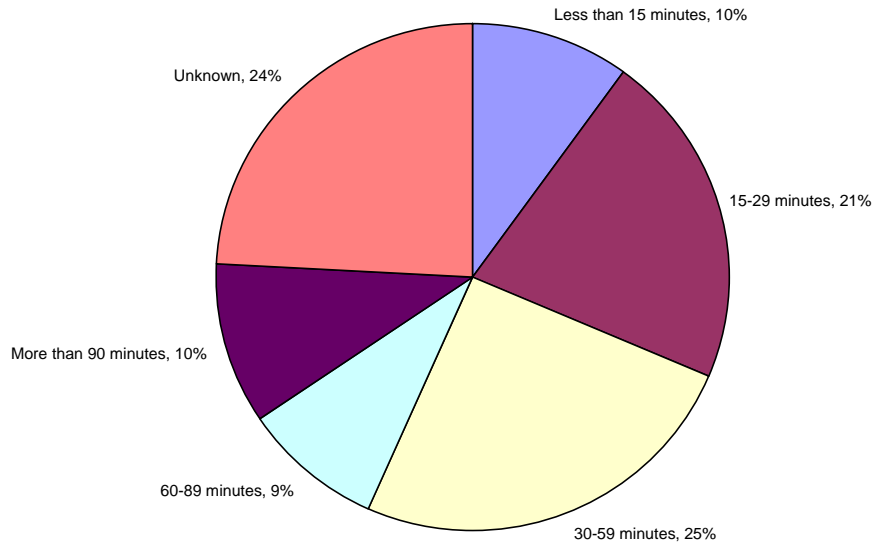
In terms of privacy, seventy-five percent of clients felt that their conversation was not overheard and 78 percent reported that their discussion was not interrupted, as shown below.

Figure 7: Privacy of Counseling Visit
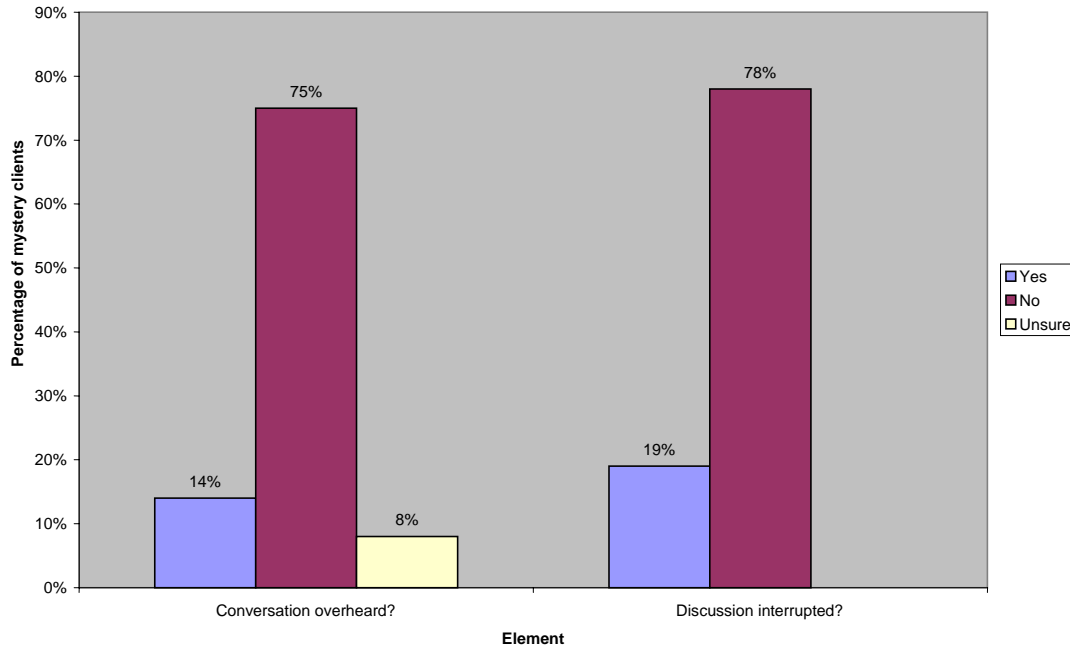
Use of visual aids during counseling was found to be low, as shown in the graph below. While 51 percent of service providers used posters, only 28 percent and 24 percent used drawings and booklets respectively.

Figure 8: Use of Visual Aids
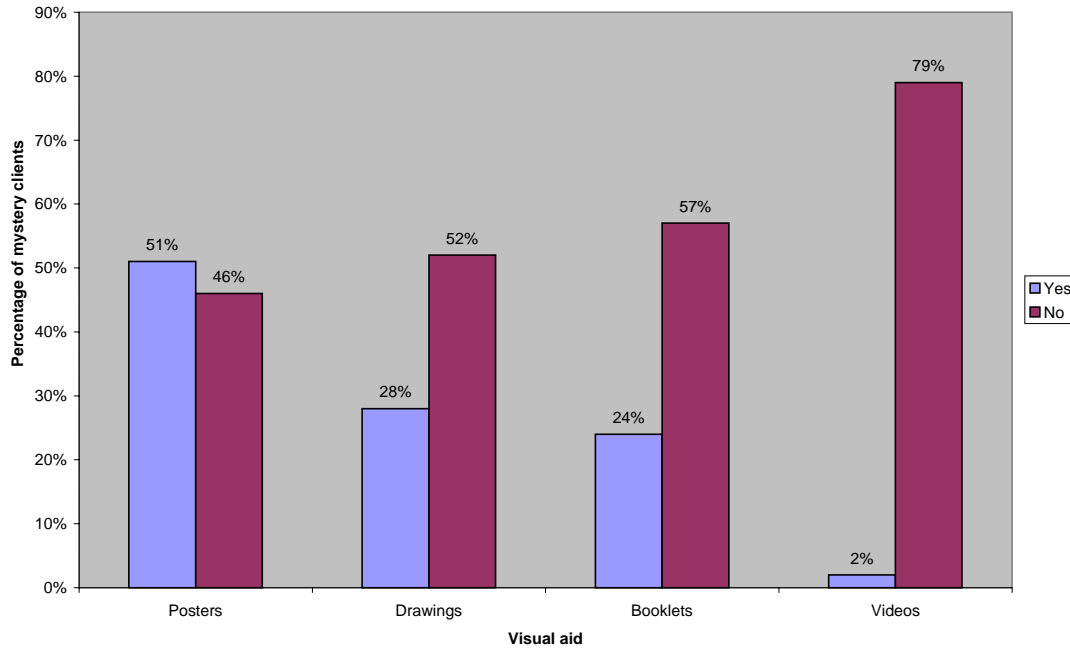
As the graph indicates, service providers had positive attitudes towards provision of sexual and reproductive health services to adolescents, and had minimal barriers to service access.

Figure 9: Barriers to Services
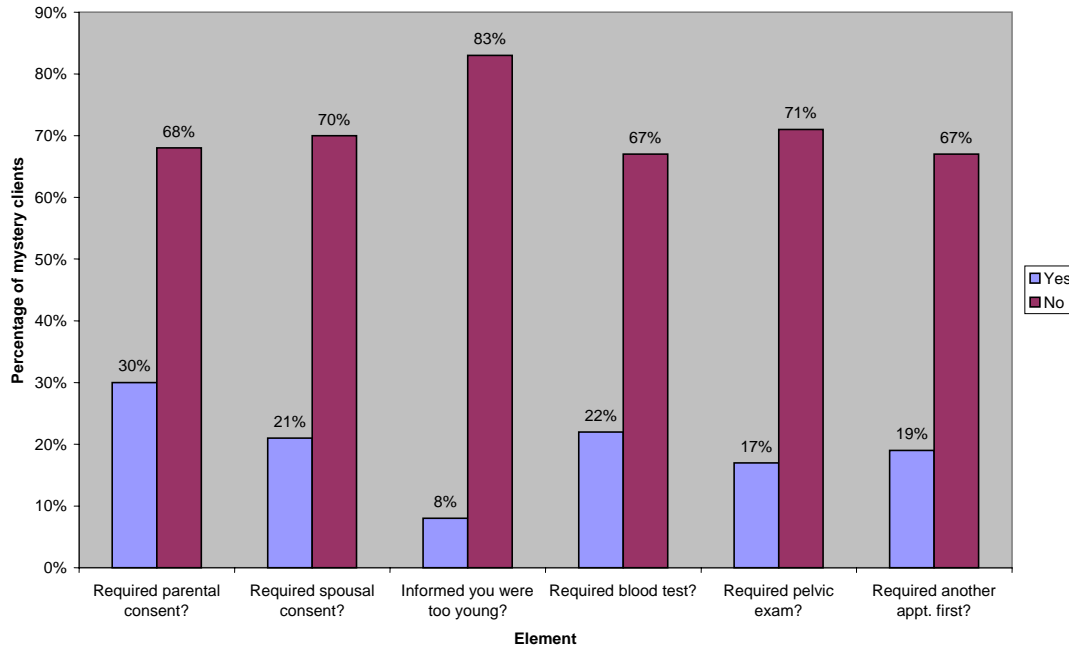
As seen below, a majority (55 percent) indicated that the cost of service was free, while 9 percent noted it was affordable or cheap. Only seven percent indicated the cost was expensive. Due to youth's inability to pay too much for services, and the fact that this can be a big barrier to youth access, this is an important factor to examine.

Figure 10: Cost of Service
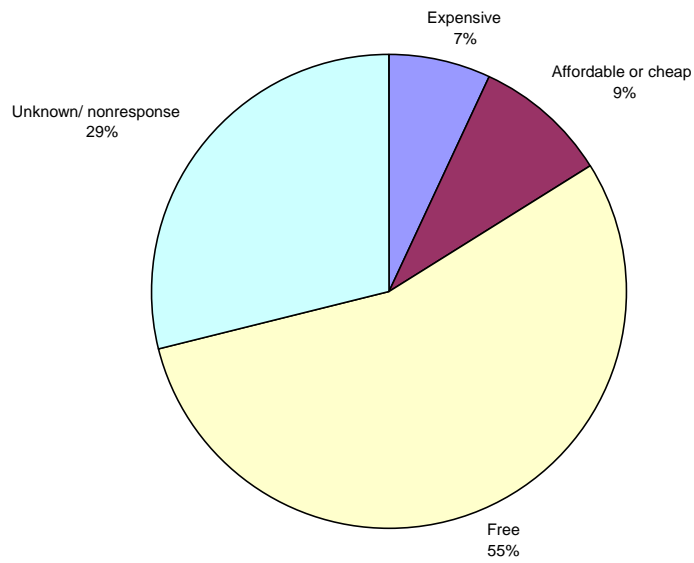
Overall, most clients (82 percent) felt that the counseling session was satisfactory and 88 percent said they would recommend the provider to a friend, as the graph below indicates.

