Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF

Synthesis Report

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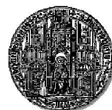
For:

Options

EURO HEALTH GROUP



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All Country Evaluation Reports and In-Country Study Reports are available to download at the following websites:

www.options.co.uk/rl-publictions.htm
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www.ippf.org

FOREWORD

The German Federal Ministry for Economic Co-operation and Development (BMZ), the Danish Ministry of Foreign Affairs, the Netherlands Ministry of Foreign Affairs, the Norwegian Ministry of Foreign Affairs and the UK Department for International Development, together with the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF), collaborated on a critical assessment of the contribution made by UNFPA and IPPF to the promotion of the reproductive rights and health of adolescents and young people since the International Conference on Population and Development (ICPD) in 1994.

This multi-donor initiative is in line with the aim of strengthening partnerships in the area of evaluation, an objective pursued by the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD/DAC) as well as UNFPA and IPPF.

The evaluation took place against the background of increasing recognition within the international community that the reproductive rights and reproductive health needs of young people have become a major issue in the world-wide debate on population and development.

Half of the world population is under the age of 25. In many countries young people still lack access to reproductive health information and services. This is a major factor contributing to the spread of HIV/AIDS. The fact that half of all new HIV/AIDS infections occur among young people aged 15 to 24 highlights the urgency of the matter.

In view of this situation, the main objective of this joint evaluation is to gain a common insight into the key challenges relating to the promotion of the reproductive rights and health of adolescents and young people, based on the experience of two of the major players in this area, UNFPA and IPPF. Ultimately, it should contribute to a better understanding of the conditions required for such work to be a success.

Based on an empirical approach, the evaluation confirms key elements for the success of programmes promoting the reproductive health and rights of young people and draws a number of strategic lessons from UNFPA and IPPF experience derived from the findings of six country evaluations in Africa, Asia and Latin America.

UNFPA and IPPF played a major role at ICPD and the ICPD +5 review. Both organisations strongly influenced the ICPD Programme of Action, which placed reproductive rights and reproductive health at the centre of the population and development agenda. Ten years after ICPD the evaluation confirms that, although progress has been achieved, much remains to be done to respond to the needs of adolescents and young people.

If UNFPA and IPPF are to be able to sustain their commitment to a rights-based approach to population and development, both organisations, whilst important players in the field of reproductive rights and health, need to be supported by increased concerted efforts on the part of the international community to ensure that development programmes involve and reach young people and that the Millennium Development Goal of combating HIV/AIDS is achieved. This, too, is one of the major lessons learned from this evaluation.

We would like to thank everyone who contributed to the evaluation exercise.

The evaluation was undertaken by an international consortium composed of Options Consultancy Services (United Kingdom), Euro Health Group (Denmark) and the University of Heidelberg (Germany). The technical leadership was assumed by Dr Neil Price who also wrote the synthesis report.

The country evaluations were carried out by Alanagh Raikes, Malabika Sarker and Hashima-e-Nasreen (Bangladesh), Meg Braddock, Corinne Grainger and Fiedel Flores (Nicaragua), Olivier Weil, Monique Munz and Lydia Tapsoba (Burkina Faso), Anthony Bondurant, Sophia Henderson and Nguyen Cuong Quoc (Vietnam), Neil Price, Kirstan Hawkins and Mangi Ezekiel (Tanzania) and Tawhida Khalil, Juliette Boog and Rania Salem (Egypt).

The in-country studies implemented in the context of the country evaluations were conducted by the Bangladesh Rural Advancement Committee (BRAC), Guadalupe Canales and her team (Nicaragua), the Centre de Recherche en Santé, CRSN (Burkina Faso), Consultation of Investment in Health Promotion, CIHP (Vietnam), the Institute of Public Health/Muhimbili University College of Health Services (Tanzania), the Population Council (Regional Office of West Asia and North Africa) and Health Care International (Egypt).

The support provided by the UNFPA and IPPF both at headquarters and their country offices was much appreciated.

Our special thanks go to Ilse Worm for her invaluable support to the Steering Group throughout the whole evaluation process.

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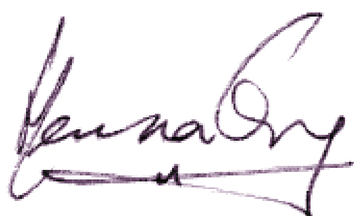

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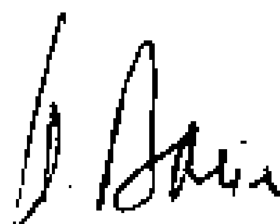

Chairman of the Steering Committee
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ACRONYMS

ABBEF	Association Burkinabè pour le Bien Etre Familial (FPA)
AFHS	Adolescent Friendly Health Services
AHD	Adolescent Health and Development
AIRH	Asia Initiative for Reproductive Health (EC-funded, UNFPA-managed)
AMUNIC	Ministry of Local Government (Nicaragua)
AMREF	African Medical Research Foundation
ARH	Adolescent Reproductive Health
AYA	Africa Youth Alliance
BCC	Behaviour Change Communication
CBD	Community Based Distribution
CBO	Community Based Organisation
CO	Country Office
CP	Country Programme
CST	Country Support Team
CT/L	Country Team/Leader
DAC	Development Assistance Committee (of OECD)
DHS	Demographic and Health Survey
EFPA	Egyptian Family Planning Association
FGC	Female Genital Cutting
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
FLE	Family Life Education
FPA	Family Planning Association
FPAB	Family Planning Association of Bangladesh
HPSP	Health and Population Sector Programme (Bangladesh: SWAp)
HTP	Harmful Traditional Practice
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPPFAR	International Planned Parenthood Federation Africa Region
ILO	International Labour Organisation
JPO	Junior Professional Officer
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MEES	Moral Ethics and Environmental Education
MIS	Management Information System
MOH	Ministry of Health
NCPFC	National Council for Population, Family and Children (Vietnam)
NPO	National Programme Officer
NPPP	National Professional Project Personnel
PDS	Population and Development Strategies (UNFPA sub-programme)
PLA	Participatory Learning for Action
POA	Programme of Action (IPCD)
PROFAMILIA	Asocioación Pro-Bienestar de la Familia Nicaragüense (FPA)
PROMEP	Programme Monitoring and Evaluation Plan (Tanzania)
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
RBM	Results Based Management (or Monitoring)
RCHS	Reproductive and Child Health Section of the MOH Tanzania
RFSU	Association for Sexuality Education of Sweden
RH	Reproductive Health
RHIYA	Reproductive Health Initiative for Youths & Adolescents (phase 2 AIRH)
SDP	Service Delivery Point
SP	Strategic Plan

SRH	Sexual and Reproductive Health
STD/I	Sexually Transmitted Disease/Infection
SWAp	Sector Wide Approach
TGNP	Tanzania Gender Networking Programme
UMATI	Chama Cha Uzazi Na Malezi Bora Tanzania (The Tanzania FPA)
UNDAF	United Nations Development Assistance Framework
UNF	United Nations Foundation
UNFPA CO	United Nations Population Fund Country Office
UNICEF	United Nations Children’s Fund
VCT	HIV Voluntary Counselling and Testing
VETA	Vocational and Education Training Authority (Tanzania)
VINAFPA	Vietnam Family Planning Association
WHO	World Health Organisation
WHR	IPPF Western Hemisphere Region
WPB	Work Programme Budget (IPPF)
YFS	Youth Friendly Services
YIP	Youth Involvement and Participation

EXECUTIVE SUMMARY

Background

The evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people since the 1994 International Conference on Population and Development (ICPD) was sponsored by the German Ministry for Economic Cooperation and Development (BMZ), the Danish Ministry of Foreign Affairs, the United Kingdom Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs. The goal was to contribute to a better understanding of the conditions necessary for achieving good practice, and to draw strategic lessons; the purpose to assess the performance in six countries of UNFPA and the IPPF-affiliates (Family Planning Associations, or FPAs) in promoting the reproductive rights and health of young people since ICPD. The six countries (Bangladesh, Burkina Faso, Egypt, Nicaragua, Tanzania and Vietnam) were selected to represent a diversity of social and cultural contexts, and the existence of significant reproductive health and rights needs, but are not representative of the range of national programmes supported by UNFPA and IPPF.

The evaluation consisted of three main phases: development of the methodology (inception phase); fieldwork for the six country evaluations; and synthesis of good practice and strategic lessons (the output of which is this report).

This summary outlines the evaluation methodology, presents the evaluation's main findings including progress made by UNFPA and IPPF in the six countries in promoting young people's reproductive rights and health since ICPD, and identifies good practice and recommendations.

Evaluation Methodology

In-depth field-based country evaluations commenced in Tanzania in March 2003, with the other five taking place in May/June 2003. Country evaluations were in two stages. During the first stage, national counterpart organisations undertook three small-scale studies of the legal status of young people with regard to reproductive health and rights; the range and availability of information, education and behaviour change communication materials produced/supported by UNFPA and the FPA; and young people's perceptions on access and quality of information and services (using focus group discussions). The second stage involved a three-person evaluation team (two international members and one national) undertaking a three-week visit to each country. The methodology developed for these individual country studies consisted of a country-adapted evaluation framework, a checklist of essential documentation and secondary data sources, a list of primary and secondary stakeholders to consult, and a structure/format for country reports. The country evaluation frameworks focused on six key issues: country and programme context, strategic focus, institutional capacity and arrangements, policy development and reform, reproductive health services, and information. Each country evaluation began with a participatory stakeholder workshop. A wide range of stakeholders was subsequently consulted, and field-visits were made to a range of UNFPA and IPPF supported programme sites in urban and rural areas. Both elements of the in-country evaluations drew on a range of qualitative methods (participatory workshops, site observations, informal and semi-structured interviews, and group discussions).

Progress in Promoting the Reproductive Rights and Health of Young People

The country evaluations adopted the ICPD Programme of Action (POA) definitions of reproductive health and reproductive rights: the former defined as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". Reproductive rights "…rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and the means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence". The POA asserts that freedom from discrimination based on gender is a key component of reproductive rights.

Contextual and Strategic Focus

The strategic focus of both agencies in most of the countries has shifted significantly since ICPD in 1994, from a demographic focus to one based on addressing reproductive health. However, the differential effects of resource and institutional constraints, as well as political and cultural sensitivities, mean that the extent to which the country programmes have been able to implement or support large-scale initiatives focused on meeting young people's reproductive rights and health needs has varied significantly.

UNFPA:

- All the Country Programmes (CPs) articulate the priority socio-cultural, religious and political factors that impact on the reproductive rights and health of young people within their respective countries. However, in some countries (Tanzania, Bangladesh and Egypt) ability to address strategically these factors is constrained by limited financial resources, absence of data for planning and strategy development, lack of capacity within government implementing agencies, and a lack of CO staff expertise and experience in young people's reproductive health and rights programming. Political and cultural sensitivities in Bangladesh, Egypt and Tanzania also seem to be mitigating factors, although the Vietnam and Nicaragua CPs operate respectively in politically and culturally constraining contexts, but have nevertheless been able to translate awareness and articulation of the priority factors into focused programme interventions. Where high profile socio-cultural research has been conducted (or supported) by UNFPA, a more strategic approach to dealing with the priority issues is evidenced.
- The CPs demonstrate variable levels of recognition and responsiveness to the range and diversity of reproductive rights and health needs of young people. While most CPs demonstrate interventions differentiated by one or more of age, marital status, in-school/out-of-school, and urban/rural, few focus strategically on young males or the poorest and most marginalised. Nicaragua and Vietnam have gone furthest in articulating diversity in their programmes. The priority challenge with regard to diversity is the paucity of efforts directed towards addressing the needs of young males.
- Only Nicaragua of the six UNFPA Country Offices evaluated, demonstrated a clearly articulated definition of young people's reproductive rights that had been translated into effective programming. Articulation of strategies to address the reproductive rights of young people has been constrained by the sensitivities surrounding reproductive and sexual rights in general, and especially as they relate to young unmarried people.
- Likewise, while there has been good progress in most CPs in articulating gender as a cross-cutting issue, there is poor understanding of strategic gender issues in many of UNFPA's partners. In a number of country programmes, gender remains primarily articulated in terms of meeting women's reproductive health and rights needs.

FPAs:

- FPA Strategic Plans and Work Programmes are on the whole rooted in a clear and careful analysis and articulation of the factors that influence young people's reproductive health in their respective countries and the priority areas for intervention. In some FPAs, ability to implement interventions focused on the priority issues is constrained by lack of capacity, and financial constraints.
- While the FPAs recognise the range and diversity of needs of young people, only a few programmes show responsiveness to this diversity. FPA strategies and programmes refer to the heterogeneous nature of young people, but the operational response by many reflects a strongly homogenous approach. Most FPAs have differentiated interventions focused around in and out of school youth, but the needs of different age groups, married/unmarried, urban/rural, young males, and particularly the poorest and most marginal groups are given little attention. Notable exceptions are Chama Cha Uzazi Na Malezi Bora Tanzania (UMATI) in Tanzania, and Association Burkinabè pour le Bien Etre Familial (ABBEF) in Burkina Faso, although both face resource constraints to coverage.
- Few of the FPAs evaluated could be said to have adopted rights-based programming. In their country contexts, most FPAs lacked clearly articulated, culturally-specific definitions of young people's reproductive rights, which in part stems from local sensitivities towards legitimising sexual relationships between young unmarried people. FPAs which were able to provide definitions, did so on the basis of IPPF's Charter on Reproductive and Sexual Rights (Vision 2000) in terms of the rights of the client. In Nicaragua the dependence of the Asocioación Pro-Bienestar de la Familia Nicaragüense (PROFAMILIA) on USAID funding has severely compromised its ability to work within a rights framework.
- There is a lack of gender-sensitivity within the FPAs. Equating gender with meeting women's reproductive health and rights needs is also common, especially in relation to service delivery. Young women continue to be the main focus of attention and the specific and different needs of young men are not strategically addressed by most of the FPAs, although PROFAMILIA and UMATI demonstrate carefully considered gender approaches and an increasing institutional sensitivity to gender issues.

Institutional Capacity and Arrangements

The evaluation took cognisance of the contrasting roles played by UNFPA and the FPA at country level. While the FPA is an implementing agency, UNFPA does not implement its Country Programme directly (except for procurement of commodities and equipment), but through government, UN and civil society partners. The primary focus of the UNFPA Country Programme is to strengthen government capacity for direct execution of its programmes. The FPAs are non-governmental, which should entail *inter alia* supporting government in geographical and programme areas where it is unable or unwilling to work, and advocacy for policy and legislative changes. Both agencies in the six countries are constrained institutionally, although in contrasting ways.

UNFPA:

- Most of the COs demonstrate an adequate level of competence and expertise to provide high quality technical support in young people's reproductive health and rights, although many lacked skills in gender analysis. The more effective COs – Nicaragua, Vietnam and Burkina Faso – have experienced national staff with appropriate social science training, and a commitment to in-house capacity-building through in-service training and consultancy support.

- The COs all had very similar shortcomings in monitoring and evaluation (M&E), but showed commitment to improving these systems with the adoption of baseline surveys and LogFrames, as part of a shift to results-based management. To date most projects and subprogrammes have not been adequately evaluated, monitoring has been at best output-focused, and consequently there is a paucity of data for lesson learning, sharing of best practice, results-based management, and evidence-based planning.
- The six country evaluations show enormous variation in terms of the quality and appropriateness of the technical assistance (TA) and support in young people's reproductive health and rights received from the Country Support Teams (CSTs). This has been exacerbated during the recent years with streamlining and staff cutbacks in CSTs.
- No young people are employed in any of the UNFPA COs (except for international Junior Professional Officers). Within the CPs, young people's participation at project level is evidenced, but there are few mechanisms for young people's participation in planning and decision-making, and the concept of young people's participation is not clearly understood within many COs or their major partners in government.
- The effectiveness of UNFPA's partnerships varies across and within the six countries. In most countries UNFPA has played a key role in UN reform (notably the United Nations Development Assistance Framework). Collaboration with other UN agencies working on young people's reproductive health issues, either directly in UN forums or through donor health committees, is on the whole effective, except in Nicaragua where there is evidence of duplication and lack of complementarity. With the exception of Bangladesh and Burkina Faso, UNFPA has chosen not to develop significant implementing partnerships with civil society, primarily it seems as a strategy to avoid prejudicing its close relationship with government (although UNFPA Vietnam works closely with quasi-governmental organisations).
- In all countries where there is a health sector-wide approach (SWAp), UNFPA has elected to continue with parallel funding, rather than basket funding. Some bilateral partners see this as limiting UNFPA's ability to exercise influence and leadership on reproductive health issues. Failure to adopt a more experience-sharing and lesson-learning position has limited UNFPA's ability to shape key agendas and to bring the reproductive health and rights of young people to prominence.
- Country Programmes have seen an increasing dependence upon non-core funding, forcing them to seek additional multi-bilateral funds in the form of discrete time-bound projects with concomitant short-term objectives. This has undermined sustainability efforts. Furthermore, while Vietnam and Nicaragua have demonstrated notable achievements in incorporating UNFPA-funded activities into the regular budgets and programmes of government partners, the others have been less successful, due to inadequate attention to hand-over strategies with government partners, insufficient involvement of partners in the planning and design of CPs, and a lack of "ownership" by partners of activities, projects and subprogrammes.

FPAs:

- In those FPAs where young people's reproductive health is a relatively new area of work there are serious human resource constraints to taking this work forward. In others (such as UMATI in Tanzania), human resource constraints have eroded much of their expertise and leadership in young people's reproductive health in recent years.
- All FPAs (with the exception of ABBEF) have serious deficiencies in their M&E systems and lack capacity and strategic vision with regard to lesson learning and sharing of best practice. Deficiencies have been exacerbated recently by human resource constraints that have led to many FPAs abolishing or downsizing their M&E units.

- Technical assistance and capacity development support from IPPF Regional Offices have been inadequate in all the countries evaluated. Many of the IPPF Regional Offices are in transition and undergoing reorganisation, focused on redefining their roles and objectives.
- While mechanisms for young people's participation have tended to be established at project level, they are not institutionalised throughout any of the FPAs' policy-making volunteer structures. There is a general perception that young people lack the capacity to participate effectively in decision-making, despite contrary recommendations in IPPF's Constitution.
- Some FPAs have failed to develop effective and strategic partnerships and alliances with other civil society groups. UMATI and the Vietnam Family Planning Association (VINAFPA) are notable exceptions (although VINAFPA's partnerships are primarily with quasi-governmental mass organisations). In some cases, the FPAs' relationships with government are too close to be effective with regards to advocacy (eg PROFAMILIA and VINAFPA). Others (UMATI and ABBEF) have formed more effective and appropriate (albeit small-scale) partnerships with government, in which they are able to share best practices and provide training.
- IPPF affiliates have experienced significant decline in core IPPF funding. The consequent dependence upon time-bound projectised funds has clearly affected sustainability strategies, as well as programming and staffing levels. FPAs have large numbers of staff posts unfilled, and have effectively been driven into subcontracting arrangements within larger donor-funded regional or national programmes, and/or the introduction of user fees in an attempt at cost-recovery (with the consequent effects of reducing access to the poorest).

UNFPA-FPA Complementarity, Coherence and Cooperation:

- The overall assessment from the six country evaluations is that there are some good examples of collaborative activities, especially in Bangladesh and Vietnam where projects like the EU-funded Reproductive Health Initiative for Youth and Adolescents (RHIYA) encourage and facilitate such collaboration. Complementarity seems to be more the result of the contrasting nature and remit of the two agencies than strategically planned. Coordination and communication is generally poor (except where UNFPA is funding a FPA); consequently there is little sharing of lessons and best practice.

Policy Development and Reform

Both agencies at country level recognise the need for reform of legislation and policies affecting the reproductive health and rights of young people. Although all national programmes have established advocacy and policy reform objectives, there is considerable variation in the extent to which they have been able to make demonstrable contributions to policy and legislative reforms, specifically in relation to young people's reproductive health and rights.

UNFPA:

- The Tanzania, Egypt and Bangladesh CPs have limited focus on policy and advocacy related to young people: political and cultural constraints, absence of rights-based approaches, limited resources allocated to advocacy work, and paucity of strategic partnerships with civil society have all undermined policy and advocacy efforts at national level in these countries. However where significant (and appropriate) resources have been allocated to advocacy and policy work (Nicaragua, Vietnam and Burkina Faso) and high-profile research into young people's reproductive rights and health needs have been supported by UNFPA, there has been valuable impact on

policy and legislative reform and an increase in public awareness of young people's reproductive health and rights issues.

FPAs:

- Given their mandates, and IPPF's Mission, it was anticipated that FPAs would be at the cutting-edge of advocacy for policy and legislative reform on behalf of young people. However, most of the FPAs evaluated are devoting very little resources or attention to advocacy and policy. UMATI is the one clear exception – having a clearly articulated strategy for advocacy on young people's reproductive health and rights issues, but limited resource availability and allocation means that its work, while pioneering, is not having as much impact as it could. ABBEF is also engaged in important policy reform initiatives. It is difficult to elicit explanations for the lack of advocacy efforts beyond the locally-specific: for instance VINAFPA is constrained by its proximity to government, and PROFAMILIA is shackled by its dependence upon USAID.

<u>Reproductive Health Services and Information</u>

The relative emphasis within the country programmes of both agencies on the development of youth-friendly reproductive health services varies significantly. Constraints to the development and implementation of services for young people are evidenced. While the national programmes of UNFPA and the FPAs have for some time relied upon rather conventional Information, Education and Communication (IEC) approaches, there is evidence in some of the country case studies that they are beginning to shift towards youth-focused Behaviour Change Communication (BCC) initiatives. However, and for contrasting reasons, neither agency has been able to scale-up innovative BCC work in their national programmes.

UNFPA:

- All the CPs allocate well over half of their budgets to reproductive health services and IEC. In terms of allocation specifically to young people's services and IEC, there is significant variation (under 10% of total budget in Bangladesh, over 20% in Nicaragua, and 33% *proposed* in the next Egypt country programme).
- Poor understanding and application of gender in many of the UNFPA CPs has led to the equating of gender-sensitive reproductive health service and information issues with meeting young women's needs, to limited attention to the reproductive health needs of men and to the role of men in determining women's access to services and information.
- Reproductive rights are – in line with ICPD – equated with the right to reproductive health services and information. Nicaragua is the most successful in terms of integrating a rights-based approach to the delivery of services and IEC. In Bangladesh and Egypt, social conservatism severely constrains access to reproductive health services for unmarried people, and similar obstacles are evident to varying degrees in the other countries, and for specific ethnic groups (eg the Mossi in Burkina Faso). More strategic partnerships with NGOs, social marketing groups or the private sector may warrant exploration in these settings.
- Most of the CPs (with the exception of Nicaragua) have made little significant contribution to promoting accessible and quality services and information for young people. Ministry of Health (MOH) institutional structures do not lend themselves to participation in service delivery design, and there are no examples of young people participating in the design of services in the six CPs. In those countries where there is a range of organisations supporting youth friendly services and youth IEC/BCC materials and interventions, UNFPA seems to have missed opportunities for collaboration,

experience-exchange, and lesson-learning. This is probably at its most stark in relation to IEC materials, where little has been done by UNFPA within its CPs to coordinate or lead on either the development of a coherent national IEC strategy or on the collation and centralisation of IEC materials.

FPAs:

- The FPAs allocate most of their programme budgets to reproductive health services and IEC/BCC. However, many continue to devote only a small proportion of their programme budgets specifically to young people's services and IEC/BCC.
- Gender and rights are not well-incorporated into the FPA strategies for the delivery of reproductive health services and information to young people, and the extent to which the FPA IEC/BCC materials and approaches address priority rights issues is disappointing. PROFAMILIA has shown that appropriate TA and institutional commitment can facilitate the development of rights-based IEC. FPA service delivery remains overly focused on meeting women's reproductive health needs, and lacks strategies to address effectively the needs of young men. Where innovative rights and gender-based IEC and service projects are successfully piloted (eg UMATI), lack of human and financial resources and capacity for lesson learning and dissemination of best practice, hamper efforts to scale up.
- Only UMATI and ABBEF have developed and are implementing youth-friendly services. ABBEF has just four (exclusively urban-based) centres, while UMATI has experienced significant constraints to implementation of its youth-friendly service strategy, and is faced with the challenge of how to reorient its core clinics (which currently focus on adults) to reach young people as their primary clients. The Family Planning Association of Bangladesh (FPAB) has started youth friendly services, but clinic staff have not been adequately trained, and young people are charged for services. The Egyptian Family Planning Association (EFPA) and PROFAMILIA in Nicaragua also charge for services but do not provide youth-friendly services, aiming to attract young people through adult clinics. Levying service user fees for young people by these three FPAs, with little or no effort to vary fees based on ability to pay, is undermining objectives aimed at increasing access to and utilisation of reproductive health services by young people.
- The FPA IEC materials and strategies are generally poor. In Burkina Faso and Egypt, materials are only accessible to educated youth. In Nicaragua, Vietnam and Egypt the emphasis is on didactic information. In Bangladesh, FPAB programme sites lack IEC materials, and one-stop educational sessions run by youth organisers are inadequate. Only Tanzania (UMATI) has made a serious shift from conventional IEC to innovative BCC initiatives, but resource constraints mean that it has been unable to scale-up this work.

Conclusions and Good Practice

The progress of the UNFPA Country Offices and the IPPF-affiliated Family Planning Associations since ICPD in promoting the reproductive rights and health of young people has been limited in the six countries. There is a paucity of successful interventions or strategies that have gone to scale and been widely disseminated. However, a number of examples of good practice with potential for wider influence and lesson learning have been identified in relation to youth friendly services, advocacy for policy reform, capacity-building and development of effective partnerships. Monitoring and evaluation, lesson learning, cultural and contextual sensitivity, and addressing vulnerability, represent areas of programming where there remains a dearth of evidence of good practice.

- Young people's vulnerability to poor reproductive health is conceptualised in many of the programmes evaluated in over-generalised and sometimes stereotypical terms. Many programmes for instance continue to address diversity of needs on the basis of approaches differentiated by focus on in and out of school youth (with in-school youth seen as less vulnerable compared to out-of school youth who are regarded as highly sexually-active and prone to 'anti-social' behaviour). Overall, the programmes of both agencies are neglecting the distinct vulnerabilities of *inter alia* young males, the unmarried, specific ethnic groups, and the poor.

- The limited capacity of government to implement effective reproductive health and rights programmes for young people through the educational and health sectors is evident from the evaluation. Some of the FPAs, who have taken a lead in small-scale pilot approaches, are grappling with how to scale-up in a sustainable way where there is little or no government commitment, and declining core IPPF funding. With a few exceptions, UNFPA at country-level has devoted inadequate attention to building the capacity of its government partners.

- The UNFPA COs and FPAs recognise that poverty, lack of educational and employment opportunities, gender inequalities, harmful traditional practices, and inadequate protection of rights combine to bring about contexts in which young people experience poor reproductive health outcomes. Despite the increasing recognition that partnerships with and between health, education, social welfare, sport, arts and culture etc is essential, the country evaluations show that the health (and to a lesser extent) education sectors remain the main partners for UNFPA and the FPAs in their work on reproductive health and rights. UNFPA's support in Nicaragua for municipal youth clubs (and in Vietnam for youth clubs at commune level through the Youth Union) has proven to be an effective multisectoral approach to supporting behaviour change and meeting young people's reproductive health and rights needs.

- Limited attention to monitoring and evaluation has been highlighted. Inadequate monitoring in some countries appears to be leading to widely-varying quality of care, and lack of standardised approaches to key policy issues such as paying for services and client confidentiality (as illustrated by Vietnam). The most effective examples of good practice are those which serve as models, and as a result of dissemination are scaled-up and/or adopted and adapted by other agencies. However, such good practice needs to be evidence-based and the absence of effective M&E clearly undermines this.

- A critical problem in making public sector health services youth-friendly and addressing key reproductive rights issues as they affect young people, is the existence of restrictive laws and policies. UNFPA's proximity to government would appear to partly explain the lack of a significant contribution to legislative and policy reform in some of the countries evaluated, although the UNFPA programmes in Nicaragua, Vietnam and Burkina Faso

have made notable progress in their work on legislative and policy reform. However, only UMATI and ABBEF of the six FPAs have chosen to engage in advocacy work for young people's reproductive rights. Young people's participation in FPA programmes seems to be linked to successful advocacy for young people's rights.

- Support to ministries of health in the development of service delivery protocols and standards for the provision of reproductive health services to young people - an important strategy for improving quality and access - is evidenced in a number of UNFPA and FPA national programmes. However, these reforms need to be accompanied by an increase in the number of public sector service delivery outlets providing youth-friendly services, which has not been the case in most of the countries.

- Efforts to strengthen and/or develop youth-friendly services and to advocate successfully for policy and legislative reform require political support. The evaluation recognises that building such political support is a necessarily slow process, constrained by cultural sensitivities. Despite such constraints, UNFPA in Vietnam and Nicaragua – who operate respectively in politically and culturally constraining contexts - have been able to translate awareness and articulation of priority issues around young people's reproductive health into successfully focused programme interventions, as indeed has the Burkina Faso UNFPA programme. UNFPA support for high-profile and widely disseminated socio-cultural research into the issues facing young people's reproductive health and rights not only provides the evidence-base for programme design, but raises public (especially government) awareness and goes some way to facilitating work within otherwise constraining political and cultural milieu. The FPAs, with some notable exceptions (FPAB's work with the Islamic Research Cell for instance), have been largely ineffective when it comes to working with and addressing political and cultural sensitivities.

- Progress with the development and implementation of youth friendly services has been slow in most of the six country evaluations. However, the Nicaragua UNFPA programme has supported the public health system in piloting and subsequently scaling up youth friendly services; while small-scale initiatives by UMATI in Tanzania and ABBEF in Burkina Faso have demonstrated service characteristics that are youth friendly. Systemic weaknesses in public sector health services constrain and limit the effective integration of youth friendly services into these services. The Nicaragua case, however, also demonstrates the importance of closely linking youth-focused IEC/BCC approaches to service delivery.

- A key component of any effective approach to the delivery of youth friendly services is the provision of information, education and behaviour change communication. The quality of IEC/BCC materials and strategies in the six countries is generally poor; and, with the exception of the UMATI programme and a small-scale NGO initiative supported by UNFPA also in Tanzania, there has been persistent use of conventional didactic IEC approaches which focus on providing information, with little attempt to address risk perception and other barriers to behaviour change. Behaviour change communication is seen as synonymous with IEC, reflected in both the dominant IEC medium (the written word) and the language and messages adopted. While young people appear to have high information levels, they are not being equipped with the ability to translate this information into behaviour that will safeguard their reproductive and sexual health. In the context of established or emerging HIV/AIDS epidemics in the six countries, this shortcoming has serious implications for the current generation of young people.

- There has been a notable lack of effective integration of reproductive health and HIV/AIDS programmes to date in much of the developing world, and there was limited

evidence of effective partnerships between youth-related and HIV/AIDS-related projects in the six countries. HIV/AIDS control is enhanced by investments in young people's reproductive health; but UNFPA and the FPAs are not capitalising on HIV/AIDS funding which would *inter alia* provide more resources for condom promotion, STI treatment, and BCC for young people.

Recommendations

Given the range and diversity of strengths and weaknesses, and successes and failures, raised by the six country evaluations, the recommendations below are those which emerge as the most common across the countries and agencies. It has not been possible within the constraints of the evaluation to assess the resource implications of implementing and sustaining these recommendations. Furthermore, as the sample of countries was not selected to be representative of UNFPA and IPPF globally, the recommendations cannot be generalised beyond the six countries. Generalisation will thus require a broader analysis of the global operations of the two agencies.

UNFPA

- *Strategically addressing diversity of needs:* Greater effort needs to be made to translate awareness of diversity of needs into programme strategies that target marginal and vulnerable young people like young males, sex workers, street youth, and ethnic minorities.
- *Rights-based programming*: UNFPA Country Offices and their implementing agencies need a clearer understanding of the scope and implications of existing government commitments to human (and specifically reproductive) rights, and how to operationalise those rights. The latter requires a firmer commitment to working with civil society, eg in the form of NGOs as implementing partners especially in support of advocacy and policy/legislative reform efforts.
- *Gender:* Country Programmes need a strengthened framework for analysis of, and more strategic focus on, gender issues as they affect young people's reproductive health and rights. Greater efforts are needed to increase government partners' strategic understanding of gender issues in young people's reproductive health programmes.
- *Participation and empowerment of young people*: All the CPs need a more strategic focus on empowering young people. Mechanisms should be developed to facilitate young people's participation in the planning and design of CP component projects related to young people. Such a shift in approach will require *inter alia* greater understanding among CO staff and government partners of issues around young people's participation. UNFPA should be leading the way in explicitly demonstrating the value to government of youth participation.
- *Monitoring and evaluation*: There have been promising attempts to improve M&E. However much needs to be done, including more technical assistance to the CPs, to improve systems for, and to develop a culture of, lesson learning and best practice identification and sharing.
- *Support from UNFPA HQ and CSTs*: It is incumbent upon UNFPA HQ to address the current shortage of technical assistance in young people's reproductive health, rights and advocacy available to COs through the CST system. A clear indication needs to be made about how much and what kinds of expertise will be available, and support in developing registers of international consultants should be provided to COs.
- *Leadership:* In order for UNFPA to exert influence at national level (both within government and within the key donor forums such as the PRSP, SWAps, bilateral and multilateral health forums), its leadership role in reproductive health needs to be more

visible and strategic in some of the countries. UNFPA HQ needs to provide clear guidance to its COs with regards to key sectoral reform issues.