Figure 11: Overall Satisfaction
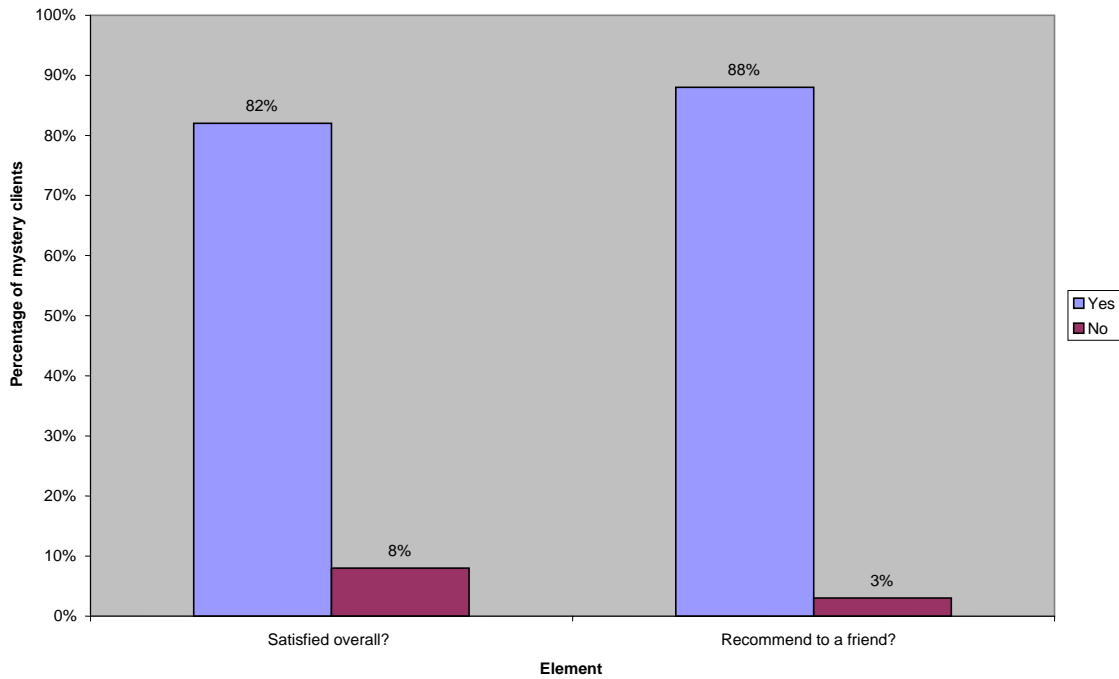
The results of the mystery client visits show that in a majority of cases, the service providers communicated well, the waiting time was not more than 30 minutes, the counseling time was at least 15 minutes, privacy was ensured, and that most barriers to service were not present. Unfortunately, the lack of visual aids is one area that needs major improvement in these facilities.

Trend Analysis

Evaluation Methodology

Service statistic data were analyzed at the end of project to examine if any trends existed and to explore reasons for those trends. Only data from three partners (UYDEL, SRD and KCC) from April 2003 to December 2004 were analyzed for this purpose. This was because district partners did not begin implementation and reporting until April 2004 (which would limit the trend analysis to only nine months) and there were no data from Busoga Diocese from March to December 2004. The table below shows the data available by partner for each quarter.

Table 6: Data Availability Per Quarter

Partner	2003				2004			
	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q
UYDEL	xx	xx	xx	xx	xx	xx	xx	xx
SRD	xx	xx	xx	xx	xx	xx	xx	xx
KCC	-	xx	xx	xx	xx	xx	xx	xx
BD	xx	xx	xx	xx	xx	-	-	-
Mbale	-	-	-	-	-	xx	xx	xx
Siroti	-	-	-	-	-	c	xx	xx
Kaberamaido	-	-	-	-	-	-	xx	-
Kabale	-	-	-	-	-	c	xx	o
Kabarole	-	-	-	-	-	-	xx	xx
Kamwenge	-	-	-	-	-	-	xx	xx
Kyenjojo	-	-	-	-	-	-	o	xx
Kapchorwa	-	-	-	-	-	-	xx	xx
Sironko	-	-	-	-	-	-	xx	xx

xx=clinic and outreach data; c=only clinic data; o= only outreach data; -=data not available

For the purposes of giving a clear picture of the reach of the project, data have also been aggregated and analyzed for all reporting partners, including those districts that started implementation and data collection after April 2004 (all district partners) or did not have complete data through 2004 (Busoga Diocese). Aggregated data for all partners includes total youth visits by age and sex (table 7) and services provided (table 8).

Data Limitations

As noted above, a big limitation was the lack of data from Busoga Diocese. Despite numerous attempts to obtain information beyond March 2004, these data were unavailable to Pathfinder. In addition, the district partners began implementation and reporting in April 2004, which limited their work and data to nine months.

Another limitation was the quality of the data. Much work was done to work with the partners to ensure data quality, however, much cleaning and work had to be done to be able to analyze it at the end of project.

Finally, lack of information on why increases and decreases were seen throughout the project is missing, limiting analysis.

Results

As noted above, results are shown both for all partners from January 2003 to December 2004 and for the three partners with data from April 2003 to December 2004.

All Partners

Table 1 shows data for all partners from January 2003 – December 2004. During this period, young people made a total of 195,591 clinic visits. More visits were made by youth 20-24 years of age than other age groups and females made more visits than males. Females 20-24 years made the most visits, followed by females 15-19, males 20-24, and males 15-19. Counseling was the most popular service, followed by family planning services, of which male condoms were most popular. Most STI testing and treatment visits were for treatment. Most pregnancy-related visits were for antenatal care.

Table 7: Clinic Visits for all Partners by Age and Sex January 2003-December 2004

Age Group	Male		Female		Total	
	No.	%	No.	%	No.	%
10-14 years	16,220	20.6	19,720	16.8	35,940	18.4
15-19 years	29,507	37.6	40,667	34.8	70,174	35.9
20-24 years	32,881	41.8	56,596	48.4	89,477	45.7
TOTAL	**78,608**	**100**	**116,983**	**100**	**195,591**	**100**

Table 8 shows the total number of youth visits for the various services at all partner facilities. Because youth often sought multiple services, the total number of visits in this chart exceeds the actual visits shown in table 7. Many of the visits included counseling, followed by family planning services.

Table 8: Service Delivery for all Partners January 2003- December 2004

| Type of Services	Total Visits		Type of Services	Total Visits	
	#	%		#	%
Pregnancy Related Services	20,895	7.1	Counseling	200,084	67.6
Family Planning Services	47,177	16	STI Testing & Treatment	27,544	9.3
TOTAL				**295,700**	**100**

UYDEL, SRD, and KCC

Number of Clinic Visits

UYDEL, SRD and KCC recorded a total of 150,367 clinic visits by young people aged 10-24 years during the period April 2003 to December 2004. From April to December 2003, a total of 94,524 visits were recorded and 55,843 visits were recorded between January and December 2004. There was a significant reduction in the number of visits in 2004, despite the lack of data from January to March 2003.

As shown in figure 12, there was a steady increase in the number of visits from April to December of 2003. For example, the number of youth visits increased from 16,383 in the second quarter of 2003, to 40,161 visits during the fourth quarter, indicating a 145 percent increase in the number of visits during this period. However, the first quarter of 2004 saw a significant decrease in visits. The numbers increased slightly in the second and third quarters, and then decreased again in the fourth quarter of 2004. Lack of supplies in 2004, particularly in the last quarter, was blamed for the decrease in visits in 2004.

**Figure 12:** UYDEL, SRD and KCC Clinic Visits April 2003 - December 2004
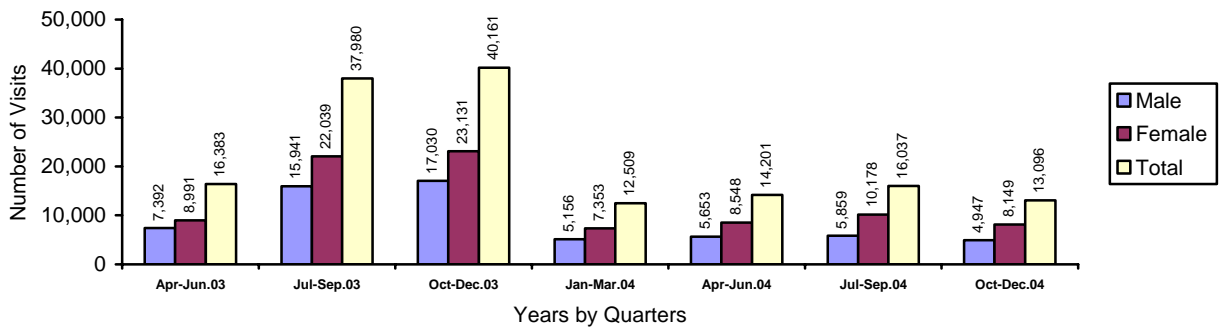
Visits by Sex and Age Group

As shown in figure 12, more females accessed services and information in the clinics than males. Visits by females accounted for 57 percent of all visits from April to December 2003 and for 61 percent of visits from January to December 2004. Visits by males accounted for 43 percent of visits in 2003 and 39 percent of visits in 2004.

From April to December 2003, visits by young females increased steadily from 8,991 in the second quarter to 23,131 in the fourth quarter. Male visits also increased, but by a smaller percentage, from 7,392 visits in second quarter to 17,030 visits in the fourth quarter. During 2004, the total number of visits declined in both sexes; the total number of female visits decreased to 34,228, while male visits decreased to 21,615 visits.

Figure 13 shows the contribution of each group to the total number of visits to clinic facilities. Of the 94,254 visits from April to December 2003, 20-24 year olds represented 50 percent of the total visits, followed by those 15-19 years old (36 percent), and 10-14 years old (14 percent). Of the 43,334 visits from April to December 2004, the percentage of visits by the 20-24 and 15-19 year olds dropped to 43 percent and 33 percent respectively, while visits by 10-14 year olds increased to 24 percent of the total clinic visits. Females 20-24 visited most in both years, followed by females 15-19 and males 20-24.

Figure 13: Percentage of UYDEL, KCC, and SRD Clinic Visits by Age and Sex
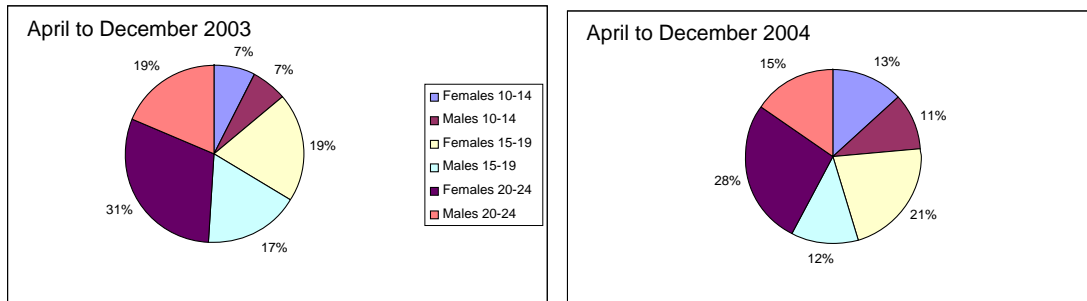
Type of Visit – New or Revisit

To determine the type of clinic visits undertaken by the target population, visits were classified as new and revisits. However, due to the limitations of the data, the new and revisit analysis does not include data for KCC.

As shown in figure 14, from January to December 2003, a total of 41,620 (51 percent) visits were classified as new and 39,678 (49 percent) were classified as revisits. However, during the same period in 2004, the dynamics changed: 27,661 (73 percent) visits were new and 10,019 (27 percent) visits were revisits. The analysis is an indication that the clinics over the two project years under review have consistently attracted a number of new clients.