- *Policy and legislative reform*: Despite widespread recognition across the UNFPA COs of legislative and policy issues affecting young people's reproductive health and rights, and evidence that some CPs have successfully supported legal and policy reforms, more effort is needed to support the development of mechanisms to implement such laws and policies, enhance the capacity of UNFPA COs to work on policy and advocacy efforts, and to collate and coordinate the work of other actors engaged in advocacy around young people's reproductive health and rights.
- *Youth-friendly reproductive health services*: Building political support for the delivery of reproductive health services to young people is often constrained by cultural sensitivity. However, CPs need to give greater prominence to youth friendly services, with greater efforts in advocacy for (and identifying for public sector providers and policy-makers the components of) youth friendly reproductive health services.
- *IEC/BCC*: COs should explore strategies to scale up innovative youth focused IEC/BCC activities. Partnerships with NGOs and an increased emphasis on lesson learning and dissemination would address this to some extent. UNFPA should lead on coordinating the production and distribution of IEC materials for young people's reproductive health, to avoid duplication, contradiction and shortages of materials.

<u>IPPF/FPAs</u>

- *Addressing diversity of needs:* There is insufficient recognition of the diversity of needs of different groups of young people and interventions to address these. Differentiated strategic interventions are needed to more appropriately address the specific needs of poor, marginal and unmarried young people, and young males.
- *Rights-based programming and advocacy*: Most FPAs need a clearer understanding of the concept of reproductive rights as it applies to work with young people in their country context; and need to take a much more proactive advocacy stance on policy, legal and rights-based issues.
- *Gender*: Gender balance within the FPA organisational structures need to be addressed at all levels. Strategic understanding of gender issues as they affect young people's reproductive health also needs attention in many FPAs.
- *Capacity:* FPAs need technical support from IPPF to re-establish capacity, but also need to undertake human resource audits to produce organograms based on available material resources and strategic priorities of the programmes. An agency that is supposed to be the lead NGO in young people's reproductive health clearly cannot function without adequate expertise in advocacy, reproductive health, IEC/BCC and M&E.
- *Monitoring and Evaluation*: M&E, and thus lesson learning and best practice sharing, is inadequate in all six FPAs evaluated. It is imperative that FPAs strengthen M&E to *inter alia* allow for analysis of trends in service utilisation by young people and to enable the FPAs to assess programme effectiveness in bringing about sustained behaviour change among young people. FPAs need to institutionalise the documentation and analysis of lessons learnt on best practice as a basis for scaling-up and integrating pilot projects into a coherent programme approach to addressing young people's reproductive health and rights needs.
- *Participation of young people:* In line with IPPF Constitutional recommendations, FPAs should institute mechanisms for young people's full participation in policy and decision-making, and ensure that these mechanisms are operational at all levels of the FPA decision-making structure.

- *Partnerships:* FPAs need to develop more strategic partnerships with other civil society groups, both for sharing experience and for increasing coverage. Diversifying funding bases at a time when IPPF support is declining, means fostering relationships and partnerships with a range of international donor agencies.
- *IPPF Regional Offices* should facilitate in-depth sharing of experiences and lessons learnt between FPAs in their respective regions, provide ongoing and consistent technical support, and ensure that there are no bottle-necks in fund-flows to FPAs, to enable them to recruit the necessary staff and to implement their programmes.
- *Youth-friendly services*: Some FPAs need to enhance their understanding of the components of youth friendly services, and to develop adequately resourced packages to deliver such services. Those that have embarked on strategies to deliver youth-friendly services need to strengthen their capacity to provide such services, with a particular focus on training existing service providers.
- *IEC/BCC*: Lack of comprehensive awareness of available IEC materials within countries and regions, and the absence of a centralised archiving of BCC/IEC materials and approaches need to be addressed. Technical capacity in IEC also needs to be enhanced in some FPAs.

Collaboration/Coherence between UNFPA and IPPF

- As the two lead agencies in young people's reproductive health and rights – both globally and in their country contexts – it is incumbent upon UNFPA and IPPF to demonstrate their complementarity and (more importantly) to coordinate and collaborate more effectively at country, regional and international level. Coordination, collaboration and communication between UNFPA COs and the FPAs at country level need to improve significantly. The agency-specific recommendations above highlight a number of common areas with potential for collaboration, notably advocacy and policy/legislative reform; monitoring the implementation of laws and policies which relate to or affect young people's reproductive health and rights, exploring strategies for the coordination, development and scaling up of IEC/BCC; and greater collaborative efforts at strategic lesson learning, sharing and dissemination.

CHAPTER 1: INTRODUCTION

1.1 Background to the Evaluation

1.1.1 Sponsors

The evaluation of UNFPA's and IPPF's contribution to addressing the reproductive rights and health needs of young people since ICPD was sponsored by the German Ministry for Economic Cooperation and Development (BMZ), the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs.

1.1.2 Evaluation objectives

The goal of the evaluation was to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons. The purpose of the evaluation was to assess the performance of UNFPA country offices and FPAs in six countries in promoting the reproductive rights and health of young people since ICPD. Although HIV/AIDS was not a specific focus of the evaluation, recognition was given in the evaluation to the potential benefits for HIV/AIDS control of investments in young people's reproductive health, notably through condom promotion, STI prevention and care, and behaviour change communication for young people. The six countries evaluated (with the title of the IPPF affiliate in parentheses) were Bangladesh (FPAB), Burkina Faso (ABBEF), Egypt (EFPA), Nicaragua (PROFAMILIA), Tanzania (UMATI), and Vietnam (VINAFPA). The final reports of the six country studies should be read in conjunction with this synthesis report for those readers looking for detailed country-specific findings.

1.1.3 UNFPA, IPPF and ICPD

The ICPD Programme of Action (POA) defines reproductive health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." (§7.2). This definition of reproductive health encompasses sexual health in that it "…implies that people are able to have a satisfying and safe sex life" (§7.2). The POA links reproductive health with reproductive rights, which "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and the means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence" (§7.3). The POA asserts that freedom from discrimination based on gender is a key component of reproductive rights.

UNFPA was the main organiser of ICPD and is the world's largest internationally-funded source of population assistance to developing countries. IPPF is the largest international non-governmental organisation (NGO) working in reproductive health and rights. IPPF played a major role at ICPD and strongly influenced the POA. Both organisations work in cooperation with other governmental and non-governmental partners to develop and implement national policies and programmes. Both UNFPA and IPPF have affirmed their commitment to the principles of the ICPD POA, in particular to reproductive rights and gender equity. In order to set out the human rights context within which the federation is active, IPPF's members' assembly adopted in 1995 the IPPF Charter on Sexual and Reproductive Rights. Although ICPD was a milestone in developing an international consensus on reproductive rights, the concept itself is still subject to different cultural interpretations throughout the world. Cultural and political sensitivities, as well as social

factors, make the development of policies and programmes based on the respect of these rights a difficult challenge. Therefore, while promoting reproductive rights and health, both UNFPA and IPPF recognise the need to be culturally sensitive.

ICPD also broke new grounds in the debate on population and development, in so far as member states recognised that young people, especially adolescents, have reproductive health needs differing from adult needs. The POA emphasises that male and female adolescents should have access to comprehensive information on sexuality and to services, in order to protect them against unwanted pregnancies, abortion, curable STIs and HIV/AIDS. It further calls for countries to remove, where appropriate, legal and social barriers to reproductive health information and care for adolescents. Finally it recognises gender differences and the importance of educating young men to respect women's self-determination (§7.41 - §7.46).

Since ICPD, the reproductive rights and health needs of young people still remain largely neglected in many countries and are therefore of increasing concern to the international development community, as expressed *inter alia* in the ICPD+5 review in 1999.

1.1.4 Young People's Reproductive Rights and Health Needs: UNFPA and IPPF Roles

In their policies both UNFPA and IPPF at HQ level give high importance to promoting the reproductive health and rights of young people. Key strategies as developed by UNFPA are to advocate for policies that promote reproductive health and rights of young people, thereby addressing gender inequalities, and discriminatory and harmful practices; to strengthen reproductive health education both in and out-of-school; and to work through multiple-entry points to broaden and facilitate the access of adolescents to youth-friendly services. UNFPA highlights the importance of empowering young people and involving them in the design, implementation and evaluation of reproductive health programmes. IPPF is committed to upholding the right of young people to information and education on sexuality; to comprehensive sexual and reproductive health services; to pleasure and confidence in relationships and all aspects of their sexuality; to participate fully as active members of society; and to the elimination of gender-based violence towards young people.

Both UNFPA and, to a lesser extent IPPF, have important roles to play in contributing to the development of national reproductive health policies. UNFPA is assumed to take a lead role in assisting governments to coordinate their policies and strategies on reproductive health and rights. IPPF recognises that the participation of FPAs is valuable to governments in the formulation of their reproductive health policies. Due to its longstanding partnerships with governments, UNFPA should have a strategic influence on the development of youth-friendly policies. By developing innovative and challenging approaches to youth-based programme design, IEC and service provision, FPAs should ensure that national standards reflect international best practice, and promote the rights and needs of young people.

In line with the ICPD POA's call for strengthening partnerships between governments, NGOs and the for-profit private sector, both UNFPA and IPPF have articulated their recognition of the growing importance of establishing effective partnerships with other actors in the field of reproductive rights and health.

1.2 Methodological Approach

1.2.1 Core Issues in the Evaluation

To achieve the objectives of the evaluation, the country case studies addressed a number of core issues, central to an effective and comprehensive assessment of the performance of

UNFPA COs and FPAs in promoting the reproductive health and rights of young people. These core issues systematically address the 11 key questions set out in the original terms of reference[1].

Country and Programme Context: While the ICPD POA provides a universal definition of the concepts of reproductive health and rights, a range of socio-cultural, religious, economic and political factors influence interpretation and practice. The country evaluations thus included a contextual analysis, which considered the historical, socio-cultural, economic and political factors influencing young people's reproductive health and rights. These analyses focused on the political, policy and legal environment; religious and cultural attitudes to sexuality, gender and power relations; young people's socio-economic status and participation in public life; the role of civil society; sexual behaviour among young people. Chapter 2, section 1 of this report summarises in two tables the key socio-economic, demographic and health indicators of each of the six countries, and the UNFPA and the FPA programmes in those countries.

Contextual and Strategic Focus: In evaluating the influence of UNFPA and IPPF on promoting the reproductive health and rights of young people, emphasis was placed on assessing the strategic role and approach of the UNFPA country offices and FPAs, specifically with regard to influencing national policy and programmes, and the extent to which their approach is consistent with the objectives of ICPD. The country evaluations also paid particular attention to the equity dimensions of UNFPA and FPA country programmes, specifically in relation to the diversity of needs of different social groups of young people. The evaluations made detailed assessment of the extent to which UNFPA and FPAs are sensitive and responsive to the gender needs of young people in specific country contexts. Chapter 2, section 2 analyses the extent to which the programmes and strategies of both agencies in the six countries:

- recognise and articulate the country-specific socio-cultural, religious and political factors that impact on the reproductive rights and health of young people;
- recognise and articulate the diversity of needs of young people;
- promote the concept and practice of reproductive rights in their respective countries; and
- demonstrate gender-sensitivity with regards to addressing reproductive rights and reproductive health needs of young people in their programmes[2].

Institutional Capacity and Arrangements: The country-level institutional analyses considered the effectiveness of the UNFPA COs and the FPAs in planning, managing and monitoring young people's programmes, including: support provided by UNFPA and IPPF central and regional offices to country programmes; the capacity of staff to implement or support youth-sensitive programmes; resource allocation to youth programmes; capacity to monitor and evaluate effectiveness of youth programmes. Detailed consideration was also given to the institutional context in which the UNFPA country offices and FPAs are operating. Young people's participation in policy decision-making and at all stages of programme design, planning, implementation and evaluation is essential to ensure an enabling environment for behaviour change. The country evaluations assessed the extent to which UNFPA and FPAs actively promote youth participation and empowerment. Chapter 2, section 3 is thus organised so as to assess the extent to which both agencies:

- have the competencies and skills to provide high quality technical support in the field of reproductive rights and health of young people;
- promote participation and empowerment of young people;

[1] See section 2.2 of *Addressing Reproductive Rights and Health Needs of Young People After ICPD: The Contribution of UNFPA & IPPF. Description of the Evaluation/Substantive Requirements of the Bid/Description of Measures*, issued by BMZ 2002 (reprinted at annex 1). With the agreement of the Steering Group, the third key question was reformulated to: "The extent to which both organisations are effective in stimulating an environment for behaviour change…".

[2] Gender, as a cross-cutting issue, is also addressed in other sections of chapter 2

- demonstrate complementarity, coherence and cooperation with each other; and
- demonstrate relevance, scope and effectiveness in their coordination arrangements and partnerships with other actors in the field of reproductive rights and health.

Policy Development and Reform: Each country evaluation assessed the extent to which both agencies are stimulating enabling environments for policy development in the field of reproductive rights and health of young people. Chapter 2, section 4 synthesises the findings from the six country studies as they relate to this policy development and advocacy role.

Reproductive Health Services and Information: The promotion of reproductive rights and reproductive health are key components in achieving behaviour change. The evaluation considered young people's access to reproductive health information, education and services as a central rights issue. Chapter 2, section 5 assesses the extent to which both agencies are effective in stimulating an enabling environment for behavioural change through provision of services and information.

1.2.2 Key Principles of the Evaluation

Contextual specificity: Country-adapted terms of reference were developed for each country study (see 1.2.3 below).

A participatory approach: The evaluation method was finalised in full consultation with the Evaluation Steering Group (which included representatives of UNFPA and IPPF). In order to ensure participation in the evaluation process, a short workshop was convened at the start of each country study to inform stakeholders of the goal, objectives and approach of the evaluation. This introductory workshop enabled participants to undertake a participatory analysis of the strengths, weaknesses, opportunities and constraints faced by UNFPA country offices and the FPA in promoting the reproductive health and rights of young people. During the country evaluations the teams consulted a wide range of stakeholders using a range of participatory methods.

Young people's involvement in the evaluation process: Young people were consulted throughout the whole country evaluation process. The counterpart organisation studies (see below) held in-depth discussions with young people involved in the UNFPA and FPA country programmes (eg peer educators, youth volunteers), users and non-users of UNFPA and IPPF supported projects, and representatives of key youth organisations. Sufficient privacy in interviews and discussions was ensured for young people to share their views, and appropriate times and locations selected to facilitate the full participation of young people. A wide range of young people were consulted, including young people of different ages, gender, socio-economic status, marital status, religion, ethnicity, and locations (eg in and out of school, rural/urban). The international teams also met with and interviewed young people involved in UNFPA and FPA programmes; and during the introductory stakeholder workshops, youth representatives had the opportunity to comment on the objectives and approach of the evaluation, as well as providing insights into the priority issues affecting young people's reproductive health and rights. A young consultant was included as a member of each country team (CT) and participated fully in the country study, including interviews and meetings with young people. A diversity of young people's perspectives on key evaluation issues in each country was thus ensured (albeit drawn heavily from samples of young people who were directly involved in or benefited from UNFPA and IPPF supported programmes).

Sensitivity and transparency: Evaluations can be a very stressful experience for staff and volunteers involved, and the issue of young people's sexual and reproductive health and rights is often sensitive. The experienced international CTs ensured that the evaluation was undertaken in a sensitive and transparent manner. The participatory approach ensured that

UNFPA and FPA staff and volunteers were consulted at each stage of the process, and that during the country evaluations the team were open to continuous discussion and cross-checking of information.

Recognising the contrasting roles played by UNFPA and IPPF: In undertaking the evaluation – and in applying the methodology and its evaluative criteria – the differences and contrasts in the roles played by UNFPA and IPPF at country level were recognised. IPPF's country-level programmes are designed and implemented by national Family Planning Associations, albeit within the policies and overall goals of IPPF. UNFPA does not implement its Country Programmes directly, but through partners (national government, UN, and non-governmental organisations). UNFPA designs and supervises with its partners the implementation of its Country Programmes (and constituent projects). The UNFPA Country Office is a partner to the national government of the country in which it operates; the Country Programme (CP) is thus effectively "government owned", and its primary focus/objective is invariably to strengthen government capacity for direct execution of its population and reproductive health programmes. The national FPA by contrast is non-governmental, implying that its role includes supporting government in geographical and programme areas where it cannot or will not work, and advocacy for policy and legislative changes.

1.2.3 Phases of the Evaluation Process

The evaluation process consisted of three main phases.

1. *Inception Phase (Methodology Development)* The methodology developed for the country studies consisted of an evaluation framework (see box below), a checklist of essential documentation and secondary data sources relating to the reproductive health and rights of young people (prior to fieldwork, the country evaluation teams undertook an in-depth analysis of this documentation); a list of primary and secondary stakeholders to be consulted; and an outline of the structure and format of the country reports.