Figure 14: UYDEL and SRD New and Revisits January 2003 to December 2004
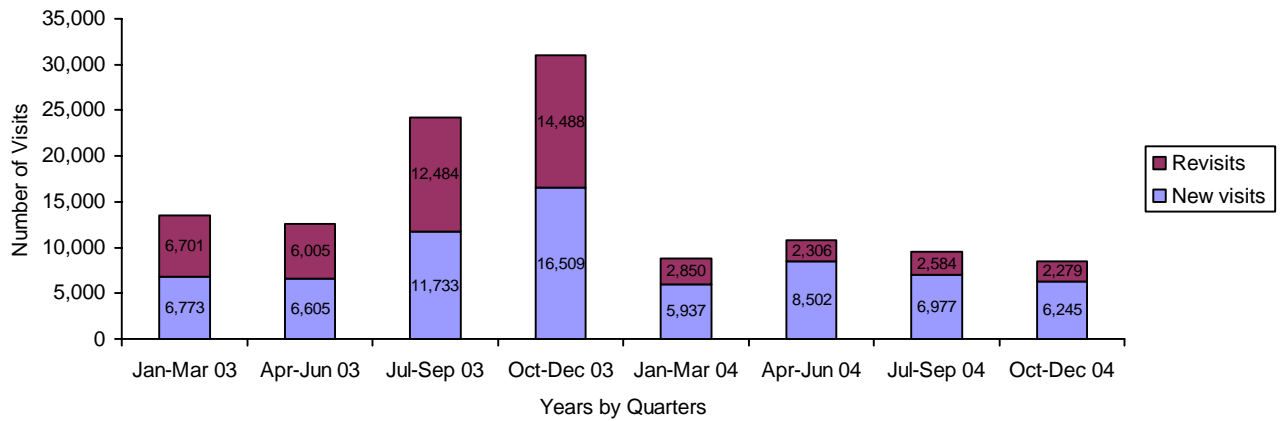
Service Delivery

During the period under review (April 2003-December 2004), the three partners provided comprehensive ASRH services, including STI testing and treatment, and Voluntary Counseling and Testing (VCT) for HIV/AIDS, pregnancy-related services, family planning services, and counseling.

STI Testing and Treatment

A total of 1,323 STI tests were conducted from April to December 2003 and 3,901 were conducted from January to December 2004. STI treatment visits totaled 7,318 in 2003 and 6,235 in 2004. VCT service visits totaled 1,017 from April to December 2003 and 4,344 from January to December 2004.

As shown in figure 4, STI testing and VCT service visits increased from the second quarter to the third in 2003, decreased slightly in the last quarter of 2003, then increased in the first quarter of 2004. STI testing saw a slight decline and VCT a slight increase in the second quarter of 2004, then both increased in the third quarter, before declining in the fourth quarter. STI treatment visits, on the other hand, increased initially in 2003, decreased in quarters one and two of 2004, increased again in quarter three of 2004, and then declined in the fourth quarter of 2004. The decline of these services in the last quarter is believed to be due to delays in provision of VCT kits and other supplies.

Figure 15: STI Testing, Treatment and VCT Services for UYDEL, KCC and SRD- April 2003 - December 2004
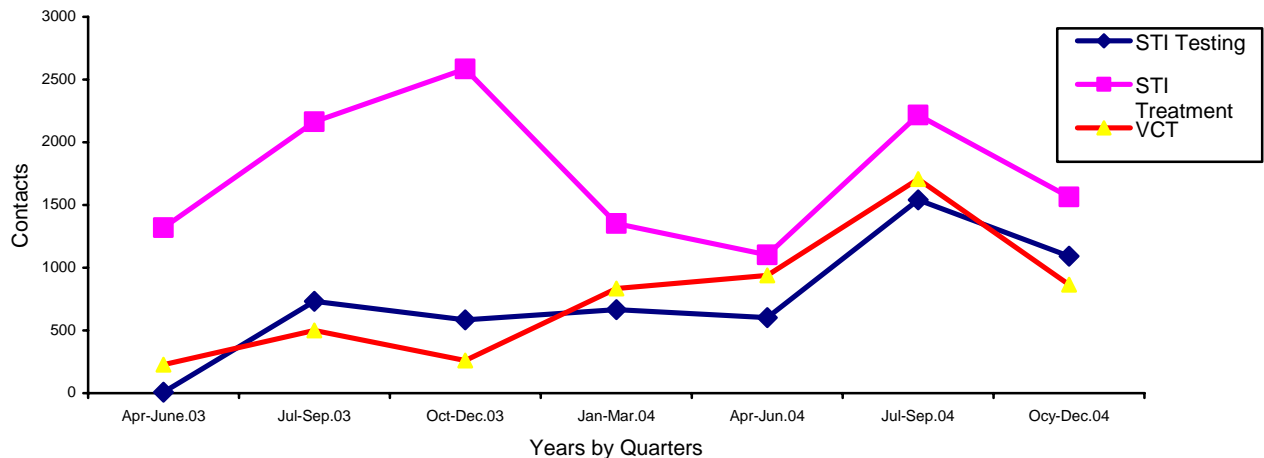
Pregnancy-Related Services

To ensure that youth-friendly clinics would be considered one-stop youth-friendly facilities for young people, a number of pregnancy-related services were provided to young people. The services included pregnancy testing, postabortion care, pre- and postnatal care, and deliveries. Figure 16 shows the number of pregnancy-related services that were provided to young people from April 2003 to December 2004.

From April to December 2003, a total of 526 pregnancy tests were given to young females; in 2004 1,299 were recorded. Also from April to December 2003, 1,292 postabortion care visits were recorded, while the number of visits decreased to 222 in 2004.

From April to December 2003, 1,113 postnatal care visits were made by young mothers while 4,753 were made from January to December 2004. In addition, 2,130 antenatal clinic visits and 277 youth deliveries were recorded from April to December 2003 and 4,753 antenatal visits and 1,206 deliveries in 2004.

Figure 16: Pregnancy Related Services for UYDEL, KCC and SRD April 2003 - December 2004
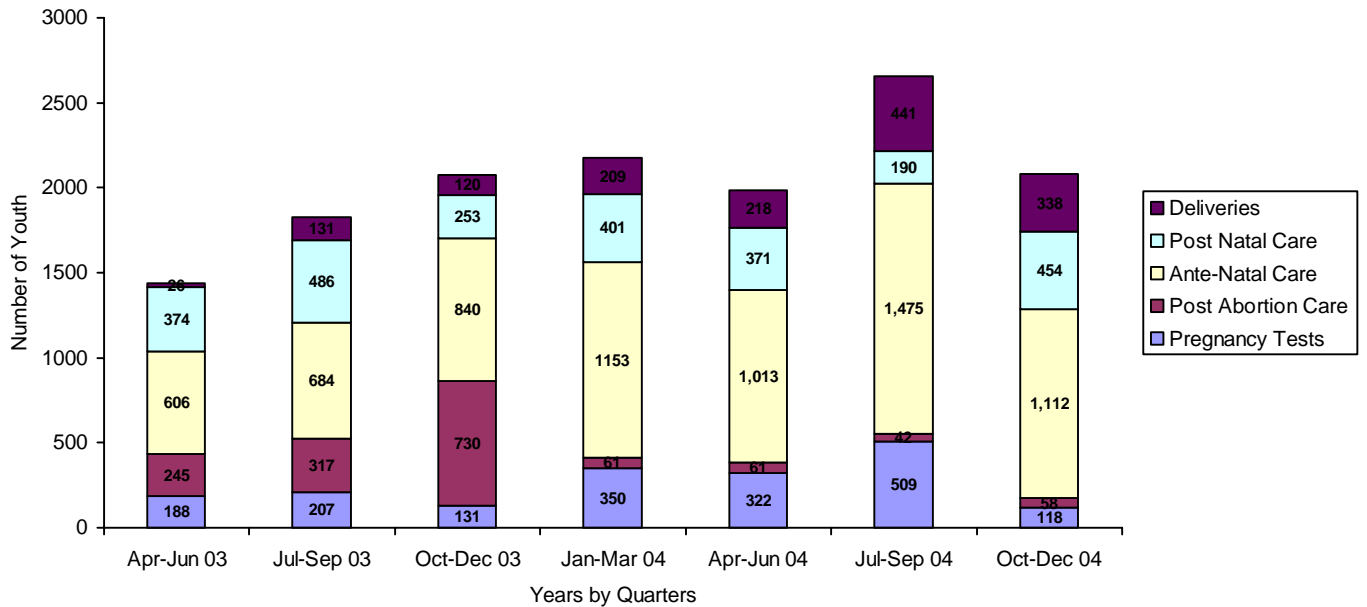
Family Planning Services

Figure 17 shows the percentage of family planning visits undertaken by young people during the periods of April to December 2003 and April to December 2004. The number of family planning visits for the three partners totaled 18,071 from April to December 2003 and 16,882 from April to December 2004.

Visits for short-term family planning methods such as male condoms, pills, and injectables (Depo Provera) accounted for more than 90 percent (75 percent, 15 percent, and 9 percent) of the total family planning visits from April to December 2003. The three methods account for 92 percent of family planning visits from April to December 2004. The analysis confirms the assertion that 10-24 year olds use short-term rather than long-term family planning methods, which in this instance accounted for less than 10 percent of all requested family planning methods. However, there is an increase in requests for pills and injectables as methods from 2003 to 2004, with a subsequent decline in condom requests. Given the risk of HIV/AIDS for youth and the focus on dual protection, this data should be examined more closely to ensure youth are getting condoms through other means and using them in addition to other methods.

Figure 17: Percentage of Family Planning Visits by Contraceptive Method for UYDEL, KCC and SRD
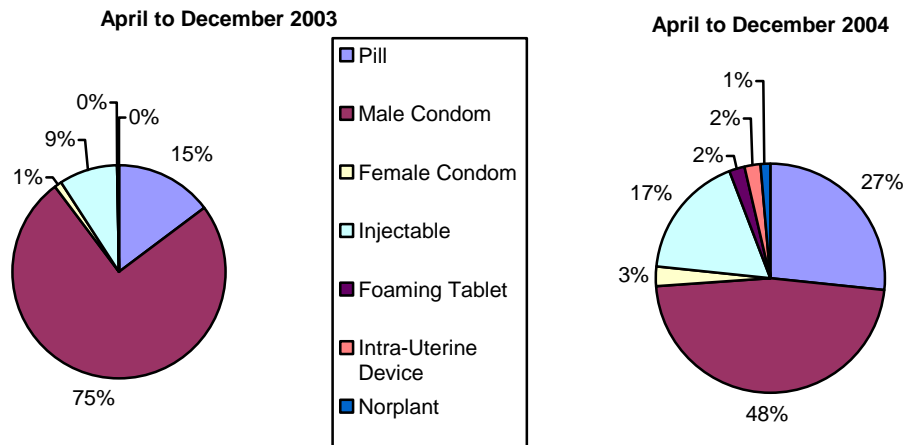
Counseling Services

The project provided SRH information through counseling sessions to young people served within the target group. The various SRH issues discussed are represented in figure 18. They included sexuality, family planning, STIs including HIV/AIDS, and other SRH issues. From April to December 2003, a total of 63,537 counseling visits were made by young people and 111,279 visits were recorded from April to December 2004.

As shown in figure 18, a large percentage (65 percent) of young people received counseling on other SRH issues as compared to 6 percent in 2004. This could be a result of an increase in record keeping capacity of the clinic staff as they became familiar with the data collection forms and system. Young people received counseling on sexuality, family planning, STI and HIV/AIDS VCT more in 2004 than in 2003.

Figure 18: Percentage of Counseling Visits by Topic for UYDEL, KCC and SRD
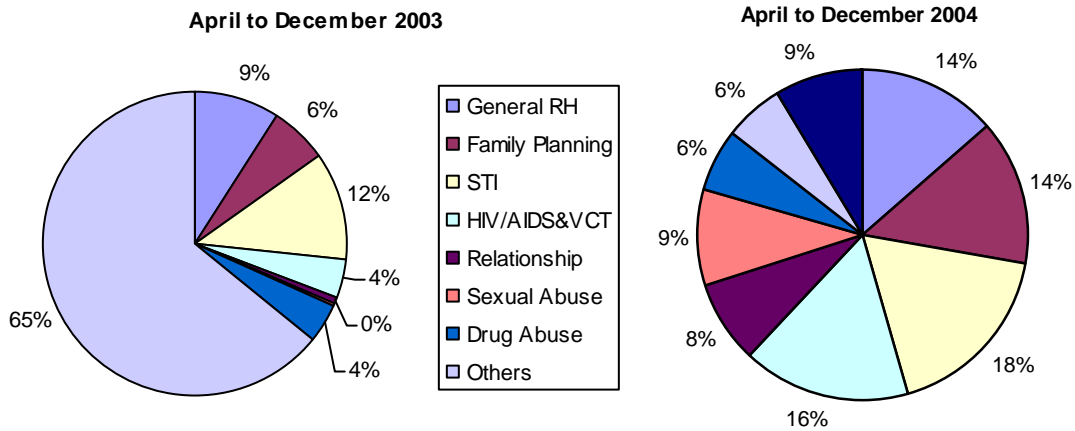
OUTREACH EVALUATION

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

Outreach Activities

Uganda implemented an outreach program as a means of reaching as many young people as possible with reproductive health knowledge and services. In Uganda, "outreach" is defined as the act of health centers routinely sending providers to "outreach sites" in the community in order to bring health education and services to the population. Outreach sites are selected as central places in specified catchment areas.[10]

Outreach programs can be staffed by both trained adults (either service providers and/or Community-based Reproductive Health Workers (CRHWs)) and youth providers. In the peer-to-peer approach, young people between the ages of 10 and 24 are trained as peer providers to promote and provide sexual and reproductive health services to fellow young people in their respective communities. A peer-to-peer approach was chosen for Uganda, in addition to outreach by adults, for the following reasons:
- youth benefit widely from programs in which they are directly involved
- youth identify, reach, and communicate with their peers more readily than any other group
- youth are the most reliable agents in providing the program with regular feedback about what does and does not work with the target audience

The Uganda outreach component consisted of the following activities:
- Peer provider identification and training
- Outreach site selection
- Training of field supervisors, CRHWs, and Quality of Care (QOC) monitors
- Peer provision
- Supervision
- Use of mystery clients

Peer provider identification and training

Districts and partners mobilized communities near YFS facilities to select young people as peer providers. They were selected using the following criteria:
- Expected to be a resident of the community for the next five years
- Known and trusted by community youth and elders
- Have a minimum of primary seven education (i.e., completed primary school)
- Can read and write in the local language

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[10] A catchment area is the geographical description of the community that is designated to use a particular service.

- Have held or are holding some responsibilities in the community
- Can work on a voluntary basis
- Are an exemplary figure in society

A total of 647 youth (a minimum of 30 youth per district) were trained as peer providers by the national and district trainers using a combination of the "*AYA/Uganda National Training Curriculum for Health Workers on Adolescent Health and Development (draft)*," "*AYA/ Uganda Adolescent Peer Service Providers Trainee Handbook*," and the "AYA/*Botswana Adolescent Sexual and Reproductive Health: A Training Manual for Service Providers*." Trainings lasted 12 days.

Peer providers received training in both ASRH theory and practice, including the following topics:
- Orientation to ASRH
- Adolescent sexuality
- Life skills
- Selected aspects of ASRH
- Working with the community
- Providing information and education
- Managing your work
- Evaluation of training

Trainers supervised the peer providers to ensure adequacy of skill and accuracy of information through a one-day field practicum during the training. At the conclusion of the training they were given incentives such as AYA caps and T-shirts. Peers working for NGO interventions were also given bicycles so they could cover a wide catchment area.

Outreach site selection

Outreach sites were chosen based on three factors: health center location and availability of services and supplies, proximity to areas in which youth congregated and/or sought services, and peer provider availability and preference. As health centers served as the base of operations for supplies, referral, and supervision, sites had to be near health centers that offered the range of services for which youth would be referred. The health centers also had to have essential supplies for peer providers to distribute and the capacity to supervise peer education activities. In some cases, outreach sites did not match with a specific health center catchment area, but were in an area that youth would congregate, such as sites that served dual purposes like businesses or markets. Finally, peer providers' availability and preference affected some sites. Although peer providers often worked in their own communities, some chose to work in other communities for purposes of learning and/or confidentiality.

Training of field supervisors, CRHWs, and quality of care monitors

A total of 55 field supervisors were trained by national trainers for 12 days using the Ministry of Health's "*Health Supervision Guide*", the draft curriculum of adolescent peer providers, and the "*ASRH National Curriculum for Service Providers.*" Two partners (South Rwenzori Diocese in Kasese district and Busoga Diocese in Iganga and Mayuge districts) were already supporting community-based programs for reproductive health and trained CRHWs and quality of care monitors as well.

One-hundred and fifty-five CRHWs had received earlier training through the Delivery of Improved Services for Health (DISH) project. However, they received refresher training by both national and district trainers for 12 days, based on the curriculum for CRHWs developed by the Family Life Education Program (FLEP). They were further trained on youth issues using the draft curriculum of peer providers.

One-hundred and twenty-seven quality of care monitors were trained for six days on information gathering for monitoring purposes by district and national trainers. Trainers used the draft "*GAMPE Training Module*," developed by national trainers using the Busoga experience. The module included the following topics:

- Orientation to the training
- Community reproductive health
- Introduction to youth-friendly services
- Why adolescent reproductive health
- Quality of care (QOC)
- Quality of care monitoring
- Duties of ASRH providers (peer and service providers and CRHWs)

- Monitoring youth programs
- Communication
- Providing feedback
- Maintaining records
- Work plans
- How to start QOC monitoring activities in the community

Peer provision

Uganda's outreach program included a number of strategies to reach youth with information and contraceptives, including:

Home visits: Peer providers provided a service in a client's home on appointment. This was usually conducted with close friends in homes where the peer provider was already known. The peer providers provided information on nonsensitive topics such as life skills, abstinence, and STI/HIV prevention strategies. According to a supervisor's report, more sensitive topics were often not addressed in the home visit (reserved for group talks), because elders have a tendency of eavesdropping on peer conversations in an effort to find out the topic of discussion. Peer reports revealed that some elders were suspicious that peer education was sex coaching and they would not allow peer providers near their children. Partner staff then put renewed emphasis on further sensitization activities in an effort to combat this belief.

Group talks: In this strategy, a peer provider mobilizes 8-15 adolescents between the ages of 15 and 19 to discuss a topic of their choice. Activity reports showed that female

adolescents usually met in groups separate from male groups. Only one activity report showed a meeting that included males and females. Ages varied in each group and the topics of discussion included STIs/HIV prevention, pregnancy, alcohol and drug use, and contraception. Minutes of peer quarterly meetings revealed that group talks were commonly held in schools and town youth gatherings.

BCC activities: These were events that drew large crowds of young people for games and entertainment, as well as for dissemination of ASRH information through talks, film shows, and debates. Venues for these activities included marketplaces, schools, churches, play grounds, video halls, and community centers.

Peer providers from different areas and projects sometimes collaborated on the BCC activities and group talks. For example, in Kamwenge, the AYA peer providers worked with UNICEF peer providers, using the same youth centers and work plans.

Monitoring and supervision

Monitoring and supervision of peer providers differed from district to district. In the government facilities supported by UNFPA, peer providers were supervised by the selected health unit's service providers. The peer providers of UYDEL, Busoga Diocese, South Rwenzori, and Kampala City Council were supervised by field supervisors, and had support and supervision as needed from community reproductive health workers and quality of care monitors in Busoga Diocese and South Rwenzori.

Supervision included the activities described below:
- Peer providers completed work plans of their planned activities with the assistance of their supervisors.
- Peer providers met supervisors weekly to submit checklists and forms that showed their performance, receive supplies (i.e., condoms and other commodities for distribution), and discuss any assistance they needed from a supervisor. Peer provider checklists and tools included:
  - A checklist for condom distribution
  - A checklist for pill distribution
  - Clients' register book
  - Home visit forms (see Appendix D)
  - Referral forms
  - BCC activity checklist
- Supervisors provided supportive supervision by visiting work areas during planned peer provider visits. Supervisors observed home visits and group education sessions and interviewed clients to check on the quality of work (see Appendix E).
- Each peer provider submitted an end-of-month report and attended a monthly meeting with other peer providers. The monthly meeting allowed for a regular review of ASRH issues in communities and gave peer providers a chance to share experiences and be mutually supportive. CRHWs also attended these meetings to supplement peer providers' review of the ASRH issues and to plan how CRHW could assist the peer providers.

- Quality of care monitors gave service providers and field supervisors weekly client feedback to develop strategies to improve peer services before crises arose.

Use of mystery clients

Mystery clients were used to assess service provision for peer providers of Mbale, Kabale, UYDEL, KCC, and SRD. With the help of the peer providers, the partner and district officers for the AYA program facilitated the selection of young people to serve as mystery clients. Mystery clients could be male or female and could not be working with the AYA program, in order to be representative of the majority of young people in the community.

Selected mystery clients were trained in the overall purpose of the exercise, the steps involved, and what they would be looking for. The mystery clients were also given the scenarios they would use during the visit, which they discussed and role-played, including responses to questions the service provider or other facility staff might ask them. The following scenarios were presented during the mystery client visits:
- Unwanted pregnancy
- Information regarding contraceptives
- Information regarding STIs
- Counseling regarding premarital intercourse

Mystery clients were instructed to assess and report on the peer provider's friendliness, communication skills, ASRH knowledge, and ability to carry out their roles. Mystery clients were interviewed following their visits with the peer providers using an interview guide (see Appendix F). Results were reviewed by the peer providers and partners and actions were taken to improve any areas that were identified as needing strengthening.

The following section discusses the various evaluation activities (analysis of training data, analysis of client satisfaction data, and trend analysis), including methodology, data limitations, and results.

Analysis of Training Data

Evaluation Methodology

The trainings of peer providers, CRHWs, and quality of care monitors were evaluated using the same methods that were used with service providers (i.e., via pre- and post-tests, daily reviews, observations during practical sessions, and end of training evaluations). Pre- and post-test results were analyzed and average gains calculated.

Data Limitations

A major limitation of the training data is that neither the pre- nor post-tests, nor the end of course evaluations, were translated into local languages, even though many of the peer providers could not read English comfortably. The criteria for selection of peers required them to be able to read and write in their local language, but not English. This may have limited their ability to respond to these forms most effectively.

Results

Peer provider's test scores increased. The average marks gained for each peer provider workshop ranged from 11 to 43 and averaged 23.6, as shown in the table below.

Table 9: Pre- and post-test analysis –Peer Provider Trainings

District	Average		
	Pre-test	Post-test	Gain
Kasese	48	64	16
Kampala	33	48	15
Mayuge	33	54	21
Iganga	34	62	26
Kasese	42	61	19
Kabale	46	82	36
Kaberamaido	28	71	43
Mbale	20	36	16
Kapchorwa	38	49	11
Sironko	25	45	20
Soroti	54	74	20
Kabarole	25	54	29
Kyenjojo	46	72	26
Kamwenge	22	55	33
TOTAL	35	59	23.6

Field supervisors, CRHWs, and quality of care monitors also showed gains in knowledge from pre- to post-test, as shown in the following charts.