Process for developing the country evaluation frameworks

- A generic evaluation framework was developed by the evaluation team leader, setting out in tabular format key questions to be addressed, and the sources of data for each question.
- For each country, the key social, demographic, political, legislative and health data relating to reproductive health and rights of young people were drawn together and presented in tabular format (the country context) by the respective country team leaders.
- The generic evaluation framework was then adapted by each of the country team leaders. This country-specific framework was combined with the country context table, and basic information on the evaluation (including counterpart organisations and team), to produce country-adapted terms of reference, annexed to each of the six country evaluation reports

2. *In-Country Evaluations* In-depth field-based evaluations were carried out in six countries: Bangladesh, Burkina Faso, Egypt, Nicaragua, Tanzania and Vietnam. The Tanzania country evaluation took place in March 2003; the other five during May/June 2003. These countries were selected to represent a diversity of social and cultural environments surrounding reproductive rights issues, low and middle-income countries, the existence of major reproductive rights issues (eg early marriage, female genital mutilation) and reproductive health needs (eg high maternal mortality and HIV prevalence), and a diversity of programmes supported by UNFPA and IPPF. The country evaluations consisted of two key elements (both of which drew on a range of qualitative methods: participatory workshops, observation and field visits, semi-structured interviews, informal individual conversational interviews, and group discussions):

- Counterpart organisations were contracted to undertake three small-scale studies of the legal status of young people with regard to reproductive health and rights; the range and availability of IEC materials produced by UNFPA and the FPA; and young people's perceptions on access and quality of reproductive health information and services.
- A three-person evaluation team (two international members and one national) undertook a three-week visit to each country. Each country evaluation began with a participatory stakeholder workshop. A wide range of stakeholders was also consulted over the course of the field visit (including UNFPA country office and FPA senior management, programme and field staff, and service providers; FPA executive board members; government officials and line ministries; representatives of key multilaterals and bilateral donors; representatives of youth organisations and key NGOs and community organisations; young people involved in UNFPA and IPPF supported programmes; users and non-users of UNFPA and IPPF supported programmes). Visits were also made to a range of UNFPA and IPPF supported programme sites in urban and rural areas. At the end of the country studies, the evaluation teams debriefed senior staff of the FPA and the UNFPA CO, and representative(s) from the government in a short meeting to present preliminary findings.

3. *Synthesis of Good Practice and Strategic Lessons* Once the six country evaluation reports were finalised, the results were analysed and synthesised by the Evaluation Team Leader, the output of which is this report.

1.3 Report Structure

The report is organised into four chapters. Chapter 1 has provided a detailed overview of the evaluation background, context and process, including the methodology; and the principles adopted in the evaluation. Chapter 2 synthesises the findings from the six country studies into five subsections, which address the 11 key questions set out in original terms of reference: Country and Programme Background, Contextual and Strategic Focus, Institutional Capacity and Arrangements, Policy Development and Reform, and Reproductive Health Services and Information. Chapter 2 describes and analyses the constraints and opportunities that both organisations face within differing contexts, and analyses where possible the reasons for the success or failure of strategies and programmes. The chapter uses boxes to illustrate key points from the individual country reports. Where there is significant diversity across the countries, the boxes contain examples from all or most countries. In other instances, limited country examples are selectively presented to support the analysis in the text. Chapter 3 identifies strategic conclusions, including a discussion of key lessons learned and good practice (including specific country case study examples); and chapter 4 sets out recommendations for UNFPA and IPPF.

CHAPTER 2: PROGRESS IN PROMOTING THE REPRODUCTIVE RIGHTS AND HEALTH OF YOUNG PEOPLE SINCE ICPD

2.1 Country and Programme Background

2.1.1 Country Background

Extensive information and data on the demographic, health and socio-economic contexts of the six countries can be found in the country evaluation reports. Table 1 below provides summary data to facilitate comparison.

Table 1: Demographic, Health and Socio-economic Indicators [1]

Country	Pop (m)	TFR[2]	Age specific fertility 15-19[3]	GDP per capita [4]	HDI [5]	Poverty [6]
Bangladesh	140.4	3.3	125	1610	139th	36.0%
Burkina	12.6	6.8	151	1120	173rd	61.2%
Egypt	69.5	3.5	34	3520	120th	3.1%
Nicaragua	5.5	3.2	138	2450	121st	15.1%
Tanzania	34.6	5.6	92	520	160th	19.9%
Vietnam	79.7	2.3	20	2070	109th	17.7%

Table 1 continued

Country	IMR [7]	MMR [8]	% 15-19 ever married [9]		HIV adult prevalence 15-49	HIV prevalence 15-24[10]	
			M	F		M	F
Bangladesh	57	320	na	50	0.02%	0.01%	0.01%
Burkina	105	484	na	45	6.5%	4.0%	9.8%
Egypt	44	84	na	14	<0.1%	na	na
Nicaragua	35	133	na	34	<0.03%	0.22%	<0.06%
Tanzania	88	529	3	25	9.6%	3.9%	8.1%
Vietnam	30	95	5	11	0.3%	0.32%	0.17%

Notes to table 1

na = not available

1. Data sources are the *2003 Human Development Report* and the respective *Demographic and Health Surveys* of the countries, unless otherwise stated (some data presented here differ from those cited in the country reports).
2. TFR is total fertility rate, and equates approximately to the number of average number of children born per woman.
3. Age-specific fertility rate is number of births per 1000 women aged 15-19. The indicator does not represent the full extent of teenage pregnancy as only live births are measured; thus overlooking stillbirths and spontaneous or induced abortions. Source: UNFPA *State of World Population 2001*.
4. GDP per capita is expressed in US$ per annum, and based on purchasing power parity (PPP), which accounts for price differences across countries and allows international comparison of real output and incomes.
5. The HDI refers to the UNDP 2003 Human Development Index, which ranks 175 countries.
6. Poverty refers to the UNDP/World Bank poverty indicator of % of population living on less than US$1 per day. Figures are taken from 2003 *Human Development Report* (UNDP) with the exception of Nicaragua for which the HDR gives a figure of 82.3%, which is clearly wrong. The figure of 15.1% is taken from the World Bank, 2002.
7. IMR is the rate of deaths to under one year-olds per 1000 live births each year.
8. MMR is maternal deaths per 100,000 live births in a year.

9. Source: United Nations Statistics Division (2001) *The World's Women 2000, Trends and Statistics*.
10. Source: UNFPA *State of World Population* 2001; except for Vietnam and Burkina where the data are taken from the UNFPA (2003) *Population and Reproductive Health Profiles*.

2.1.2 The Country Programmes

All the UNFPA Country Programmes since around the time of ICPD show a significant reorientation away from the family planning and demographic focus of earlier CPs to a more reproductive health focus. However, the extent to which there is an explicit focus on young people and on reproductive rights in the CPs since 1994 varies between countries, as does the extent to which countries have been able to operationalise these shifts. In Nicaragua, the current CP has a strong focus on the reproductive rights of young people, and UNFPA has had considerable impact through supporting national legislative and policy change alongside demonstration projects to enable young people to exercise their rights. In Vietnam, the current CP has a focus on adolescent services and to a lesser extent rights, and the combination of a strong reform movement and trusting relationship with government has enabled UNFPA to move the adolescent reproductive health agenda forward. In the other countries, the ability to make a significant contribution to addressing the reproductive heath needs and rights of young people has been limited by institutional weaknesses and financial constraints. In Burkina Faso, young people's reproductive health has been a central concern for the last three CPs, but the paucity of sustainable results is attributable to a context characterised by limited human and financial resources, and institutional weaknesses in government. In Tanzania, despite strategic objectives in the past two CPs relating to young people, institutional weaknesses in the CO and partners, and persistent political and cultural sensitivities have limited effectiveness to date. In Bangladesh and Egypt, the concepts of adolescent reproductive health and rights are still new, and the socio-cultural context significantly constrains the ability to implement youth-focused activities. In Bangladesh, the current CP addresses service provision to young people and is moving towards a rights-based approach, but provision for unmarried youth remains taboo. In Egypt, the strategic focus shifted from family planning to reproductive health (but not rights) after ICPD, but social and cultural constraints have led UNFPA to a very cautious approach to advocacy. Three of the six CPs depend upon substantial non-core funding for their work on young people's reproductive health and rights: Bangladesh on the European Commission (EC) funded Sexual and Reproductive Health Initiatives in Asia, and on the United Nations Foundation (UNF); Tanzania on the Bill and Melinda Gates Foundation funded Africa Youth Alliance (AYA); and Vietnam on the EC-funded Reproductive Health Initiative for Youth and Adolescents (see table 2 and the notes [5], [11], and [12] to table 2 for financial detail).

All the FPAs evaluated also demonstrate a shift in focus (as evidenced by their Strategic Plans) since around the time of ICPD, from family planning services and broad-based IEC to reproductive health (and to a lesser extent) rights. Some of the FPA Strategic Plans demonstrate a significant focus on addressing the reproductive rights and health needs of young people, but human and financial resource constraints have been limiting factors. In Tanzania, for example, UMATI's current Strategic Plan represents a bold shift to integrated reproductive health, with an exclusive focus on youth, but capacity to implement the shift is constrained. In Burkina Faso, ABBEF has played a pioneering role in addressing the reproductive health needs of young people, but the programme consists of a series of parallel, externally funded projects rather than an integrated strategy for addressing youth issues. In Vietnam, the impact of VINAFPA's youth-focused work is once again constrained by lack of human and financial resources. In Bangladesh, FPAB's recent and current Strategic Plans focus heavily on IEC, and limited youth friendly services have only recently been introduced. In the other countries, although the strategic focus has shifted away from family planning to reproductive health, there has been limited focus on young people. In Nicaragua, PROFAMILIA's strategy does not include services specifically aimed at youth (and access is limited anyway to those who can afford to pay). In Egypt, youth work has not

been a focus of the EFPA's Strategic Plans, and where small-scale youth projects have been undertaken with external funding, access has tended to be limited to married women with ability to pay. EFPA's new Strategic Plan includes a focus on young people, but capacity to implement, and financial resources, are likely to be limiting factors.

Full details of the evolving strategies and objectives of the national programmes of both agencies can be found in chapter 2 of each of the six country reports.

Table 2 below provides an overview of the current country programmes of the six UNFPA and the FPA programmes, focusing on total budgets (and sources of funding: regular/core funding versus extra-budgetary funds), and allocation of country funds to policy/advocacy, and reproductive health services/IEC respectively.

Table 2: Country Programme Budgets, Sources of Funding and Allocation by Activity[1]

	UNFPA				FPA			
	Tot 5yr budget US$m	UNFPA regular resources(2)	Allocation of resources (3) (4)		Estd 5yr budget US$m	IPPF funding	Allocation of resources (3) (4)	
			Policy/ Advocacy	Services/ IEC			Advocacy	Services/ IEC
Bangladesh	32.0[5]	97%	25%	66%	8.25	68%	1.4%	98.6%
Burkina	8.9[6]	77%	30%[6]	70%	3.85	48%	9.9%	90.1%
Egypt	18.0[7]	80%	21%	66%	na[8]	na[8]	0.0%[9]	100%[9]
Nicaragua	18.0[10]	77%	12%	61%	14.0	2%	0.0%	100%
Tanzania	28.3[11]	37%	9%	62%	11.25	27%	15.0%	85%
Vietnam	27.0[12]	74%	39%	53%	2.5	na	9.4%	90.6%

Notes to table 2

(1) The data relate to current national programmes, unless indicated. For UNFPA, the budgets relate to five-year cycles (over the periods indicated for each programme note). For the FPAs, no five-year budgets were available, so for comparison with UNFPA the table extrapolates from spend during the financial year 2002.
(2) The % of funds from regular resources for UNFPA are not based on actual spend, but on projected % of total CP budget at time of approval of CP by UNFPA HQ (except in Bangladesh and Egypt, where these are actual spends – see notes 5 and 7).
(3) Allocation to policy/advocacy and services/IEC are expressed as percentages of total country budget (not exclusively youth-focused).
(4) Percentage allocations of funds to policy/advocacy and services/IEC in the UNFPA programmes do not add up to 100%, as programme funds are allocated to other activities (census support, multisectoral population interventions etc, usually under the PDS sub-programme category). Percentage allocations relate only to programming funds (ie do not include office overheads and costs). In Vietnam and Bangladesh, BCC (but not conventional IEC related to services) is included in advocacy, thus inflating the % compared to other CPs. The division between policy/advocacy and services/IEC is indicative in the other programmes, as elements of the PDS sub-programme in UNFPA CPs include advocacy and policy reform, and large parts of the Advocacy sub-programme are not focused on policy/advocacy, but on gender mainstreaming. Percentage allocations in the FPA programmes are also programme budgets, but do add up to 100%.
(5) This figure is expenditure under the previous five year programme (1998 – 2002) and includes funding from the European Commission (Sexual Reproductive Health Initiatives in Asia), and the United Nations Foundation (UNF), of which US$2,720,955 and US$200,000 respectively were allocated to youth activities
(6) Total budget for 1994–2003 = US$ 17.96m. UNFPA was unable to break down budgetary allocation by advocacy/policy and services/IEC, but estimated that UNFPA staff spend at least 30% of their time on advocacy and policy reform efforts
(7) Spend for 1998-2001 was US$18 million; budget for 2002-2006: is US$18 million.
(8) Total budget for EFPA is not available. IPPF froze all project funding to EFPA for the last three financial years, only staff salaries were funded, and in current financial year the IPPF grant was reallocated to setting up a new central office for EFPA.

(9) The proportions relate only to IPPF funds, and should be read with caution: in 1999, advocacy accounted for 3%, service delivery 32%, salaries/admin 55%; in 2000, advocacy was 0%, service delivery 8% and salaries 92%; in 2001, the comparable figures were 0%, 0% and 100%; and in 2002, 0% was on advocacy, 27% on general service delivery and 50% on salaries.
(10) Budget for 2002 – 2006.
(11) Budget for 2002 – 2006, includes US$7.3m from the Bill and Melinda Gates Foundation through the Africa Youth Alliance (AYA) project, which became operational in 2001, with a total five-year budget of US$16.5 million (Pathfinder International and PATH receive US$4.9m and 4.3m respectively).
(12) Budget for 2001–2005, does not include the budget for EC-UNFPA Reproductive Health Initiative for Youth and Adolescents (RHIYA), estimated to be 2.4m Euros (US$2.85m) for 33 months 2003-05.

2.2 Contextual and Strategic Focus

This sub-section focuses on the conceptualisation of country programmes and strategies, notably the extent to which the agencies have incorporated important elements of the ICPD POA into their national programmes. Substantive issues relating to programming and strategy development – and reasons for successes and failures - are explored in sections 2.4-2.5, and in chapters 3 and 4 which highlight lessons and best practices and present recommendations. Gender-sensitivity (2.2.4) is a cross-cutting issue, which is thus also addressed in these other sections.

2.2.1 Recognition and Articulation of Country-Specific Factors that Impact on Young People's Reproductive Rights and Health

This subsection focuses on the extent to which both agencies recognise and articulate country-specific socio-cultural, religious and political factors that impact on young people's reproductive rights and health in their country programmes and strategies.

UNFPA

Each of the six country reports, begins with an analysis of the country-specific factors that influence the reproductive health and rights of young people. The overall finding of the evaluation is that the UNFPA Country Programmes (CPs), and the relevant sub-programme and project documents, articulate the priority socio-cultural, religious and political factors that impact on the reproductive rights and health of young people within their respective countries. On the basis of interviews and discussions with key staff (see section 2.3), the country evaluations further confirmed that most of the UNFPA Country Offices (COs), and to a lesser extent the implementing agencies supported by the UNFPA CP, demonstrate a clear understanding of the priority socio-cultural, religious and political factors that impact on the reproductive rights and health of young people. This understanding does not, however, include how gender impacts on the reproductive health and rights of young people.

In three of the countries, Tanzania, Bangladesh and Egypt (see box 1), focus on addressing the factors which undermine young people's reproductive health and rights is dissipated due to the absence of, or failure to implement, specific sub-programmes or projects targeting young people. For example, in the Bangladesh and Egypt UNFPA CPs, young people are included in the general target group in the reproductive health sub-programme, thus handicapping the extent to which the CPs can strategically address (and prioritise) key factors affecting their reproductive health and rights. Further constraints in Tanzania, Bangladesh and Egypt include limited (or shortfalls in) financial resources, and absence of data for planning and strategy development. Despite general understanding of the problems facing young people, a lack of specific expertise and experience in young people's reproductive rights and health programming within the UNFPA CO and government

implementing agencies in these three countries limits the responsiveness of programmes to young people's locally-specific needs.

Box 1: UNFPA constrained in addressing country-specific factors

Bangladesh Although the CO recognises the socio-cultural factors that impact on the reproductive rights and health of young people, and the importance of socio-economic and cultural changes (such as rapid urbanisation and current changes in Islamic culture), the CP has failed to address many of the priority issues that face young people, including gender-based violence and dowry payments (the new CP, however, has a project that includes advocacy on gender-based violence).