Table 10: Pre- and post-test analysis –Field Supervisor Trainings

Partner	Average		
	Pre-test	Post-test	Gain
Iganga, Mayuge	61	76	15
Kampala	60	85	25
TOTAL	60.5	80.5	20.0

Table 11: Pre- and post-test analysis –Community Reproductive Health Worker Trainings

Partner	Average		
	Pre-test	Post-test	Gain
SRD Kasese	35	56	21
Busoga	44	72	28
Busoga	38	59	21
TOTAL	39	62	23

Table 12: Pre- and post-test analysis –Quality of Care Monitor Trainings

Partner	Average		
	Pre-test	Post-test	Gain
SRD Kasese	44	68	24
Busoga	47	72	25
TOTAL	45.5	70	24.5

Generally the average scores (pre- and post-tests) for the peer provider trainings were lowest among all the different categories of service providers, however, they showed a higher average gain compared to the service providers and CRHWs. According to the trainers, the peer providers were introduced to a lot of new information during this workshop (as opposed to the clinic service providers and CRHWs who were refreshing their knowledge on reproductive health and were adding ASRH/YFS information). The information introduced made a bigger difference in the level of knowledge of peer providers at the beginning and at the end of the training workshop. A comparison of the gains made by all trainees is shown in the chart below.

Figure 19: Average Training Scores

<u>**Analysis of Client Satisfaction Data**</u>

Evaluation Methodology

The primary means of assessing client satisfaction was through analysis of mystery client interview forms from Kampala, Mbale, Kasese, and Kabale.

A total of 101 mystery client visits were carried out between April and November 2004. The list below outlines the districts visited, the number of visits in each,[11] and the communities within each district in which the visits occurred:

- Kasese (19): Kiteso, Kahokya, Kuyateka, Malisa, Muhokya, Kinyamaseke, Kitsutsu, and Nyakatunzi
- Kampala (38): Kawaala, Komamboga, Busabaala, Kawempe, Kitebi
- Kabale (19): Rubaga, Katenga, Muko, Bufundi, Kasheregyenji, and Kakoomo
- Mbale (20): Buwundu, Bukokho, Bunatsimi, Bumushikho, Bunamubi, Bumatanda, Bunabutiti and Buchida

The following table shows the breakdown of mystery clients by district, age, and sex.

Table 13: Age group by sex

Age (years)	Kabale			Kampala		Kasese		Mbale		Unknown	
	M	F	UK	M	F	M	F	M	F	M	F
10-14	0	0	0	0	0	0	0	0	0	0	0
15-19	0	1	0	5	9	5	3	4	6	4	1
20-24	2	4	0	19	3	11	0	9	1	0	0
>24	2	2	0	2	0	0	0	0	0	0	0
Unknown	1	4	3	0	0	0	0	0	0	0	0
Totals	*5*	*11*	*3*	*26*	*12*	*16*	*3*	*13*	*7*	*4*	*1*
	19			*38*		*19*		*20*		*5*	

Interview data were analyzed using Excel. Data were analyzed by question and, where differences were seen, by district.

Data Limitations

In addition to the lack of responses on interview forms, a limitation of the mystery client exercise was the use of close ended questions on the mystery client questionnaire, which limited the amount and quality of information gathered. There was a need to use probing questions like, "give reason for your answer," to describe or explain responses and enrich the data gathered. Also, the ranking that was used may have been misleading for some questions. For example, question 13 includes both "satisfactory" and "good" as responses, whereas "satisfactory," "unsatisfactory," and "I don't know" would have been more appropriate responses.

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[11] It is unclear from the forms in which districts five of the visits were conducted.

Results

Mystery Clients

The mystery client visits showed positive results in most of the elements under observation, including locating and talking with peer providers, distribution of contraceptive supplies, provider performance, referral, time spent with provider, and overall satisfaction. The individual results are shown in the following graphs.

Mystery clients had little difficulty in finding and talking with peer providers. Ninety-seven percent found the peer providers easily, 99 percent found the peer providers easy to speak with, 92 percent said they had opportunities to ask questions, and 100 percent felt the peer providers listened to their concerns.

Figure 20: Finding and Talking with Peer Educators
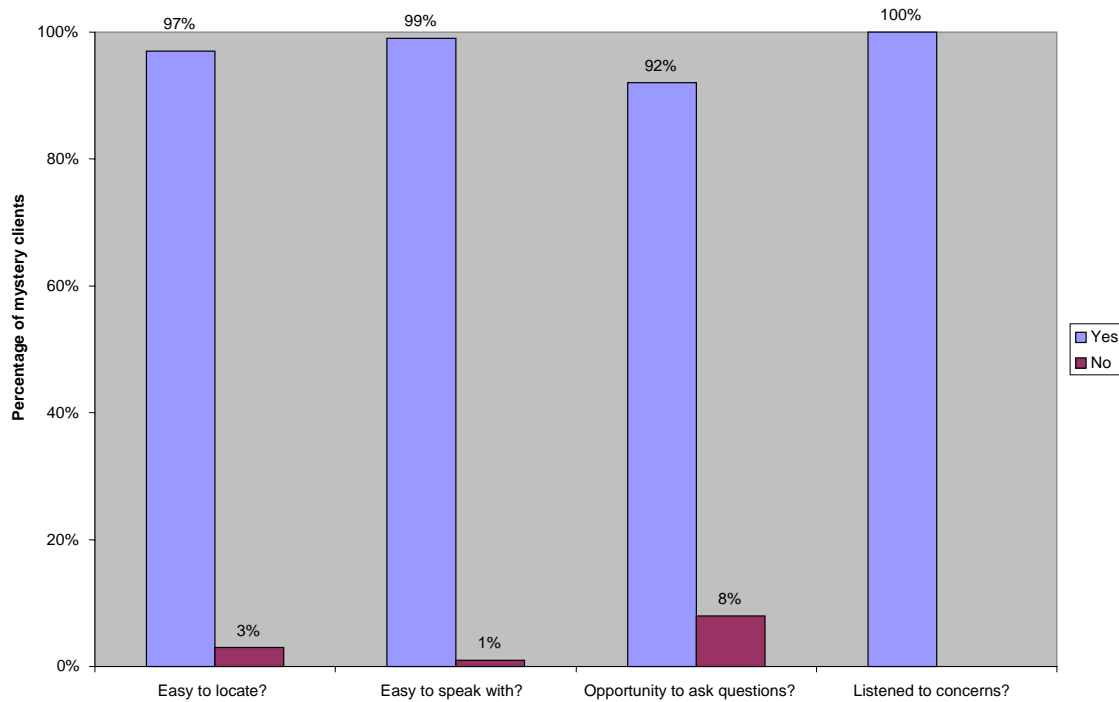
Distribution of supplies was good overall in three districts (Kampala, Mbale, and Kasese). However, almost no Kabale mystery clients received contraceptive supplies. It is difficult to tell whether this was due to peer providers running out of supplies or refusal to provide supplies at client request. Further follow-up of this issue is needed by partner staff.

Figure 21: Contraceptive Supplies Distributed
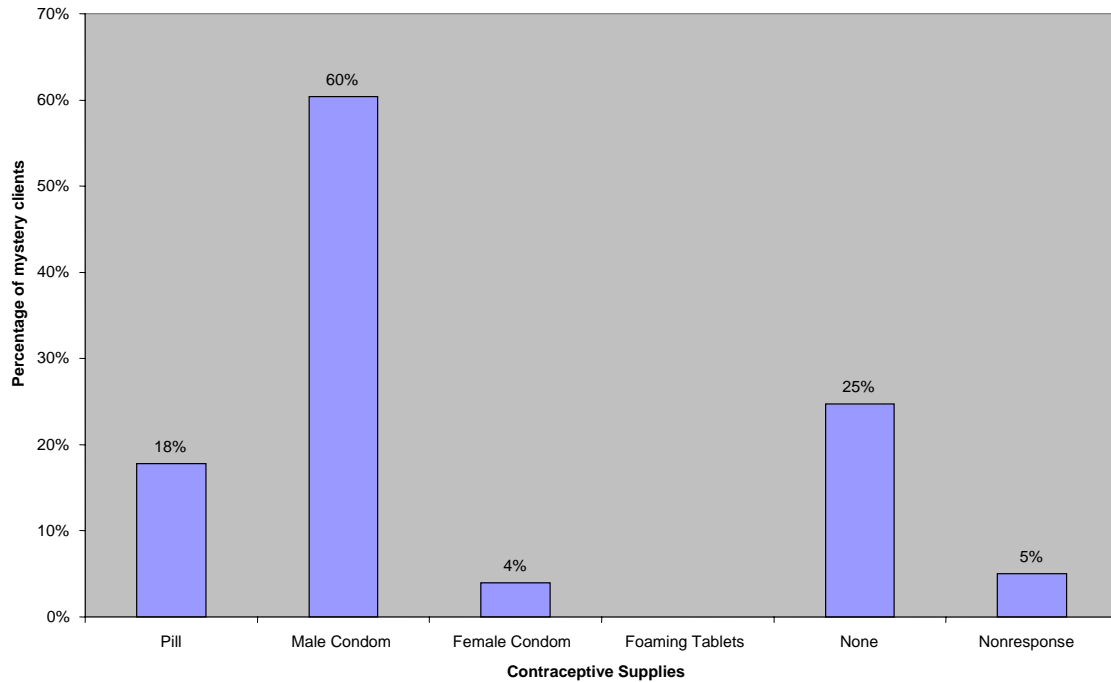
Proper usage and possible side effects were explained to the majority of clients. Only a few of the peer providers did not record the client's details in their register.

Figure 22: Performance of Peer Educator
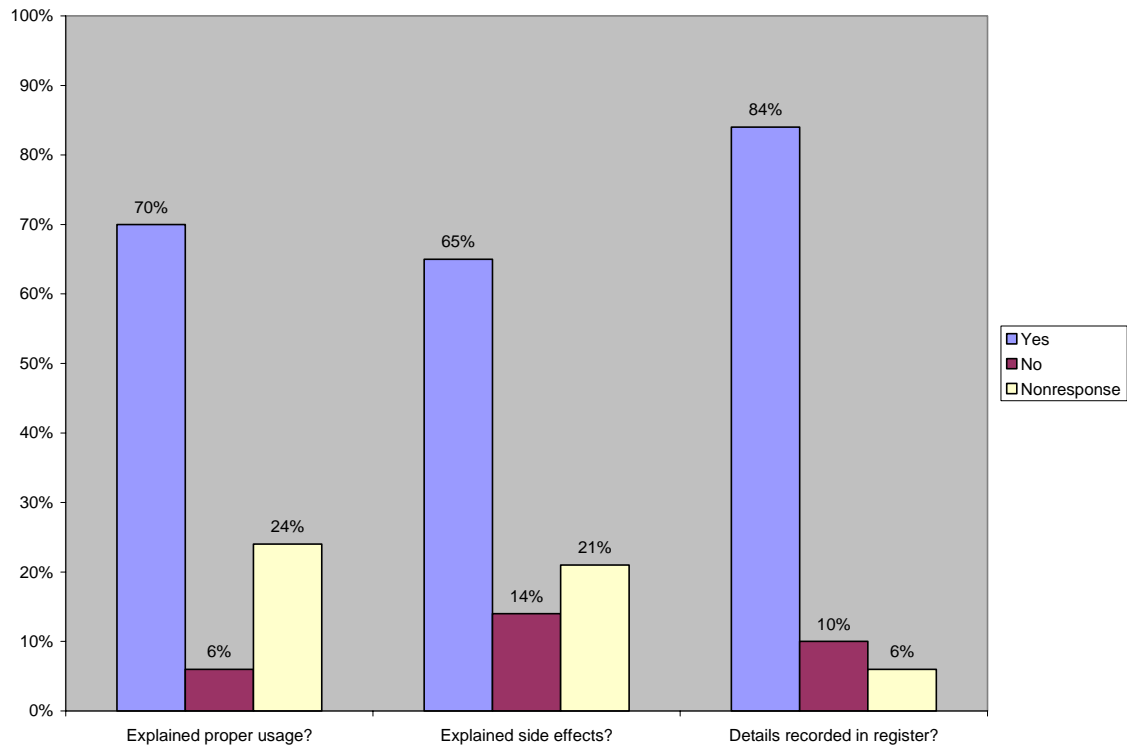
59 percent of clients for whom a referral was made received a referral card. In the cases where a referral was made but no referral card was given, it was not clear whether this was due to lack of referral cards, or if the peer providers had them but did not give them to the youth.

Figure 23: Peer Educator Referrals
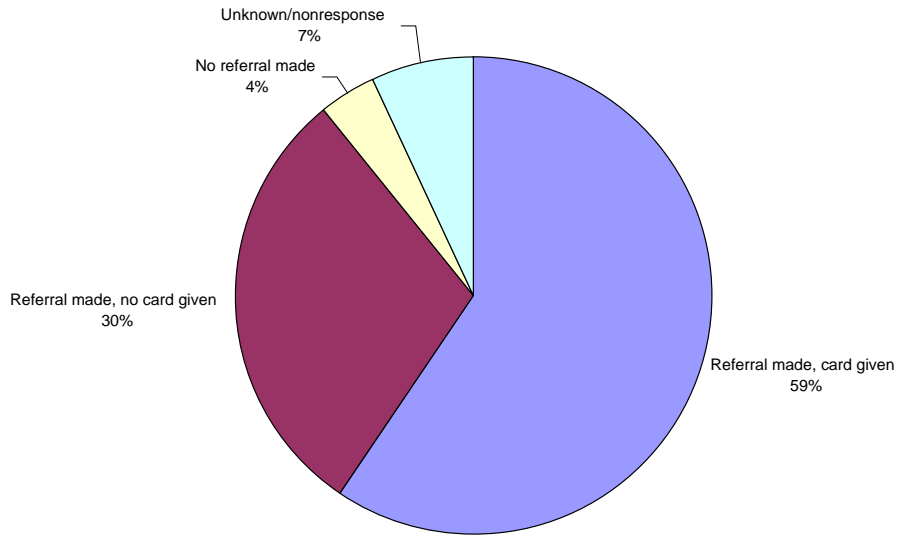
Many clients (71 percent) expressed that the time spent with the peer provider was enough.

Figure 24: Time Spent with Peer Educator
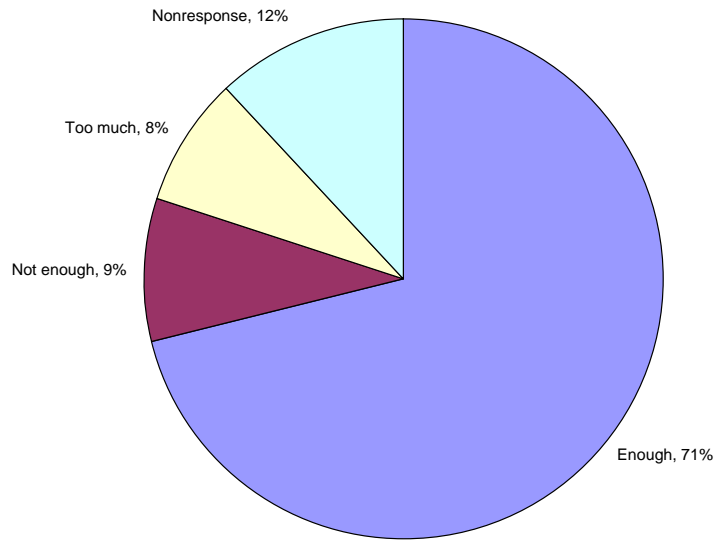
Most clients (90 percent) ranked the visit as good or satisfactory.

Figure 25: Overall Satisfaction with Peer Educator

Nonresponse, 3%   Unhelpful, 7%

Satisfactory, 32%

Good, 58%
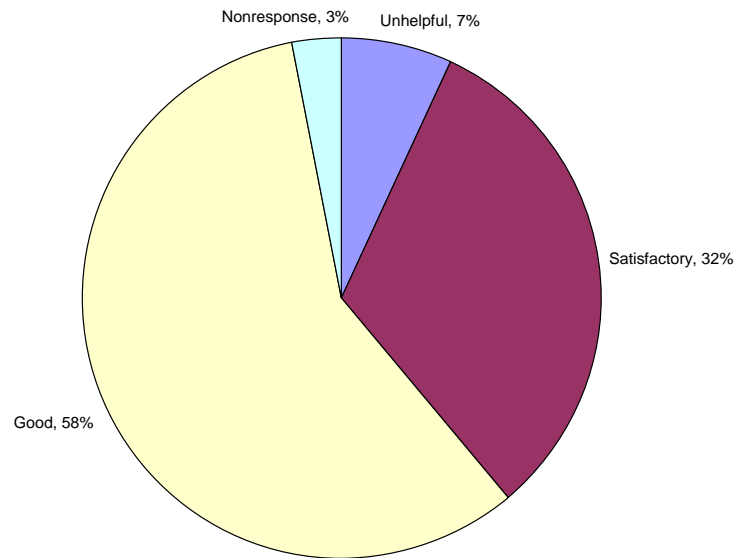
All but one mystery client said they would recommend the peer provider to a friend.

Figure 26: Recommending Peer Educators to Friends
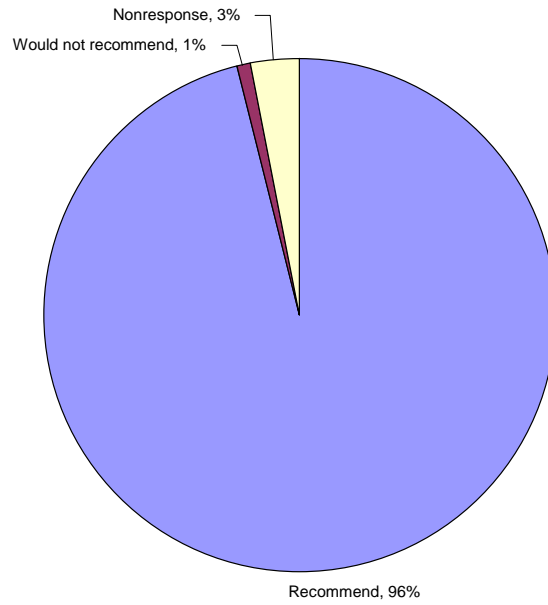
The results of the mystery client visits show that in a majority of cases, the peer providers were easy to locate and talk with, explained and recorded details correctly, referred appropriately, and spent enough time with the mystery client.

Trend Analysis

Evaluation Methodology

Peer service data were cleaned, aggregated, and analyzed in Excel to examine trends from April 2003 to December 2004. As was the case with the facility data, only UYDEL, SRD and KCC data are included in the trend analysis, as Busoga Diocese did not submit data for all of 2004 and district partners did not begin reporting until April 2004.

For the purposes of giving a clear picture of the reach of the project, data have also been aggregated and analyzed for all reporting partners, including those districts that started implementation and data collection after April 2004 (all district partners) or did not have complete data through 2004 (Busoga Diocese). Aggregated data for all partners include total youth visits by age and sex (table 3). Outreach program reports were also reviewed and analyzed for challenges and weaknesses, and to provide supplemental information.

Data Limitations

Outreach monitoring data are not available for all partners for the entire implementation period and specific information on increases and decreases is missing, therefore trend analysis of peer services is limited in some cases below.

In addition, peer providers had a difficult time completing forms. According to supervision reports, peer providers had difficulty adapting to new data formats, requiring a lot of technical assistance and patience. To date there is problem in collecting relevant data, recording it appropriately, and interpreting data meaningfully by the peer providers. This has had significant bearing on the expected monitoring and evaluation output.

Supervisors noted that the peer provider's limited literacy and numeracy hampered their efforts to complete forms. The forms were very crowded with many small boxes to check, making interpretation complicated for peer providers. The record format is in English with lots of abbreviations that the peer providers did not understand. Because many cannot do addition, they had difficulty giving totals in their monthly reports. Consequently, supervisors had difficulty interpreting these data. Despite requests by peer providers and supervisors to fix this problem (by translating the language, reducing abbreviations, enlarging spaces, and eliminating the need for peer providers to calculate), the problem was not resolved by program staff.

Results

As noted above, results are shown both for all partners and for the three partners for whom data can be shown from April 2003 to December 2004.

All Partners

Table 14 below represents the total outreach visits undertaken by young people as captured by all partners during the period January 2003 - December 2004. During this period, a total of 580,771 outreach visits were made by young people.

Table 14: Outreach Visits for all Partners by Age Group – January 2003 - December 2004

Age Group	Male		Female		Total	
	No.	%	No.	%	No.	%
10-14 years	68,172	23.1	71,348	24.9	139,520	24.0
15-19 years	103,947	35.3	104,205	36.5	208,152	35.9
20-24 years	122,562	41.6	110,537	38.6	233,099	40.1
Total	**294,681**	**100**	**286,090**	**100**	**580,771**	**100**

UYDEL, KCC and SRD

As shown in figure 27, a total of 345,232 outreach visits were made by young people to the UYDEL, KCC, and SRD for various SRH information and services. From April to December 2003, a total of 168,855 visits were recorded and from January to December 2004, 176,377 visits were recorded. As shown in figure 9, there was a steady increase of visits in 2003, followed by a sharp decline in early 2004, and fluctuations in total visits throughout 2004. Lack of contraceptive supplies throughout 2004, and particularly in the last quarter, may have affected outreach visits. The primary cause of condom shortage was the recall of the government supplied (no cost) ENGABU condoms. The condoms were withdrawn after complaints that the brand was not good; users complained of tearing and smallness.

Figure 27: UYDEL, KCC and SRD Outreach Visits by Sex April 2003 - December 2004
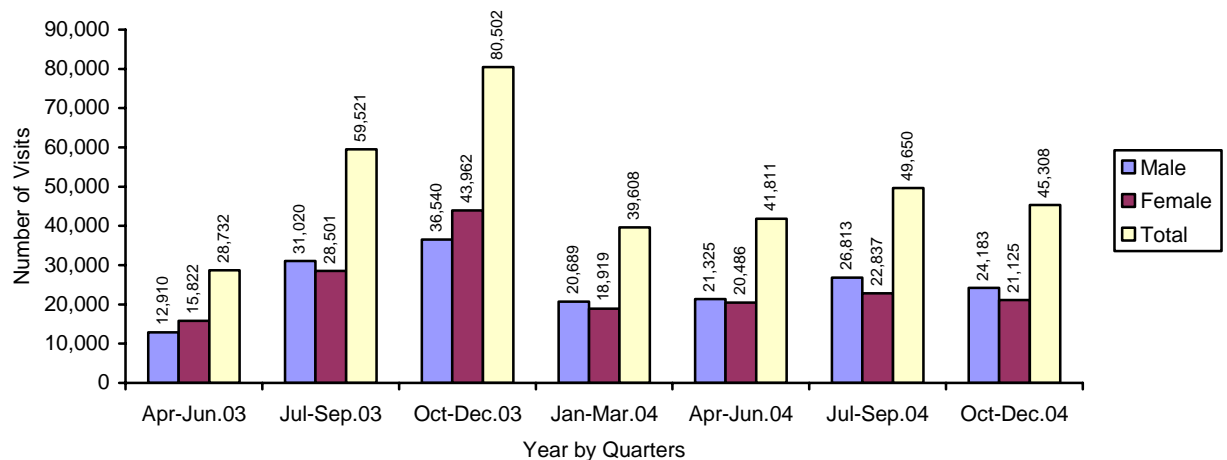
Visits by Age and Sex

As shown in figure 27, visits by young females outnumbered that of young males during the period under review. From April to December 2003, a total of 80,470 (47.7 percent) male visits were recorded, as compared to 88,385 (52.3 percent) female visits. However, from January to December 2004, more male visits were recorded 93,010 (52.7 percent), than female visits 83,367 (47.3 percent).