Egypt The CO recognises the key reproductive health and rights issues, which include early marriage, FGM, violence against young women, and poor access to information and quality care, but interventions to address these issues have been limited due to lack of capacity in government partners, poor CP coordination, and cultural and religious conservatism (including negative media coverage post-ICPD).

Tanzania The CP articulates the priority reproductive health and rights issues facing young people in Tanzania (notably harmful traditional practices such as early marriage for women and female genital cutting). Lack of capacity within the CO and government implementing agencies, and political and cultural sensitivities, have constrained efforts to address the priority issues.

Although political and cultural sensitivities appear to be mitigating factors in Bangladesh, Egypt and Tanzania, this report shows later that two of the other three country programmes (Vietnam and Nicaragua) also operate in politically and/or culturally constraining contexts, but have nevertheless been able to translate awareness and articulation of the priority factors into focused programme interventions. A key finding is that where focused socio-cultural research has been conducted (or supported) by UNFPA – as in Burkina Faso, Vietnam and Nicaragua – a more strategic approach to dealing with the priority issues is evidenced (see box 2).

Box 2: UNFPA addresses country-specific factors

Burkina Faso UNFPA has contributed to a better understanding of the determinants of young people's reproductive health through socio-cultural research that it has funded. This research has provided UNFPA with the information necessary to refocus its programme towards addressing the needs of the most needy, and UNFPA projects are now concentrated in the poorest zones.

Nicaragua Research commissioned by the CO has explored determinants of adolescent reproductive health, and provided the CP with a clear understanding of the socio-cultural and economic factors that determine young people's reproductive heath and rights, and their ability to exercise those rights (notably the impact of low self-esteem and lack of future expectations). In service provision UNFPA's focus on low-income groups through the public sector indicates awareness of the economic constraints on young people's access to reproductive health services.

FPAs

Like the UNFPA country case studies, the evaluations of the IPPF affiliates in the six countries confirm that most of the FPAs demonstrate a good awareness of the factors that influence young people's reproductive health in their respective countries. Examination of the FPA Strategic Plans and Work Programmes show that on the whole they are rooted in a clear and careful analysis and articulation of the priority areas for intervention. However, implementation of interventions specifically focused on the priority issues is constrained in Tanzania (UMATI) and Vietnam (VINAFPA) by lack of capacity and funds. With the exception of Bangladesh, FPAB staff and volunteers demonstrated a clear understanding of the priority socio-cultural, religious and political factors that impact on the reproductive rights and health of young people (see box 3).

Box 3: Recognition and articulation by FPAs of country-specific factors

Bangladesh FPAB demonstrated a lack of understanding of the socio-cultural influences on reproductive health and rights, although it is seeking to address barriers to access to reproductive health information and services, recognising problems of affordability and judgmental attitudes of health providers.

Burkina Faso ABBEF understands well the context of and constraints to young people's reproductive health. Recent ABBEF research on reproductive health needs, behaviour, and attitudes has been used to develop a three-year action research project piloting new approaches to services through health facilities and peer educators, in which services are adapted to the specific needs of young people in rural areas.

Egypt EFPA has conducted several studies at both national and local levels, which have identified priority issues, notably female genital cutting and early female marriage. Projects since 1994 have tailored activities that acknowledge social and cultural contexts.

Nicaragua Key PROFAMILIA staff demonstrated a high level of knowledge of socio-cultural and economic factors related to young people's reproductive health and rights. However, their main strategy for addressing these is through school or university.

Tanzania UMATI's current Strategic Plan articulates the priority areas correctly as STI/HIV prevention, elimination of harmful practices, reduction of unsafe abortion, and prevention of unwanted pregnancies. Capacity to address these issues - and to reorient staff and service delivery approaches - is severely constrained by recent declines in human and financial resources.

Vietnam Within VINAFPA some staff showed a high level of understanding of the socio-cultural and economic factors influencing young people's reproductive health and rights; others showed much less. Knowledge has been achieved through assimilation as well as through direct training.

2.2.2 Recognition and Articulation of the Diversity of Reproductive Health Needs

This sub-section examines the extent to which both agencies recognise and articulate the diversity of reproductive health needs among different social categories of young men and women in their country programmes. The evaluation reveals that a priority challenge with regard to diversity is the paucity of efforts directed to young males. The evidence from the six countries indicates that this challenge remains a central obstacle for effective reproductive health and rights programming for young people in both agencies (see Chapter 3 for an elaboration of this discussion).

UNFPA

The objectives of the UNFPA CPs and sub-programmes demonstrate variable levels of recognition and responsiveness to the range and diversity of needs of young people (see box 4). Few of the country programmes are making strategic choices based on vulnerability, with regards to targeting specific groups of young people. While interventions in the Bangladesh, Burkina Faso, Egypt and Tanzania country programmes differentiate by one or more of age (adolescents/young people), marital status, school status (in-school/out-of-school), and urban/rural, only Nicaragua and Vietnam have developed programme strategies to meet the needs of the poorest and most marginalised. A number of factors explain this failing, including the absence of situational analyses of the differential needs of young people, inadequate partnerships with civil society organisations, and the persistence of stereotypes of vulnerability in young people leading to simplistic categorisation of out-of-school youth as the group most vulnerable (by nature *inter alia* of their lack of education, see Chapter 3 for further discussion of this).

Box 4: UNFPA recognition - and programme articulation - of diversity

Bangladesh UNFPA has focused most of its attention on the contrasting needs of in and out of school youth (the latter reached through the state non-formal education programme and youth clubs). Small-scale work with the private sector recognises the needs of young female garment workers and tea plantation workers.

Egypt Awareness of the diversity of needs among young people is very limited. Diversity is seen in terms of geography, residence (urban/rural) and education level, but the implications of such diversity for young people's reproductive health and rights programming is not well-articulated.

Nicaragua The CP works with male and female, older and younger adolescents, rural and urban groups, and adolescents in and out of school, through an integrated range of educational and development activities aimed specifically at low income adolescents, taking account of the diversity of needs within the 10-19 age group, but with little work specifically aimed at young adults.

Tanzania Although there is recognition of the diversity of young people's reproductive health needs, the CP is constrained in addressing these needs by the lack of a coherent strategy, including failure to create a supportive environment for NGO participation in the implementation of the CP

Vietnam UNFPA recognises the need to address diverse populations of youth. In the EC/UNFPA funded Reproductive Health Initiative for Youth and Adolescents (RHIYA), UNFPA focuses more in rural areas than previously, and upon a wide range of youth, including poor and marginalised (eg street children).

FPAs

Interviews with FPA staff and volunteers – and close examination of FPA Strategic Plans and Work Programmes – revealed a reasonably good level of recognition of the range and diversity of needs of young people within most of the FPAs evaluated . However, the country evaluations also indicate that most of the FPA programmes have a very limited degree of responsiveness to the diversity of reproductive health needs of young men and women in the form of strategic interventions (see box 5).

Box 5: FPAs with limited focus on diversity

FPAB works with young people from different socio-economic and cultural backgrounds, but with a focus on rural young people, little work is done with the urban, marginalised or excluded. FPAB is however culturally-sensitive to young people's needs, and has projects with Imams, teachers and parents. Financial constraints have limited programme reach.

ABBEF focuses predominantly on young people who are both literate and in school. Interventions targeting vulnerable young people (defined as those not in school and those who are illiterate) rely mainly on peer educators, and have limited scope.

EFPA management are aware that greater investments need to be made in devising culturally-appropriate approaches tailored to the diversity of sub-groups of young people.

PROFAMILIA does not have an explicit strategy to reach the most marginalised young people, working mainly with urban male and female school pupils and students. Community outreach is also focused on schools, with little work in poor urban neighbourhoods. However, a large proportion of the young people in state schools are undoubtedly poor. Some young people with drug and alcohol problems are reached through clubs but PROFAMILIA is not really equipped to support them.

VINAFPA staff and volunteer recognition of the diverse needs of young people is not translated into programmatic responses, which currently focus on in and out of school young people. While VINAFPA staff and volunteers talk of the heterogeneous nature of young people, the strategic operational

response reflects a strongly homogenous approach. VINAFPA is however developing approaches to reach commercial sex workers, and injecting drug users, but lacks capacity and expertise in this area.

While FPA strategies and programmes refer to the heterogeneous nature of young people, the operational response by many to young people's reproductive health needs often reflects a strongly homogenous approach. Most FPAs as illustrated in box 5 above persist with differentiation of interventions focused around in and out of school, with attention to the needs of different age groups, married/unmarried, urban/rural, and particularly the poorest and most marginal groups given little attention. The notable exception is UMATI, which nevertheless faces resource constraints in terms of coverage and expansion (see box 6).

Box 6: UMATI addresses diversity

UMATI staff have a clear understanding of the complexity and diversity of needs. Many projects seek to address site-specific priority issues, including rights-based issues through advocacy on FGM and the rights of young people to access education, information and services. Efforts have been made to respond to the diversity of needs among young people, including the most marginal and vulnerable, including projects with refugees, differentiated strategies to reach in-school and out-of-school youth, CBD agents to reach rural youth, and different service delivery to meet the needs of married and unmarried youth. Resource constraints limit coverage and reach.

2.2.3 Defining and Operationalising Reproductive Rights

This subsection explores the extent to which both agencies understand the concept of reproductive rights (as defined in the ICPD POA) within the socio-cultural and political contexts in which they work, and are able to translate such an understanding into a rights-based approach in their programmes. As promotion of young people's reproductive rights is analysed in sections 2.4-2.5, the discussion here is limited to overall programme strategy and to institutional understanding of rights.

UNFPA

Articulation of strategies to address the reproductive rights of young people is in most CPs embryonic, as indeed it is in many development agencies. Burkina Faso and Nicaragua are notable exceptions. In Burkina Faso the UNFPA programme has coherently addressed young people's reproductive rights, as illustrated by its extensive lobbying for eradication of FGM, which has now filtered down to community-level advocacy campaigns. UNFPA in Nicaragua also demonstrated a clearly articulated definition of young people's reproductive rights that had been translated into effective programming, as illustrated in box 7.

Box7: Reproductive rights in the UNFPA Nicaragua CP

The CP has a strong focus on reproductive rights for young people. Rights are integrated into programme norms, processes and activities. All UNFPA's partner organisations and projects interviewed during the evaluation were aware of reproductive rights and the key role they play in UNFPA's work. The reproductive health sub-programme is clearly framed in terms of rights and gender equity, its purpose being "to support the full exercise of sexual and reproductive rights by the Nicaraguan people and to achieve gender equity throughout their lifespan". Within the work with young people, rights of access to services and information, and the right to participate are included in every activity. Other rights such as non-discrimination are included where appropriate and wherever there is an opportunity to introduce them. Policy-level work supported by UNFPA has shown clear advances in knowledge and awareness of rights and gender equity issues, and the CO has played a key role in supporting the development of legal structures and policies to protect young people's reproductive rights. The legal structures are now in place, but more work needs to be done in assisting young people to exercise their rights. UNFPA has supported the inclusion of a module on sexual and reproductive rights in the human rights course of the University of Central America (UCA) law degree, which will ensure that future generations of lawyers have a good grounding in the subject. At project

level, the starting-point of IEC materials and methods is rights and gender equity. MOH norms for service provision to adolescents, which has received substantial technical input from UNFPA, emphasise rights and gender equity, and the draft teacher manual for sex education in schools includes a clear focus on rights and gender.

While the other country evaluations showed that most key CO staff and partners were able to cite the ICPD definition of rights (in terms of the individual's rights to services and information), and, in the case of UNFPA staff, to refer to the rights-based approaches of the broader UN programmes (notably UNDAF), there was a paucity of initiatives that seek to empower young people to understand and exercise the rights to which their governments are obligated through signed covenants: the right to education and information, to the benefits of scientific progress, to equal legal status of women and men, to freely choose a marriage partner (within national legal age), to bodily integrity, to legal protection from abuse, torture or exploitation, and the right to the highest attainable standard of health. Articulation of rights in some CPs, notably Bangladesh and Egypt, continues to focus exclusively on rights related to number and timing of births.

Cultural sensitivities (particularly in Egypt and Bangladesh, where "reproductive rights" has been systematically removed from key Country Programme documents) and political constraints (in Vietnam) mean that it has proved difficult in these countries to operationalise a broad concept of reproductive rights since ICPD. In these three setting there is an overt dissonance between the concept of reproductive rights, central to which is the autonomy of decisions regarding sexuality and reproduction, and prevailing cultural and political norms, particularly with regard to the unmarried. UNFPA COs remain uncomfortable with the concept of rights and refrain from open dialogue with government partners on how to develop a culturally-specific rights-based approach (see box 8).

Box 8: Examples of limited UNFPA operationalisation of reproductive rights

Bangladesh No sub-programme or project in the CP is specified as being rights-based, although the new CP was formulated in line with the Bangladesh UNDAF (which has adopted a rights based approach).

Tanzania The CP articulates rights in terms of individuals' ability to make decisions that affect their personal and reproductive life, and as such seeks to promote the participation of individuals in policy-making in relation to population issues, to provide education and information to the public about individuals' rights, and to increase the rights of all individuals irrespective of age, marital status, ethnicity etc to access reproductive health information and services. While this is a relatively narrow definition of rights, it is not inconsistent with the ICPD definition. In effect, the main focus of the CP is on educating and informing the public about rights to services, with little effort on empowering clients (including young people) to know their rights to demand quality services.

Vietnam The UN Interagency Working Group on Youth confirmed that "rights-based programming" is not well understood by either UN staff or Vietnamese counterparts. The CP's focus is on the provision of information and services. Rights is a delicate issue in Vietnam, and in the past reproductive rights of young people (or human rights) were rarely discussed publicly (although this is changing). The rights of the child and rights of the client remain the preferred discourses. UNFPA focuses on promoting the concept and practice of sexual and reproductive health rights to the extent that it is possible in Vietnam. Critical thinking on adolescent rights is encouraged in a teachers manual, distributed by UNFPA to secondary schools and teaching colleges. The *Core Messages* issued by the National Council for Population, Family and Children (NCPFC), one of UNFPA's key partners in government, highlight the need for service providers to ensure adolescents have "client rights."

FPAs

Few of the FPAs evaluated could be said to have adopted rights-based programming. Disappointingly, most also demonstrated a poor understanding of the concept of reproductive rights. Those that were able to provide definitions did so on the basis of IPPF's Charter on Reproductive and Sexual Rights (Vision 2000) in terms of the rights of the client, in this case the rights of all young people to access reproductive health information and services. In their specific country contexts, most of the FPAs lacked clearly articulated, culturally-specific definitions of young people's reproductive rights. In part this stems from the political and cultural sensitivity in some of the countries to the concept of rights (as highlighted above). In Vietnam for instance, "the government has rights, and the people have responsibilities", leaving VINAFPA (see box 9) to discuss rights publicly in an oblique and non-threatening manner. In Nicaragua (see box 9), PROFAMILIA's dependence upon USAID funding has severely constrained its ability to work within a rights framework as illustrated below.

Box 9: FPAs and reproductive rights

FPAB showed only a vague understanding of rights, and a lack of understanding of cultural influences on reproductive rights. FPAB has no project that could be considered as rights-based, and staff commented that in Bangladesh "…encouraging reproductive rights is not acceptable. Young people may make unjustified demands or engage in unacceptable [sexual behaviour] if reproductive rights are promoted."

ABBEF's work on addressing the reproductive rights of young people is undertaken mainly through awareness raising rather than lobbying: the current strategic plan has objectives for instance relating to reaching "women so they become aware of their reproductive health statutes… and people in positions of authority in the justice, health, social action systems as well as parliamentarians and religious and traditional leaders to set down actions that favour the rights of women".

PROFAMILIA's mission statement is not specifically rights-based, although its aim to increase access to information and services is consistent with the ICPD definition, and IPPF's Vision 2000. While there is a clear understanding of young people's rights within PROFAMILIA, rights have not been specifically incorporated into working norms, processes and practices. An important breach of young people's rights stems from PROFAMILIA's inability to deal with abortion-counselling or post-abortion care as a result of signing the Mexico City Accord (PROFAMILIA has been primarily funded by USAID since 1992), although this is contrary to IPPF policy. PROFAMILIA's mission statement previously included a reference to rights ("PROFAMILIA is a private national organisation whose mission is to foster family planning and reproductive health awareness and use as a fundamental right of all individuals"). Following a USAID evaluation in 1997, a new mission and objectives were issued, and the reference to rights disappeared.

UMATI The main focus of UMATI's rights-based approach is on the rights of the client, and the rights of all young people to access reproductive health information and services. On a limited scale UMATI has tried to address the rights of pregnant girls to continue to access education.

VINAFPA does not explicitly articulate young people's reproductive rights as a strategic goal or programme objective, and no projects are considered by VINAFPA to be rights-based. Staff and volunteers demonstrate a strong albeit culturally nuanced grasp of reproductive rights as defined by IPPF, and in line with ICPD. All programmes concerning young people are formulated around the right to information and education, access to services, privacy and confidentiality. VINAFPA is rhetorically and programmatically supportive of young people's reproductive rights, but addresses rights in terms of needs, which is non-threatening and acceptable to government.

2.2.4 Gender and Reproductive Health and Rights

In this subsection, an analysis is undertaken of the extent to which both agencies are gender-sensitive in addressing reproductive rights and reproductive health needs of young

people, as evidenced from country programme statements of how they aim to address gender issues, and the extent to which each agency collects data disaggregated by sex.

UNFPA

All CPs (except Egypt) have established gender as a cross-cutting issue, notably by shifting away from the convention of having a discreet gender (previously "women and development") sub-programme in the CP. However, there remains a paucity of understanding of and sensitivity to gender issues within many of UNFPA's government partners. In Tanzania it was noted that gender analysis in the CP remains weak, although improving, with the mid-term evaluation of the previous CP concluding that the programme had "failed to develop a framework within which to address gender issues related to service delivery and IEC". In most CPs gender remains primarily articulated in terms of meeting women's reproductive health and rights needs, with little strategic articulation of male involvement and men's service needs, although as illustrated below there are embryonic attempts to address these shortcomings. In Burkina Faso, the country evaluation notes that gender issues are "in general properly addressed in the strategies and methodologies used to implement activities in various projects". This is evidenced in the Burkina Faso UNFPA CP's successes in rights-based advocacy and policy work around female genital mutilation (FGM) and female rights regarding marriage (see also section 2.4 below). While almost all the public sector service delivery programmes supported by UNFPA disaggregate data on service users by sex, few did so on the basis of age. There is thus an absence of data on young people disaggregated by sex in the UNFPA country programmes. Box 10 below contrasts briefly the application of gender issues in the Nicaragua and Vietnam CPs.

Box 10: Gender analysis in the UNFPA Nicaragua and Vietnam country programmes

Nicaragua UNFPA staff and CP partners show a high level of awareness of gender issues. Gender is a cross-cutting issue in the CP, and taken into account in all youth-related activities. Historically this has manifested itself in an over-riding concern to ensure participation of young women, however UNFPA is aware of the importance of involving young men and the current CP includes a specific project on gender and masculinity. Promoter training and IEC materials used in UNFPA-supported adolescent projects include gender analysis as a basic building-block.

Vietnam While the need for implementing gender equity was discussed between UNFPA and partners, the discussion appears to have been more rhetorical than practical. For example, though young males are under-represented in service utilisation, UNFPA is not focused on how this should be redressed. On the positive side, indicators for utilisation are included for both males and females, so this will perhaps address at least one component of gender equity.

FPAs

Equating gender with meeting women's reproductive health and rights needs is widespread, especially in relation to service delivery. Young women continue to be the main focus of attention, in ways that do not necessarily reflect or recognise the impact that gendered social norms have on women's and men's sexual and reproductive health, and their access to reproductive health services. The specific and different needs of young men are not strategically addressed by most of the FPAs, although there were some promising signs within PROFAMILIA and UMATI of carefully considered gender approaches and of increasing institutional sensitivity to gender issues (see box 11). While most of the FPAs collect service delivery data by sex for their MIS (FPAB was a notable exception) only PROFAMILIA disaggregated by age.

Box 11: Gender in selected FPA programmes

FPAB's current Strategic Plan states it will establish equal rights for women and men to enable them to exercise control over their reproductive rights. However, until the organisation becomes more gender-sensitive it is difficult to see how this objective can be realised. No staff have received gender training.

PROFAMILIA is currently rolling-out gender training for all staff. A designated staff member reviews all new documentation and materials for gender sensitivity. Youth activities are gender-sensitive: gender issues are included in training, IEC and outreach work. PROFAMILIA's training courses for medical students focus on gender and youth-friendly services; gender is covered in most chapters of the youth promoters manual (in relation to rights, and men's and women's sexuality). PROFAMILIA clinics all have a "male clinic", but efforts to encourage young men to attend these clinics are inadequate. PROFAMILIA is working with the Association of Men against Violence.

UMATI Small-scale location-specific projects are working successfully to address issues related to gender, power and sexuality, and to reach young men with strategies to support behaviour change and to improve their access to services.

2.3 Institutional Capacity and Arrangements

This section examines UNFPA CO and FPA capacity in young people's reproductive health and rights programming in terms specifically of the numbers and expertise of staff. It also explores institutional arrangements in terms of the participation of young people in the two agencies' programmes (including for the FPAs, their participation in governance structures, according to IPPF policy); the complementarity and coordination between UNFPA and FPAs at country-level; and the two organisations' partnerships with strategic actors. The country evaluations took cognisance of the differences and contrasts in the roles played by UNFPA and IPPF at country level. The FPA is an implementing agency (guided by the policies and overall goals of IPPF). Apart from the procurement of contraceptives and reproductive health supplies and equipment, UNFPA does not implement its CPs directly, but through government, NGO and UN partners. A UNFPA CP is effectively "government owned", and its primary focus is to strengthen government capacity for direct execution of its population and reproductive health programmes. The FPA by contrast is non-governmental. The analysis in this section goes some way to explaining the contextual and strategic deficiencies highlighted in section 2.2, and provides the background for interpreting the quality and effectiveness of the UNFPA and FPA work on policy, services and information presented in 2.4 and 2.5.

2.3.1 Competencies and Skills in Young People's Reproductive Rights and Health

This subsection examines the extent to which both agencies have the competencies and skills to provide high quality technical support in the field of reproductive rights and health of young people, specifically in terms of whether the UNFPA CO and the FPA are adequately and appropriately staffed vis-à-vis their programme strategies and objectives (and monitoring and evaluation needs); staff of the UNFPA CO and the FPA head office are qualified and/or trained in key areas of young people's reproductive health (notably advocacy, gender, reproductive rights, adolescent reproductive health services), and were able to demonstrate such skills and competencies in interviews and discussions with the evaluation team. A final brief section examines the quality of capacity building and support in key areas of ARH programming provided by the regional UNFPA Country Support Team or CST (for UNFPA) and the regional IPPF office (for the FPA).

UNFPA

Overall Staffing levels

Common patterns emerged regarding staffing levels in all the UNFPA COs. Many UNFPA Representatives considered that their offices were under-resourced, in terms of professional and administrative staff. However UNFPA, as noted, is not an implementing agency, and some of the staffing issues could perhaps be addressed by more efficient and appropriate allocation of responsibilities, better prioritisation of work (staff in some UNFPA offices currently spend a huge amount of their time at UN meetings), more in-service training for staff, more capacity-building of key partners (to reduce demands on CO staff), and better technical support from CSTs or international consultants. Box 12 below illustrates some of these points (and recognition by COs of them) with short excerpts from Burkina Faso and Tanzania, before the discussion moves on to looking specifically at capacity in young people's reproductive health.

Box 12: UNFPA Burkina and Tanzania country office staffing issues

Burkina Faso. Although the CO has been organised and staffed to fit its role as a provider of technical support rather than as implementer, and despite regular CST support, staff skills and competencies do not match the needs of the CP, especially as they must make up for weaknesses of government partners. The CO is conscious of this situation, and currently planning to reorganise and build management capacity.

Tanzania There is a paucity of expertise in the CO in key youth programming areas, and the CP is working with cultural and political complexity. The CO has recently been upgraded to a UNFPA Type IV programme, which allows four core national staff (aside from support staff). UNFPA's Office of Human Resources authorises Type IV staff complements if a convincing case can be made at the time of the design of new CPs. The Tanzania UNFPA Representative made such a case at the time of the evaluation of the previous CP.

Competencies/skills to provide technical support in young people's reproductive health & rights

Most COs had the competencies and skills to provide highly effective technical support in young people's reproductive health and rights (see box 13), with the exception of Tanzania and Egypt (the latter having relied heavily in the past on CST support to compensate for its limited capacity and expertise in young people's reproductive health). All COs lacked skills and experience in gender analysis (see 2.2.4). A key lesson is the need for national staff to be experienced in working in youth reproductive health, to have social science backgrounds (to enhance cultural awareness and thus address more strategically the factors determining young people's reproductive health and rights), along with CO commitment to build the technical capacity of its staff through in-service training and external consultancy support. When these attributes are evidenced, as they are in four of the COs, there is clear capacity and competence to provide quality support for national young people's reproductive health programmes.

Box 13: UNFPA competencies and skills in young people's reproductive health and rights

Bangladesh A number of experienced senior staff have been in post for over twenty years. Recent funding from the EC (RHIYA) and UNF have enabled the CO to employ two new National Professional Project Personnel (NPPP), trained and experienced in adolescent reproductive health work.

Burkina Faso Most of the national UNFPA CO staff have worked previously within government or NGOs in reproductive health and/or with young people. In addition, several have social science backgrounds. Together these attributes provide the CO with valuable and relevant experience.

Nicaragua Staff in the CO have suitable qualifications and experience for implementation of the CP. A National Programme Officer - specifically assigned to young people's reproductive health and rights work - has been with UNFPA for five years, having previously spent 12 years working with international NGOs on young people's reproductive health; and is well-qualified to take the programme forward.

Tanzania The CO lacks expertise in young people's reproductive health and rights, and in advocacy. A newly-approved enhanced staff complement and additional NPPP posts are expected to redress these gaps in expertise in young people's reproductive health and rights, and in advocacy.

Vietnam The CO's Adolescent Programme Officer has worked for over 15 years in the public and NGO sectors in adolescent reproductive health. Other staff have gained expertise in young people's reproductive health and rights on the job rather than through formal training, and would benefit from training in M&E, BCC strategy and material development, rights-based programming, and advocacy.

Competencies and practice in M&E and lesson learning

The COs all had very similar shortcomings: inadequate M&E systems, lack of evidence-based planning, and a paucity of lesson learning and sharing (see box 14). However, a commitment to improving these systems according to UNFPA norms and standards was evidenced. This has meant that all the COs (except Nicaragua) have recently undertaken CP baseline surveys and introduced LogFrames, as part of a reorientation towards results-based management (RBM), as opposed to activity monitoring. This followed the introduction of the LogFrame programming approach in UNFPA in 1997 and the adoption of a results-based monitoring policy in 2000. However, its is clear that to date few projects in have been adequately evaluated, monitoring has been at best output-focused, and consequently – irrespective of level of commitment to lesson learning, sharing of best practice, results-based management, and evidence-based planning – there is a paucity of data.

Box 14: UNFPA CO competencies & practices in M&E and lesson learning

Bangladesh There is little or no promotion of lessons learned and best practice. The Mid-Term Review of the previous CP recommended thematic evaluations to identify "critical gaps" and "lessons learnt" which could provide substance for future planning.

Burkina Faso The M&E system appears theoretically well conceived. However, a number of projects have not been evaluated, and recommendations from reviews and evaluations are not used to modify programming.

Egypt The CO is committed to lesson-learning and evidence-based planning and design. However, while some projects are evaluated effectively and the lessons learned used in the design of future programmes, not enough project evaluations are conducted.

Nicaragua In the absence of reliable indicators, UNFPA has developed an M&E system based on six-monthly SWOT analyses. Evidence-based planning has suffered from the absence of valid data and lack of appreciation by partners of its importance (the MOH has only recently started to disaggregate statistics by age). UNFPA project baseline studies have not been used as planning and design tools, with projects designed on the basis of literature reviews of project models in other countries. There is little analysis or documentation of lessons learnt: eg project participants and UNFPA CO staff reported popular theatre as one of the most effective IEC methods, but there has been no systematic analysis of this experience.

Tanzania M&E is weak, but improving. The CO response to RBM has been to develop a programme monitoring and evaluation plan (PROMEP), with a specific project budget line within the CP (funded by 5% of each component project's budget). In addition to focusing on results and outcomes, PROMEP emphasises use of M&E findings for lesson learning and dissemination (which to date have been

lacking). The CST provided support to PROMEP, and the CO has established (but not yet filled) new M&E posts.

Vietnam M&E in the previous CP (and phase 1 of RHIYA) was extremely weak, with unclear benchmarks and no baseline or endline surveys, rendering measurement of specific outcomes difficult. An improved M&E system in the new CP should allow for better assessment of outputs and outcomes: UNFPA is developing survey tools for baseline, midline, and endline measurements. The CST has provided limited but useful assistance to the CO and government partners in M&E.

Role of CST

The wider goal of the CST system is defined by UNFPA as "to build national capacity, sustainability of national programmes, and promotion of self-reliance to achieve ICPD goals". CSTs are also mandated to disseminate good practice and lessons learnt. CST support to UNFPA COs focuses, through technical assistance, on sectoral context issues (including SWAps, UNDAF etc), design of CP and sub-programmes, capacity building/implementation of CPs, and M&E. Subsequent discussions (see sections 2.3.4 and 2.4, as well as chapter 3) will demonstrate that CST support to COs in the areas of sectoral development and dissemination/lesson learning have been limited and/or ineffective.

With regards to young people's reproductive health and rights programming, the six country evaluations show enormous variation in terms of the quality and appropriateness of the technical support received from the CSTs (box 15 illustrates). Despite variable levels, quality and specificity of expertise, it is clear that the CSTs are (or will very soon be) unable to meet the demands of UNFPA COs. This has been exacerbated during the recent years with further streamlining and staff cutbacks in CSTs. The CST in Addis Ababa for instance was recently scaled-down from 17 to just 10 advisers, as part of a wider UNFPA initiative to encourage COs to develop and access a Register of International Consultants for technical support. Evidence from Tanzania, Vietnam, Nicaragua and Bangladesh (below, box 15) shows that this process has started, but in the transitional period many COs have been left without adequate TA and backstopping in young people's reproductive health.

Box 15: CST support to selected UNFPA Country Offices

Bangladesh The CST has been a valuable resource for the CO. During the final year of the last CP, four out of 37 CST missions were specifically for ARH, with others for advocacy and M&E. Recent cutbacks in staffing mean that the CO will need to access its own international consultants for technical support.

Egypt The CST has provided effective and much-needed support to the CP in population and development strategies, but only limited support in young people's reproductive health and rights

Nicaragua Experienced CST advisers have been able to negotiate at ministerial level and carry out high quality technical work in a sensitive political environment. Senior government officials referred to the high quality and effectiveness of the CST. A CST member said the Country Representative has been astute in his use of the CST, calling for support immediately a political door opens or an opportunity for key developmental work arises. The CST did not have capacity to provide sufficient support for the young people's reproductive health work during 2001-2003 as advisers retired and their posts were not filled.

Tanzania Despite long-standing shortfalls in capacity and technical expertise within the CO in ARH, rights and advocacy, technical support from the CST over the past three years focused largely on the PDS sub-programme (especially support for the 2002 Census), on M&E capacity building, and on design of the new CP. In 2003, because of restructuring the CST office, no support had been received by the time of the evaluation, but requests have been confirmed for support in FLE and in advocacy. Key partners acknowledge the important role played by the CST in the development of the draft national AHD strategy.

Vietnam The CST has provided limited but useful assistance to the UNFPA Office and government partners, mostly in development of LogFrame and M&E systems. The CST in Bangkok was recently scaled down by 50%. Currently there are only two CST staff with expertise in reproductive health. This has meant that support from the CST has been limited, although UNFPA staff report satisfaction with the limited assistance provided.

FPAs

Competencies/skills to provide quality technical support in young people's reproductive health and rights

In those FPAs where young people's reproductive health is a relatively new area of work – Bangladesh, Egypt, Vietnam – there are serious human resource constraints to taking this work forward, as illustrated below. Furthermore, in FPAB and EFPA there was a lack of gender-sensitivity. The Bangladesh country evaluation for instance notes that FPAB remains "a male-dominated hierarchy", and although women volunteers are in the majority in most FPAB districts, few are elected to serve on governing bodies. In Egypt, the country evaluation notes that "many women are involved in running project activities, but most high executive positions [in EFPA] are occupied by men".

The FPAs from Tanzania, Burkina Faso and Nicaragua have reputations for being leaders in the field of young people's reproductive health and rights in their respective countries. While ABBEF and PROFAMILIA appear well-equipped with staff expertise to take forward their ARH agendas (including skills in gender analysis), UMATI's serious human resource constraints have eroded much of its expertise and leadership in ARH in recent years.

Box 16: FPA competencies and skills in young people's reproductive health and rights

FPAB staff lack skills to implement programmes focused on young people's reproductive health and rights. All staff require more training; there is no capacity building programme in the organisation. Medical officers receive no clinical training on STI diagnosis and treatment, counsellors receive no counselling training

ABBEF has provided training in young people's reproductive health issues to all staff. Staff and volunteers are competent and motivated, have backgrounds in sociology, health, education and communication, and have worked or are working (in the case of volunteers) with government, NGOs and academia in roles relevant to young people's reproductive health. ABBEF's competency in young people's reproductive health is well recognised by partners: staff and volunteers are regularly engaged to provide training or to lead workshops.