As shown in figure 28, from April to December 2003, young people within the age group of 20-24 years accounted for the largest percentage (42 percent) of visits to the outreach programs, followed by the age group of 15-19 years (30 percent) and 10-14 years (28 percent). From January to December 2004, the 20-24 age group visits increased to 65 percent of all visits, while the 15-19 age group decreased to 20 percent, and visits by the 10-14 age group decreased to 15 percent.

Figure 28: UYDEL, KCC and SRD Outreach Visits by Age April 2003 - December 2004

56
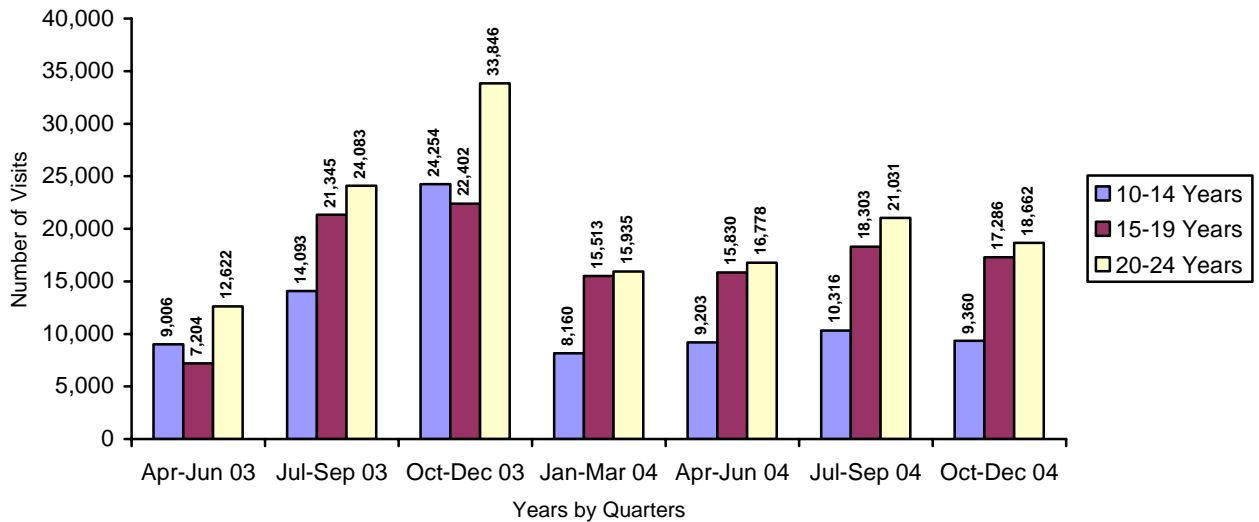
Service Delivery

As was the case with the facilities, the most frequently sought service by youth from peer providers was counseling, followed by family planning (particularly for the male condom).

Family Planning Services

As shown in figure 29, the most common short-term family planning methods for young people were male condoms and pills. From April to December 2003, male condoms and pills accounted for 86 percent and 13 percent of family planning outreach visits respectively. From April to December 2004, male condom visits accounted for 71 percent and the pill for 19 percent of visits.

It should be noted that female condom distribution was lower than anticipated due to scarcity, lack of knowledge, and unpopularity of the method. Also, peers reported being uncomfortable distributing pills, as they required more technical knowledge than male condoms. Therefore, many peers referred clients to clinics to receive methods other than the male condom. Despite the high percentage of condom visits, the lack of supply of male condoms certainly affected the provision of this contraceptive method.

Figure 29: Family Planning Outreach Visits for UYDEL, KCC and SRD
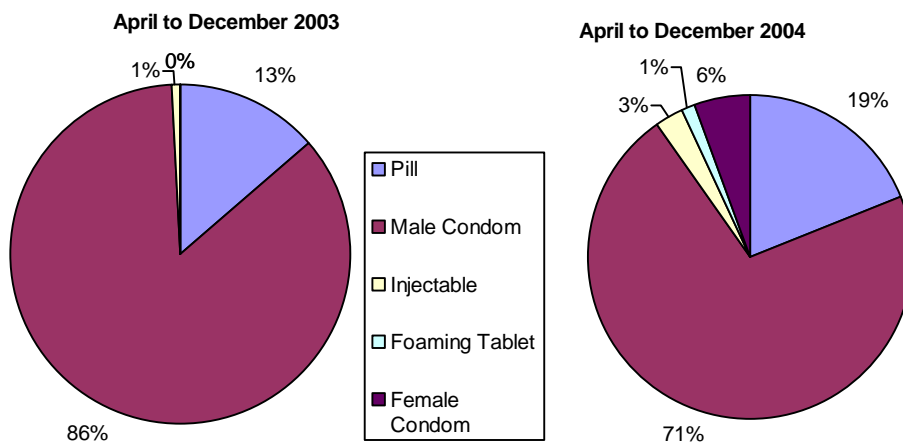
Counseling Services

As shown below, from April to December 2003, 32 percent of young people were given counseling on STI prevention, 16 percent on family planning, and 12 percent on HIV/AIDS and VCT. From April to December 2004, STI counseling increased to 26 percent, HIV/AIDS and VCT to 25 percent, and family planning declined slightly to 13 percent of all visits.

Figure 30: Counseling Outreach Visits for UYDEL, KCC and SRD April -December 2003 and 2004
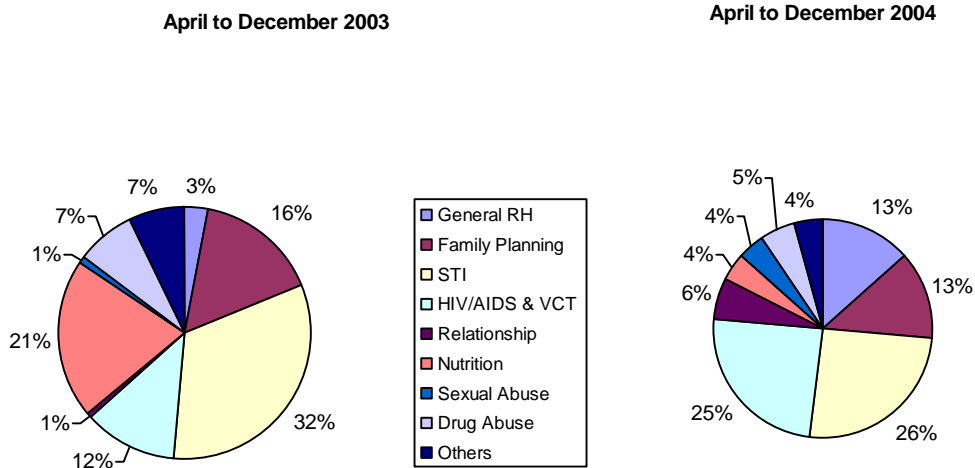
<u>**Analysis of Monitoring Data**</u>

Peer provider and supervisor reports submitted throughout the project were reviewed and analyzed in March 2005 to gather lessons learned from the outreach component.

Results

Lessons learned were identified as follows:

- Though peer providers agreed to serve on a voluntary basis, lack of financial remuneration was often sited as a reason for peer dropout. The economic situation of most youth in Uganda, is reflected in the following quote from a peer provider: "We cannot work without money when we need food, soap, and other essentials."

- Peer providers were chosen because they were considered exemplary figures in their communities, but supervisory reports comment on negative behaviors. For example, a number of female peer providers got pregnant. Unfortunately, this tarnished the peer providers' name and hindered program progress due to community perception of their efforts. However, supervisors could have turned this into an opportunity by having the peer discuss her own experiences with other young people, which may have been more effective in terms of peer education.

- Some trained peer providers were in-school youth, and their return to school created a gap in service delivery in their service areas. The same applied to city youth who abandoned the work to get back to their businesses. This had a big impact on peer education in Kampala.

- Long distances hindered satisfactory mobilization of youth activities. Reports and minutes of quarterly meetings from district programs reveal demands for transport facilitation. "We need transport or else we give up. The parish is very big and mobilization is difficult. We need bicycles." To address this issue, AYA/Pathfinder provided bicycles in certain cases to allow for increased mobilization of peers.

- Clarification of roles and responsibilities of QOC monitors in relation to peer providers and skills building in mentoring and constructive feedback would have helped strengthen relations between the QOC monitors and the peer providers in their community.

- Peer providers sometimes had difficulty in finding suitable and consistent places to carry out their group activities. Peer providers usually encouraged youth in their area to join others in a renowned attractive place like Hamukungu landing site video shed for activities (e.g. debate). Explained one peer provider, "It is also difficult to follow-up with youth in the same meeting places. You have to trace them from different meeting places. Peer education activities are mobile."

- The UYDEL peer outreach program consisted of a unique group of peer providers – Commercial Sex Workers (CSWs) – and therefore had unique service provision. CSWs frequently change locations, therefore as peer providers, they served for a short term, making it necessary to recruit and train replacements. The turnover of peer providers was high, making it difficult for the project to cope with training needs. UYDEL supervisors also reported that their peer providers had the time to mobilize peers for clinical sessions at outposts and also to distribute condoms, but did not have time for documentation. This made it difficult for UYDEL to have accurate data of peer services.

- UYDEL supervisors also reported challenges in the nature of their outposts. They met peer providers and their clients in bars, clients' rooms, and similar informal locations. There were a lot of interruptions from bar patrons and drug users. The environment also hindered the progress of CSWs in adopting nonrisky behaviors.

CONCLUSIONS AND RECOMMENDATIONS

The AYA/Pathfinder intervention improved the youth-friendliness of services in facilities, as evidenced by the changes from baseline to endline facility assessment scores. Monitoring data revealed that involving district officers and area young people in the assessment introduced the AYA program to local communities and promoted a sense of ownership in the activity and the program by the districts. This has been reflected by the active involvement of the district officials in planning for and monitoring improvements in the facilities. Some districts have also expanded YFS to more facilities with funds they have since secured from the Global Fund.

The YFS training of service providers, whether through pre-service or in-service modalities, addressed not only the need for improvement in the quality of care offered by providers to young people throughout the health system; but the training simultaneously served as a tool for advocacy and increased understanding of special reproductive health needs and the barriers to care and education of this population. Pre- and post-tests showed increased scores for all service provider trainings, however, many indicated that more time for the practical during the training would further boost their confidence in their abilities to serve young people in their facilities. In-service and pre-service training efforts resulted in the significant and long-lasting achievement of the development of three curricula (pre-service, ASRH training of trainers, and ASRH service provider) as well as training service providers in all project districts.

Service data showed large numbers of young people accessing reproductive health services demonstrating the popularity of services both for static units and outreach sites. Youth typically seek multiple services at any one visit, with counseling being the most popular service, followed by family planning services, of which male condoms were the most popular. Data analysis confirmed that youth use short-term rather than long-term family planning methods, which accounted for less than 10 percent of all requested family planning methods.

Clients who visited the health units reported satisfaction with services and furthermore felt comfortable to refer a friend to the provider attending them. The assessments of service providers indicated that they were friendly, demonstrated good two-way communication skills, and gave enough time to young people during their visits. Facilities also managed to create privacy for young people during their visits either through separation of space, noise barriers, or other means. However, the use of BCC materials was limited by the providers during the client visits and in the facilities, and is probably due to shortages in supplies.

Training of peer providers was carried out to improve outreach services. These trainings showed the highest increases from pre- to post-test scores among all the categories of training conducted by the national trainers. Client satisfaction, which was evaluated using mystery client interviews, showed that peer providers were found to be friendly and have good communication skills. The peer providers were also found to be effective at distributing supplies, making referrals, and keeping records.