EFPA in recent years has suffered a high turnover of senior management and programme staff, including several changes in Executive Director and the loss of the Advocacy and IEC assistant. Until recently no specific staff member was assigned to work on youth-related issues, although a youth and gender assistant is to be appointed, and a woman and youth committee has recently been established with responsibility *inter alia* for developing strategies for working with youth.

PROFAMILIA's youth work is managed by a Coordinator at Head Office, and receives support from the training team and social marketing division. In addition there is a local coordinator in each of the 11 youth clubs. These staff are skilled, competent and committed. Medical staff in the clinics are also committed, but administrative and financial staff are less concerned to give the work high priority as it represents a cost without generating any income, an important consideration in the current financial crisis.

UMATI Key management posts are currently unfilled, notably the Clinic Services Manager and IEC/Advocacy Manager, with the Youth Manager the only management post exclusively focused on young people. Management posts which are currently occupied have seen high turnover in recent years, including several changes in the Director of Programmes and Youth Manager. Staff attrition is due to better employment packages elsewhere and a perception of poor career development prospects within UMATI due to its declining resource base. There is no training department: the Youth Manager and

Director of Programmes are responsible for overseeing the training of service providers in youth friendly services, although the capacity of both these staff members is limited.

VINAFPA has considerable human resource capacity constraints, with a Volunteer Board acting in a dual governance and management role, and the absence of a middle management layer within the organisational structure. VINAFPA has experienced severe staffing constraints over the last few years related to cuts in IPPF core funding. While there is a widely-held commitment within the FPA to working with youth, the competency and skills base in this area is weak.

Competencies and practice in M&E/Lesson Learning:

IPPF is working on a global Integrated Management System (IMS) that will enable all FPAs to record specific information about programme activities, objectives and achievements and to assess their programmes against universal indicators of reproductive health (which will include strategic planning, shared working evaluation and user participation). This is designed to enable all FPAs to share information on best practice, experiences and lessons learnt. However, it was not clear from any of the six country evaluations, as to when specific FPAs might take part in this development or how it will be integrated with their own (in some cases newly developed) MIS.

Clearly, however, urgent action is needed. All FPAs (with the exception of ABBEF) have serious deficiencies in their M&E systems (including a persistent and in some cases exclusive emphasis on monitoring the family planning components of their programmes, especially numbers of new and continuing acceptors of contraception), and lack capacity and strategic vision with regard to lesson learning and sharing best practice, as box 17 illustrates. Deficiencies have been exacerbated recently by human resource constraints which have led in many FPAs to the abolition of the M&E unit or its down-sizing.

Box 17: FPA competencies and skills in M&E/lesson learning

ABBEF has a well-developed M&E system, based on logical frameworks, data from which (along with specially commissioned studies) provide the evidence-base for planning. Lesson learning is evident: eg after an evaluation of youth services reported lack of counselling on the dangers of clandestine abortions and lack of capacity to deal with complications, there was increased attention to training of service providers and integration of abortion counselling into services.

PROFAMILIA used to have an M&E Division, but M&E responsibilities are now shared among other Divisions. The M&E system does not capture data on age of clients, and does not produce information necessary for good management. A new system is currently being designed with external technical support. PROFAMILIA promotes lesson learning internally through regular workshops and meetings. The latest Strategic Plan contains a detailed SWOT analysis which involved wide consultation among PROFAMILIA staff. The aim is to use the strategic plans as a tool for lesson learning.

UMATI Declining funds mean that the only occupied post within the Research and Evaluation Unit is the existing well-qualified and experienced Research and Evaluation Officer. Routine data from youth centres and peer education activities do not disaggregate by age group or socio-economic status; and are not used to analyse trends. The MIS for reporting to IPPF has not been revised to reflect the strategic focus on young people and reproductive rights. Clinic data are also not disaggregated by age, and therefore there is no means of monitoring utilisation of services by young people. Reporting to IPPF is focused on family planning data, and non-contraceptive services provided by FPA clinics. These data provide no means of monitoring and reporting impact on young people's reproductive health and rights. UMATI are well aware of the shortcomings of the MIS and are in the process of accessing technical assistance. In light of these M&E deficiencies, unsurprisingly lesson learning is poor.

VINAFPA Diminishing funds means the M&E Officer post no longer exists. The M&E system is basic, and focuses on measuring activities and outputs, with no attention to outcomes and impact. Baseline surveys are not routinely undertaken, nor are formal evaluations. Monitoring visits to field-level are supervisory not data collection in nature. A lot of routine data are generated, but there is no capacity for

this to be analysed and used effectively. Information generated is not recognised within VINAFPA as valuable in providing insights into progress or highlighting where weaknesses are. Inadequate monitoring is leading to widely varying quality of care being provided, lack of standardised approaches to key issues such as paying for services and client confidentiality. Lesson learning is limited to annual board meetings, in which branch offices share lessons with other staff and volunteers.

IPPF Regional Office Support

Technical assistance and capacity development support from IPPF Regional Offices to FPAs have clearly been inadequate in all the countries evaluated[3] (see box 18). Many of the IPPF Regional Offices are in a period of transition and reorganisation, focused on redefining their roles and objectives. Interviews with senior staff and volunteers in the FPAs revealed a desire for IPPF Regional Offices to foster more south-to-south exchange of different models among the FPAs in their Regions, and thereby encourage lesson learning and best practice (see also Chapter 4 on recommendations). Such exchange could be achieved effectively through programme-to-programme support, rather than exclusively through Regional or Sub-Regional workshops. There also seems to be delays in key documentation on best practice, policy issues etc reaching the FPAs from IPPF London through the Regional Offices.

Box 18: Support from IPPF Regional Offices

South Asia Regional Office FPAB report that they have received very little TA from the Regional Office in key areas of young people's reproductive health and rights

Africa Regional Office (IPPFARO) For ABBEF and UMATI, technical assistance from IPPFARO has been limited, as it undergoes what it describes as a "transitional period". UMATI expressed frustration at the lack of strategic focus and support provided by the Regional Office, although ABBEF were satisfied with the support received.

Western Hemisphere Regional Office (WHR) PROFAMILIA's support from WHR - which is undergoing an internal consultation process to redefine its role, and identify how to accomplish "its social objectives while promoting financial sustainability" – has been very limited. However, the relationship between PROFAMILIA and IPPF/WHR is somewhat atypical: because of its dependence on USAID support, IPPF funding is limited to donations of contraceptives. IPPF plans to increase TA to PROFAMILIA and has set up a multi-disciplinary country team to coordinate a more intensive programme of support. IPPF/WHR has provided small project-specific TA to PROFAMILIA, and has facilitated exchange of information and lessons learned with the FPAs in the region, usually through annual workshops.

South-East Asia Regional Office (SEARO) Support to VINAFPA has been variable over the last ten years. In terms of technical assistance and capacity building focusing on ARH, VINAFPA claims to have received most support from UNFPA, and not IPPF. Technical assistance visits from IPPF have increased recently, following a period in which VINAFPA received very little support (coinciding with the period in which there were financial mismanagement issues and in-fighting among the VINAFPA Volunteer Board). UNFPA Vietnam has been vocal in calling for additional support from IPPF. VINAFPA acknowledges that despite the capacity building support received thus far, it is still in need of greater institutional strengthening.

2.3.2 The Participation and Empowerment of Young People

This subsection explores the extent to which both agencies promote the participation and empowerment of male and female adolescents and youth, focusing specifically on whether they actively promote such participation in their national programmes and within their institutions (including the Volunteer Boards of the FPAs). Particular attention is given to the extent to which institutional arrangements/mechanisms are in place to enable young people

[3] It was not possible to assess IPPF regional office TA to EFPA as project funding and support was frozen from 1999-2002.

to participate actively in planning, implementation, monitoring and evaluation of the two agencies' programmes and component projects.

UNFPA

The evaluations show that no young people are employed in any of the UNFPA Country Offices, although many employ Junior Professional Officers (JPOs). JPOs are not nationals of the country programmes; they are funded by donor governments and tend to be nationals of donor countries. They are selected on a highly competitive basis, and are required to have a Masters degree, written and spoken capacity in at least two of UNFPA's three working languages, relevant work experience, as well as qualities such as leadership, initiative and the ability to work under pressure. Consequently, JPOs tend to be aged in their late 20s to early 30s.

There are few mechanisms for young people's direct participation in the planning, design and decision-making of Country Programmes, although Bangladesh and Burkina Faso appear to have been more successful in this than the other CPs. Participation in piloting and review of IEC materials and in implementation (as peer educators/motivators) is evidenced in a number of the CPs (as box 19 illustrates). The concept of young people's participation is not clearly understood within UNFPA's major partners in government, wherein there is often resistance. A major constraint identified by UNFPA to effective youth participation in Country Programme planning and decision-making is the time-scales imposed by donors. Participatory planning and decision-making is a lengthy process, and there is often insufficient time available before project deadlines.

Box 19: Participation and empowerment of young people in UNFPA CPs

Bangladesh Active participation by young people in programme design and planning is evidenced in baseline studies, conferences and workshops, and the formation of a National Youth Forum, which "is a good example of the CO attempting to bring youth into the process". Young people have been encouraged and included in planning for the CP and in the EC/RHI and UNF work.

Burkina Faso While there are no formal mechanisms to involve young people in programme planning, implementation or monitoring, young people are widely consulted during project design, and are active in implementation (notably in review of IEC materials, as peer educators, and in young people associations).

Egypt UNFPA has no institutional arrangements in place to enable young people to have a say in the design, management of implementation of the CP. The Youth Leadership Development project ended without sharing the evaluation findings with the implementing youth NGO. UNFPA staff admitted that institutional arrangements needed to be developed.

Nicaragua Young people's participation in decision-making and planning is limited, but more evident in implementation, monitoring and evaluation at local level. CO staff identify a number of obstacles to participation, including lack of youth organisations with capacity to be interlocutors, and donor timeframes. The principal target group is adolescents (10-19 years); young people (20-24) are largely overlooked. UNFPA has assisted in setting up mechanisms within government (SEJUVE and Youth Ombudsman) to help young people exercise their rights. At operational level, UNFPA is supporting the development and application of norms for service provision to adolescents in MOH health units. The norms clarify young people's reproductive rights and explain how service providers should respect them.

Tanzania There are few mechanisms for young people's participation in the CP, although there was a high level of engagement with young people in the design of the draft National Adolescent Health and Development Strategy, supported by UNFPA. The concept of participation is not clearly understood within the CO or its major partners in government. MOH recognises that there are few mechanisms for young people's participation in service delivery; and there is very limited youth involvement in design and implementation of UNFPA supported in-school FLE work, which is a top-down teacher-led

approach. Youth involvement and participation (YIP) is a key strategy within the Africa Youth Alliance (AYA) project (of which UNFPA is a major partner).

Vietnam There are few mechanisms for young people's participation in the CP. The concept of young people's participation in Viet Nam is still very new. The design of RHIYA Phase 2 included consultations with youth, a small step, but if continued and expanded would be a significant one. When asked about youth participation, the common refrain in Vietnam (not only with UNFPA) was that the "Youth Union is involved." The Youth Union is the largest mass organisation with a focus on young people, but most of the representatives are over 30 years of age.

FPAs

While mechanisms for young people's participation have tended to be established at project level (with the exception of EFPA which is yet to establish any mechanisms), youth participation is not institutionalised in any of the FPAs' policy-making volunteer structures (see box 20). There is a general perception among volunteers that young people lack the capacity to participate effectively in decision-making, despite IPPF's policy of encouraging participation of young people throughout the functioning of the FPAs from design through to implementation and on policy-making structures, including the Executive Board and General Assembly. IPPF recently passed a resolution stating that FPAs should have at least 20% representation by young people on their Executive Boards, with each FPA having at least one young person on their boards. None of the FPAs evaluated come close to such representation.

Box 20: Participation and empowerment of young people in the FPAs

FPAB Young people are working at community level as youth organisers and peer educators, but are not involved in management or planning. Selection to volunteer boards actively restricts young people: the nomination process only allows senior experienced males to be elected.

ABBEF Although young people participate in needs assessments, design and testing of IEC messages, and as peer educators, they are not represented on policy or decision-making structures

PROFAMILIA provides little opportunity for participation by poor, rural and other marginalised youth in its programme. Other young people participate in programme implementation, validation of IEC materials and local level planning, and to some extent in M&E. There is no representation of young people on policy-making forums, and no active participation of young people in the decision-making process at Head Office

UMATI youth centres have established youth committees (to represent views of young people to centre staff), but these are separate from the youth centre volunteer boards that are formal UMATI policy-making bodies. There is currently limited participation of young people on the UMATI National Council (the main policy-making body) and there is resistance among volunteers at Regional and District level to include young people in decision-making.

VINAFPA Youth participation is negligible. There are no arrangements in place to enable young people to participate actively in planning, managing, monitoring, or evaluation of VINAFPA's activities. At local level, project steering committees have youth representation but tend to see the Youth Union (who are not usually young) as providing the "youth perspective". Youth participation in project implementation focuses on IEC and awareness-raising in which young people are encouraged to participate in running competitions and clubs. Young people are not given autonomous oversight of these activities, and there is a dominant level of adult involvement. VINAFPA is working towards the IPPF principle of youth participation in its governance structure, although the VINAFPA constitution stipulates that a member of the Executive Committee has to be president of a local branch of VINAFPA.

2.3.3 UNFPA-FPA Complementarity, Coherence and Cooperation

This subsection explores the extent to which both agencies demonstrate complementarity, coherence and cooperation with each other at country level, in terms of the level and nature of collaboration (through projects financed by co-funding or subcontracting arrangements); complementary roles (as demonstrated by their advocacy, reproductive health services and IEC/BCC interventions and strategies in relation to addressing the priority reproductive health and rights issues facing young people); and mechanisms which allow UNFPA and the FPA to discuss their strategies and to share lessons learned.

In terms of collaboration, good examples are reported in the Bangladesh and Vietnam country evaluations, wherein it was noted that the EC-UNFPA RHIYA funding framework facilitated such arrangements (as illustrated in box 21). In Tanzania, despite UNFPA's lead role in AYA (Africa Youth Alliance), there is no collaboration between UNFPA and UMATI.

Box 21: UNFPA-FPA collaboration

Bangladesh FPAB collaboration with UNFPA is primarily in its role as an implementing agency in the EC/UNFPA initiative, RHIYA, under which UNFPA has expressed its recognition of FPAB's potential capacity for addressing adolescent and youth reproductive health and rights issues compared to many other national NGOs.

Tanzania There are no collaborative projects between UNFPA and UMATI. UMATI does not receive any core funding from UNFPA. During the evaluation UMATI expressed willingness for much greater collaboration and coordination with UNFPA, and to play an active role in the UNFPA CP.

Vietnam UNFPA and VINAFPA relate to each other through two key projects, the EC/UNFPA RHIYA and UNFPA's capacity building project for VINAFPA, with UNFPA in the role of donor and VINAFPA implementing. In addition to their collaboration at project-level, the two agencies coordinate through the NCPFC, with VINAFPA the only 'local organisation' to be a member.

While there is a good degree of complementarity between UNFPA and the FPA in the six countries, this appears to be the result of the inherent contrasts in the nature, roles and remits of the two agencies, rather than the outcome of joint planning (see box 22). Coordination and communication between the two is generally poor (except where UNFPA has entered into funding agreements with the local FPAs as illustrated in box 21 above in relation to Bangladesh and Vietnam), and in Burkina Faso. Consequently, opportunities for sharing of lessons and best (or good) practice have been lost in three of the six countries evaluated. In Egypt there is no complementarity in young people's reproductive health and rights between UNFPA and EFPA, as EFPA is not working with young people, although the proposed five-year UNFPA project on meeting the reproductive health needs of adolescents (in which EFPA is the implementing agency) will provide an albeit limited opportunity to demonstrate complementarity.

Box 22: UNFPA-FPA complementarity

Burkina Faso UNFPA and ABBEF interventions are on the whole complementary. Good communication between the two agencies and with government has facilitated sharing of experiences and permitted the development of common initiatives.

Nicaragua There is some complementarity between the approaches of UNFPA (which concentrates on policy change, IEC and service provision in the public sector) and PROFAMILIA (which concentrates on community-based IEC for young people). This complementarity is more by accident than design: the two organisations work independently and have little contact, which leads to duplication of efforts and lost opportunities for lesson-learning and analysis. Adolescent promoters' manuals and other IEC materials developed by the two organisations cover the same content; both organisations are independently promoting work through youth clubs; opportunities for joint analysis of lessons learnt on contrasting approaches to service provision (UNFPA promoting differentiated

services for adolescents free of charge, PROFAMILIA offering adult services on a fee-paying basis) have been missed.