Despite data collection limitations, there was increased interest and effort to improve monitoring systems both of facilities and peers. Additional resources for staff time and supervision could have increased capacity even further in this area.

The following recommendations are made to guide implementation of such programs in the future:

- Youth overwhelmingly demonstrated their interest in receiving reproductive health services throughout the project. Further examination is advisable of what means of promoting services over time are most effective to sustain the number of visits and repeat visits.
- In a project of this size, more staff time and funding should ideally be allocated to supervision. This would have allowed for additional technical assistance and support of service and peer providers on the quality of services as well as for the data collection and analysis to be provided to partners to ensure more effective monitoring.
- Although the demand for YFS increased throughout this project, lack of supplies (e.g., contraceptives, testing kits, etc.) throughout Uganda at various times, including the districts of the project area, did hamper service use for certain sites and districts. National and regional responses within Uganda to improve contraceptive supply systems and their management overall are needed to ensure that projects and other efforts to address adolescent reproductive health needs can indeed reach their objectives.
- Given the risk of HIV/AIDS for youth and the focus on dual protection, further study should be taken up on whether Ugandan youth across all districts are consistently using condoms when sexually active.
- When implementing and funding YFS on a wide geographic scale, the assessment processes, including the facility assessment and action plan, should be efficient and use the least time necessary to obtain quality information and yet keep the integrity and benefits of the participatory processes intact.
- Program processes should be consistently documented to preserve institutional memory when staff members leave.
- Evaluation processes should be built into the program from the outset so that these activities can start sooner, particularly for more effective involvement of all key stakeholders and implementers.

APPENDIX A: YFS Implementing Facilities, by District

Mbale	Kabarole	Kyenjojo	Kaberamaido
Magale Mission HCIV	Kataraka HC	Butiti	Alwa HC III
Bubuto HCIII	Kagote HCII	Kisojo	Kaberamaido
Bupoto HCIII	Bukuuku HCIV	Kyenjojo HCIV	Otuboi HC III
Bumwoni HCIII	Kijura HCIII	Kyegegwa HCIV	Bululu HC III
Bududa Hospital	Mugusu HCIII	Kasule HCIII	Kalaki
Bukigai HCIII	Kasende HC	Mpara HCIII	Kabulubulu
Kamwenge	**Kabale**	**Sironko**	**Soroti** Dakabela HC III
Ntara HCIV	Kakomo HC	Buwalasi HC III	Kamuda HC III
Kicheche HCIII	Kamuganguzi HC	Sironko HC III	Pingire HC III
Mahuyoro HCIII	Rubaya HC	Buwasa HCIV	Kadungulu HC III
Rukunyu HCIV	Kasheregyenyi HC	Butandiga HC III	
Kamwenge HCIV	Muko HC	Budadiri HCIV	
Rwamwanja HCIII	Bufundi HC	Mbaya HCIII	
Kasese	**Kampala**	**Kapchorwa**	**Iganga**
Katwe HCIII	Busabala Rd. Nursing Home	Binyiny	Bulamagi HC
Hamukungu HCII	Kitebi HC	Kaproron HC	Bunyiiro HC
Kahokya HCII	Kawaala HC	Chemwom	Kasolo Methodist
Kinyamaseke HC	Nakulabye Drop in Center	Kapchorwa Hospital	
St. Paul HCIV	Mpererwe Drop in Center	Chema	
Nyamirami HCIII	Kawempe HC	Tegeres	
Kanamba HCIII	Komamboga HC	Tuboboi	
Buhaura HC	Mpererwe		
Mayuge			
Bufulubi HC			
Kyando HC			
Baitambogwe HC			

APPENDIX B: Assessment Scores

Table B.1: Privacy Ensured

DISTRICT	FACILITY	BASELINE	ENDLINE	IMPROVEMENT
Mbale	Bubuto	0	2	2
Kasese	Kinyamaseke	1	1	0
Kampala	Komamboga	0	2	2
Kabale	Kasheregenyi	0	2	2
Mayuge	Bufulubi	0	2	2

Table B.2: Competent Staff

DISTRICT	FACILITY	BASELINE	ENDLINE	IMPROVEMENT
Mbale	Bubuto	0	1	1
Kasese	Kinyamaseke	1	1	0
Kampala	Komamboga	0	2	2
Kabale	Kasheregenyi	1	1	0
Mayuge	Bufulubi	0	1	1

Table B.3: Minimum Package of Services

DISTRICT	FACILITY	BASELINE	ENDLINE	IMPROVEMENT
Mbale	Bubuto	1	1	0
Kasese	Kinyamaseke	1	1	0
Kampala	Komamboga	1	2	1
Kabale	Kasheregenyi	1	1	0
Mayuge	Bufulubi	0	1	1

Table B.4: Peer providers/Counselors Available

DISTRICT	FACILITY	BASELINE	ENDLINE	IMPROVEMENT
Mbale	Bubuto	0	2	2
Kasese	Kinyamaseke	1	2	1
Kampala	Komamboga	0	2	2
Kabale	Kasheregenyi	0	2	2
Mayuge	Bufulubi	0	2	2

Table B.5: Publicity for YFS

DISTRICT	FACILITY	BASELINE	ENDLINE	IMPROVEMENT
Mbale	Bubuto	0	0	0
Kasese	Kinyamaseke	0	2	2
Kampala	Komamboga	0	1	1
Kabale	Kasheregenyi	0	1	1
Mayuge	Bufulubi	0	1	1

APPENDIX C: Numbers Trained

Table C.1: Number of Service Providers Trained by District (2003-2004)

District	Number Trained	
	Male	**Female**
Kasese	8	9
Kampala	3	17
Kabarole, Kasese	3	19
Kyenjojo, Kamwenge	2	19
Kampala	0	10
Kabarole	5	19
Mbale, Sironko, Soroti, Kaberamaido, Kapchorwa	7	22
Kabale, Kamwenge, Kyenjojo, Kabarole	5	19
Mbale, Sironko, Soroti, Kapchorwa	8	15
Iganga, Mayuge	2	10
TOTAL	43	159

Table C.2: Number of Peer Providers Trained by Partner (2003-2004)

Partner	Breakdown	2003	2004
Mbale	Male	---	17
	Female	---	13
	District Total	---	30
Soroti	Male	---	17
	Female	---	13
	District Total	---	30
Kaberamaido	Male	---	20
	Female	---	10
	District Total	---	30
Sironko	Male	---	17
	Female	---	13
	District Total	---	30
Kapchorwa	Male	---	15
	Female	---	15
	District Total	---	30
Kabarole	Male	---	14
	Female	---	14
	District Total	---	28
Kamwenge	Male	---	18
	Female	---	12
	District Total	---	30
Kabale	Male	---	13
	Female	---	17
	District Total	---	30
Kyenjojo	Male	---	21
	Female	---	9
	District Total	---	30
KCC Kampala	Male	75	---
	Female	45	---
	District Total	120	---
South Rwenzori Diocese	Male	33	---
	Female	27	---
	District Total	60	---

Busoga Diocese Iganga	Male	45	---
	Female	18	---
	District Total	63	---
Busoga Diocese Mayuge	Male	33	---
	Female	23	---
	District Total	56	---
UYDEL Kampala	Male	20	20
	Female	20	20
	District Total	40	40
TOTAL FOR UGANDA	Male	206	172
	Female	133	136
	Country Total	**339**	**308**
		647	

Table C.3: Number of Field Supervisors Trained by Partner (2003-2004)

Partner	Breakdown	2003	2004
Busoga Diocese	Male	04	---
	Female	10	---
	District Total	14	---
South Rwenzori Diocese, Kasese	Male	---	8
	Female	---	4
	District Total	---	12
UYDEL Kampala	Male	---	5
	Female	---	5
	District Total	---	10
KCC Kampala	Male	10	---
	Female	10	---
	District Total	20	---
TOTAL FOR UGANDA	Male	14	26
	Female	20	29
	Country Total	**34**	**21**

Table C.4: Number of Community Reproductive Health Workers (CHRWs) Trained by Partner (2003)

Partner	Breakdown	2003
South Rwenzori Diocese, Kasese	Male	32
	Female	27
	District Total	59
Busoga Diocese	Male	30
	Female	66
	District Total	96
TOTAL FOR UGANDA	Male	62
	Female	93
	Country Total	**155**

Table C.5: Number of Quality of Care Monitors Trained by Partner (2003)

Partner	Breakdown	2003
South Rwenzori Diocese	Male	41
	Female	14
	District Total	55
Busoga Diocese	Male	38
	Female	34
	District Total	72
TOTAL FOR UGANDA	Male	19
	Female	48
	Country Total	**127**

APPENDIX D: Kampala Youth in Action (KAYA) Home Visit Form

Date   Zone
Time   Parish
Purpose
LC1 Chairperson
Head of family   Occupation
Number of people

Adolescents/Youths

10-14 years	M	F
15-19 years	M	F
20-24 years	M	F

In-school	M	F
Out of school	M	F

At what level did they drop out?

Give reasons

Salient issues

    a. Target group

    b. Parents

    c. Action Point

APPENDIX E: Monthly Checklist for Observation on Quality of Care Provided by Peer Providers

Name of Peer Provider:

Catchments are   Sub-county   Village

Month   Date

No.	Area for monitoring	Responses		COMMENTS
	Peer Service provider	Yes	No	
1	Targets for youth services			
2	Provides supplies to the youth			
3	Conducts health education talks in the community			
4	Conducts home visits			
5	Refers young people for services			
6	Has good relationship with youth			
7	Readily available			

Comments about peer provider by fellow peers

Comments about peer providers by local leaders

General comments

Name of quality Care monitor

APPENDIX F: Peer Provider Mystery Client Questionnaire

Interviewers Name   Date:

Interviewers Age   Interviewers Sex:

Peer Visited: Location:

Time:

Scenario Enacted:

☐ Unwanted Pregancy

☐ Information Regarding Contraceptives

☐ Information Regarding STI's

☐ Counseling Regarding Premarital Sex

☐ Other

Was the peer provider easy to locate?   Yes   No

Was the peer provider easy to speak with?   Yes   No

Did the peer provider provide you an opportunity to ask questions?   Yes   No

What, if any of the information/basic counseling did the peer provider provide

☐ Sexuality

☐ General RH/FP

☐ STI

☐ HIV/AIDS

☐ Relationship or Family

☐ Nutrition

☐ Abuse/Rape

☐ Drug Abuse

☐ None

☐ Other

What, if any supplies did the peer provider distribute?

- ☐ Pill
- ☐ Male Condom
- ☐ Female Condom
- ☐ Foaming Tablet
- ☐ None

If the supplies were distributed did the peer provider explain proper usage?   Yes   No

If the supplies were distributed did the peer provider explain side effects?   Yes   No

What types of referral did the peer provider make?

- ☐ FP
- ☐ HIV/AIDS & VCT
- ☐ STI
- ☐ ANC
- ☐ PNC
- ☐ PAC
- ☐ Rape/Abuse
- ☐ Drug Abuse
- ☐ None
- ☐ Other, please list

Was a referral card given?   Yes   No

What, if any educational material did the peer provider distribute?

Did the peer provider record your details in a register?   Yes   No

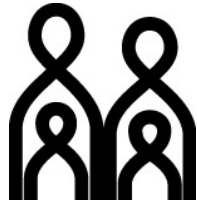Was the time spent with the peer provider: Enough   Not Enough

In general how did you find the visit with the peer provider?

- ☐ Unhelpful
- ☐ Satisfactory
- ☐ Good

Would you recommend a visit with this peer provider to a friend?   Yes   No

If not, please explain why:

Pathfinder International
9 Galen Street, Suite 217
Watertown, MA 02472
U.S.A.
617-924-7200
http://www.pathfind.org