Tanzania UMATI's approach is largely complementary to that of UNFPA. UNFPA aims to support MOH to improve youth friendliness of services in the public sector, with UMATI piloting reproductive health service delivery to young people. UNFPA is supporting FLE in schools, UMATI prioritises peer education and lifeskills approaches to reach out-of-school youth, but is also complementing UNFPA's FLE programme through the development of school-link activities in selected project sites to increase teachers' competencies in working with young people on lifeskills. Despite complementarity of approaches, coordination and lesson learning between UNFPA and UMATI have been limited. There is great potential for scaling-up best practice through improved coordination between UNFPA and UMATI and through including NGOs such as UMATI as implementing partners in UNFPA's CP.

2.3.4 Coordination and Partnerships with Others

This subsection looks at the extent to which both agencies demonstrate relevance, scope and effectiveness in their coordination arrangements and partnerships with other actors in the field of reproductive rights and health.

UNFPA

Partnerships and coordinating arrangements are assessed in terms of the extent to which UNFPA is a full and active member of relevant development assistance forums (such as bilateral and multilateral committees, SWAp steering committees, Health Sector Reviews, and the Poverty Reduction Strategy process/PRS); has succeeded in getting youth reproductive health and rights issues onto the agendas of these forums/committees; and has developed effective and meaningful partnerships with other UN agencies, national government and civil society.

The effectiveness of UNFPA's partnerships varies significantly across and within the six countries. In all the countries evaluated, with the exception of Nicaragua, UNFPA has played a key role in UN reform (notably UNDAF) and has collaborated well with UN agencies such as WHO, UNAIDS and UNICEF who are working on young people's reproductive health issues (see box 23), either directly in UN Theme Groups or interagency forums, or through multilateral and bilateral health forums. In contrast, in Nicaragua, coordination with other UN agencies has been less effective, with evidence of some duplication and lack of complementarity.

Box 23: UNFPA and the UN system

Bangladesh UNFPA has taken an active part in the development of UNDAF (leading the basic services task force), and chairs the UN Theme Group on HIV/AIDS. UNFPA is collaborating with UNF and UNICEF on an initiative for adolescent girls in six districts; and with UNICEF and WHO in joint programming on maternal mortality, adolescent reproductive health and education.

Egypt UNFPA's current country programme was developed on the basis of the United Nations Common Country Assessment (CCA). Through the CCA and UNDAF gaps and priorities were identified in relation to reproductive health, which have subsequently been articulated in the CP.

Nicaragua Coordination with UN agencies could be strengthened to avoid duplication and ensure complementarity of activities and approaches. More coordination and experience-exchange with PAHO and UNICEF who are working directly with young people and supporting similar models would be particularly fruitful.

Vietnam UNFPA has been an active player in UN Reform, which started in 1997. CO staff participate in a number of coordination meetings, such as the Health Sector Working Group, Heads of Agency meetings, and the numerous interagency working groups or task forces focusing on key cross-cutting

issues, namely youth, gender, human rights, knowledge management, external communication/ advocacy, and the UN Theme Group on HIV/AIDS.

UNFPA's effectiveness in bringing young people's reproductive health and rights to the fore in the Poverty Reduction Strategy (PRS) process has varied significantly, with identifiable success in Bangladesh, but "limited contribution, despite good intentions" in Tanzania. In all countries where there is a sector-wide approach (SWAp) in the health and/or education sector, UNFPA has elected to continue with parallel funding, rather than get involved in basket funding. UNFPA New York has made it clear that it is at the Country Representative's discretion whether to join basket-funding. Many COs are faced with a dilemma: donors are pushing for results-based programmes (encouraging UNFPA CPs to demonstrate their distinct contribution to meeting *inter alia* the Millennium Development Goals), while simultaneously encouraging UNFPA to pool funds through basket funding arrangements under SWAps. Some Country Representatives fear losing the ability to demonstrate the impact and effectiveness of their programmes if they disburse country programme funds through donor-government baskets, while many bilateral partners see UNFPA's persistence with parallel funding as limiting UNFPA's ability to exercise influence and leadership on reproductive health issues.

Failure to adopt a more experience-sharing and lesson-learning position has also limited UNFPA's ability to shape key agendas and to bring the reproductive health and rights of young people to prominence.

Box 24: Selected examples of UNFPA and sector reform/PRSP

Bangladesh UNFPA coordinates monthly donor-government health sector meetings, and has advocated strongly around reproductive health issues in the PRSP, especially regarding resource allocation for the vulnerable and hard to reach populations. While UNFPA's CP is part of the Health and Population Sector Programme (HPSP), the strategic framework for the health and population SWAp, UNFPA persists with parallel funding. In a recent controversy within HPSP, in which donors partially suspending funding, UNFPA played a significant role in ensuring continued contraceptive supplies.

Nicaragua UNFPA participates in all the main MOH and Ministry of Education commissions on reproductive health and rights, and has taken the lead role in donor coordination for the MOH in the development and implementation of a National Sexual and Reproductive Health Programme. However, UNFPA has not made full use of opportunities which its comparative advantages provide for taking a more proactive role in experience exchange and lesson-learning with donors. UNFPA's almost exclusive focus on the public sector has made the programme vulnerable to political change and to ministerial reshuffles (which partly explains lack of CP activity during 2002).

Tanzania UNFPA is a full and active member of the Bilateral and Multilateral Health Forum (and its subcommittee on Reproductive Health), the health SWAp steering committee, and the annual government-donor Health Sector Review. These forums offer an opportunity for UNFPA to contribute to strengthening health sector capability to respond to unmet reproductive health needs. However, to date UNFPA's ability to exert influence has been limited, due to human resource constraints, and its decision to remain outside the SWAp Health Sector Basket Fund (HSBF). UNFPA is engaged in the Poverty Reduction Strategy process (PRS), but the CO recognises the need to strengthen its role: as with the SWAp, UNFPA has made only a limited contribution to the PRS process to date.

With the exception of Bangladesh (where there is commitment within government to working with civil society organisations, especially in sensitive areas like young people's reproductive health, see Chapter 3 on good practices) and Burkina Faso, UNFPA has elected not to develop meaningful partnerships with civil society, primarily it seems to avoid prejudicing its close relationship with government (see box 25). The Tanzania and Egypt CPs currently have no NGO implementing partners working on young people's reproductive health issues (see box 47 re Tanzania). The paucity or absence of civil society partners has handicapped

UNFPA's ability to advocate for policy and legislative reform around young people's reproductive rights (as discussed in 2.4 below).

Box 25: Selected examples of UNFPA and civil society

Burkina Faso UNFPA works closely with NGOs, voluntary associations, and community-based organisations, in its work with young people. Following ICPD, UNFPA initiated the creation of a national network of NGOs working on young people's reproductive health. Unfortunately, the network folded due to conflict around leadership. The Network of Young People against HIV/AIDS is supported financially by UNFPA, and has more than 200 NGO members

Nicaragua Although reproductive health NGOs in Nicaragua have been working from a gender and rights-based perspective for some time, UNFPA's links with civil society have weakened in recent years (only two projects out of 26 in the CP have NGOs implementing). This is due to the uneasy relationships between NGOs and the previous government, and UNFPA's concern that close links with civil society groups might prejudice its public sector programme.

Vietnam UNFPA links with civil society and the private sector are limited by the lack of clarity of the roles of the "non-state sector" in Vietnam. Even the practical definitions of "civil society" and "local NGO" in Vietnam are unclear. There is no legal framework as yet establishing clear rules and roles for NGOs, though one has been in development for years. Mass organisations, such as the Youth Union, Women's Union, Farmer's Union, are part of the government and party structure.

FPAs

On the whole, the FPAs have not developed effective and strategic partnerships and alliances with other civil society groups working on young people's reproductive health and rights, although UMATI is a notable exception (along with VINAFPA, albeit with quasi-governmental mass organisations) (see box 26).

Relations between the FPAs and government are in most of the country evaluations considered as good – perhaps "too good" in the sense that most of the FPAs have chosen not to engage in political advocacy around policy and legislative reform (see section 2.4).

Box 26: Selected examples of FPA coordination and partnerships with civil society and government

FPAB has good relationships with government and with civil society. At the community level, FPAB's activities are accepted and highly valued, although this is for the quality of their general reproductive health service provision, and not for their work with adolescents and youth, as this is in its infancy.

PROFAMILIA has limited working relationships with other organisations. Because of the sensitivity around reproductive health service provision, relations with the MOH are covert. Synergies that could be gained through closer cooperation are thus missed. Coordination with bilateral and multilateral agencies has been very limited as PROFAMILIA's financial needs are covered by its USAID grant. PROFAMILIA will need to make a concerted effort to establish relations with other donors when USAID support declines in 2004.

UMATI has long-standing partnerships with international NGOs, in particular the UK-based Population Concern and RFSU (the Association for Sexuality Education of Sweden), who have supported UMATI's pilot approaches to young people's sexual and reproductive health and rights. UMATI is collaborating with AYA across all three components (advocacy, BCC and youth friendly services). UMATI is also collaborating with NGOs in integrating voluntary counselling and testing (VCT) services into some of its youth centres. UMATI has formed effective, albeit small-scale, partnerships with government, who recognises UMATI's capacity in lifeskills, peer education and counselling training (notably the Vocational Education Training Authority in the Ministry of Labour and Youth, the MOH on linking rural outreach with government service delivery points, and the Ministry of Education on school-link activities).

VINAFPA collaborates well with mass organisations, other local organisations, and local and central government authorities and bodies. VINAFPA receives support from the Youth Union, NCPFC, and

the MOH, due to its volunteer structure (in which VINAFPA members are often officials from mass organisations and government), but also because of the quasi-mass organisation status that VINAFPA holds and the obligation at local level to include influentials within project steering committees, to ensure project acceptance and a supportive environment for implementation. Members of mass organisations are also members of local VINAFPA project steering committees, thereby providing opportunities for sharing information on each organisation's activities on ARH, and ensuring duplication does not take place. VINAFPA's engagement in the ARH agenda will continue under RHIYA phase II, in which it will take not only an implementing role, but also an executive role. This should continue to enable VINAFPA to maintain good coordination of its ARH work with that being undertaken by others.

2.3.5 Sustainability

The country evaluations explored sustainability in terms of (i) the implications of dependence upon short-term "projectised" funding for the sustainability of interventions (particularly those of the FPAs); and (ii) the extent of incorporation of externally-funded time-bound activities/projects into the regular programmes of in particular UNFPA's implementing agencies. Issues related to institutional sustainability through capacity-building (including for partner organisations) are discussed in sections 2.3.1 and 2.3.4 above.

Table 2 shows current levels of core funding from UNFPA and IPPF to the six country programmes. With the exception of Bangladesh, the UNFPA country programmes have all seen an increasing dependence upon non-core funding[4] (ranging from the highest dependency of 63% in Tanzania to between 20% and 26% in the other four). This has had the effect of forcing Country Offices to seek increasing levels of multi-bilateral funds, which are often in the form of discrete time-bound projects, with concomitant short-term objectives, unsuited to addressing long-term aims (including the incorporation of UNFPA-supported activities into the regular budgets of government partners).

The IPPF affiliates have experienced an even greater decline in core IPPF funding. PROFAMILIA and EFPA, for unique reasons (as previously indicated), have received very little IPPF core support for some time. Of the other four FPAs, the proportion of total budget made up of IPPF support ranges from 27% in the case of UMATI in Tanzania to 68% in FPAB in Bangladesh.

Declining core funding, and the consequent dependence upon time-bound projectised funds have clearly affected programming and staffing levels in both agencies (as already indicated). This has been particularly acute for many of the IPPF affiliates who have large numbers of staff posts unfilled; and have effectively been driven into subcontracting arrangements within larger donor-funded regional or national programmes, and/or the introduction of user fees in an attempt at cost-recovery (with the consequent effects of reducing access to the poorest).

The six UNFPA CPs have shown variable success in incorporating activities that they support into the regular budgets and programmes of government partners. Vietnam and Nicaragua have demonstrated notable achievements, whereas the other four (see box 27) have been less successful, due to varying degrees to inadequate attention in the design of the CPs to strategies for hand-over to government partners, insufficient involvement of partners in the planning and design of CPs, and a consequent lack of "ownership" by partners of activities, projects and subprogrammes. In the Nicaragua CP, an effective strategy to increase the likelihood of public sector partners' incorporating time-bound UNFPA projects into their regular programmes has been to develop partners' capacity to raise additional external funding. UNFPA recognises that in the context of budgetary constraints

[4] Additional (non-core) funding for young people's reproductive health in Tanzania, Bangladesh and Vietnam has come from AYA and RHIYA (see 2.1.2, and notes to table 2 for further information).

within government departments, an enhanced capability to generate funding from other sources is an effective short-term strategy for sustainability.

There has been a significant inflow of international funds for HIV/AIDS in five of the six countries in the past two years (all except Egypt have received support from the Global Fund, and in Tanzania this includes funds explicitly for addressing HIV vulnerability among youth). Greater efforts to capitalise on these additional funds for HIV/AIDS programming to support activities with young people are thus warranted.

Box 27 illustrates some of the consequences of the issues raised above for sustainability within the FPAs and the UNFPA CPs.

Box 27: Sustainability

FPAs

ABBEF Activities remain strongly dependent on external funds, linked to specific donor-driven projects. These projects undermine the coherence of ABBEF's interventions by creating fragmentation rather supporting a truly integrated strategy. The sustainability of interventions is also undermined: funding gaps arise as projects end, breaking the momentum of activities.

PROFAMILIA Sustained financing of young people's activities will depend on ability to raise funds externally, a skill lost during the recent years of abundant funding from USAID.

VINAFPA's rapidly diminishing core funding base makes it impossible to incorporate externally-funded time-bound youth focused activities into its regular programme - a situation that is likely to persist for the foreseeable future until VINAFPA is able to strengthen its core funding base.

UNFPA

Burkina Faso The Country Programme suffers from inadequate planning for project sustainability, and lacks clear strategies for hand-over to government partners, who do not participate sufficiently in the planning process, resulting in lack of ownership (evidenced also in the country evaluations of Egypt and Tanzania).

Nicaragua Notable successes with full hand-over to government are evident: municipal governments are supporting adolescent clubs (see box 42), and the army and police continue to meet the costs of educational work in their colleges. UNFPA has provided support to strengthen partners' capacity to formulate projects and seek additional external funding.

Vietnam Successive CPs have been designed with sustainability and scale-up firmly in mind. UNFPA, and government, report UNFPA's greatest strength is in testing demonstration models, especially at provincial level, which the government can then take to scale.

2.4 Policy Development and Reform

This section explores the extent to which both agencies are stimulating enabling environments for policy development and reform in the field of reproductive rights and health of young people. The discussion and analysis focuses on the adequacy of resources allocated to policy and advocacy work on young people's reproductive health and rights; awareness and understanding of key policy and laws, and of the socio-cultural, religious and political factors, that impact on the reproductive rights and health of young people; and the perceptions of key partners of the two agencies' influence on the development of national policy, guidelines, and professional norms/ standards relevant to young people's reproductive health and rights.

UNFPA

Most of the UNFPA COs evaluated were fully cognisant of legislation and national policies which affect young people's reproductive health and rights, and recognise the need for clarification and reform of many of these policies and laws (Egypt appears to be the exception). In terms of resource allocation, Table 2 shows the range of share of CP budgets (from 9% to 39%) allocated to policy and advocacy work. There is a paucity of financial data disaggregated to show proportions allocated specifically to policy and advocacy work on young people's reproductive health and rights. However, from the country evaluations it is evident that the CPs in Tanzania, Bangladesh and Egypt (see box 28) have only a limited focus on policy and advocacy in general, and on young people's reproductive health and rights in particular. The absence of an articulated rights-based approach by UNFPA in Bangladesh and Egypt, as noted in section 2.2.3, is in part the result of cultural sensitivities (the term "reproductive rights" has even been removed from CP documents). It has proved difficult for these UNFPA Country Offices to operationalise a broad concept of reproductive rights, and they tend to refrain from open dialogue with government partners on how to develop a culturally-specific rights-based approach. In Tanzania, although UNFPA is recognised by many bilateral and multilateral agencies as an effective lead agency in relation to wider population and development issues, some consider that it has failed to develop fully its leadership role in reproductive health and rights (see box 24).

Box 28: Policy and advocacy for young people's reproductive health and rights by UNFPA in Bangladesh, Egypt and Tanzania

Bangladesh While government attributes successes to date in policy development to its collaboration with UNFPA, donors and NGOs are more critical: the former with the lack of clear leadership from UNFPA on reproductive health, the latter about the small-scale of UNFPA's work and the failure to embrace a rights-based approach in its advocacy work.

Egypt UNFPA's advocacy efforts have focused on FGM, working with the media, religious leaders and government. The country evaluation, however, notes that " a wider range of rights-related issues, such as violence still need to be included and tackling of (traditional) gender roles among (rural) youth should continue". Lobbying for reproductive rights has been difficult following the very negative media response to ICPD, as well as the UNFPA CO's "unfamiliarity with reproductive rights in general (let alone with those oriented at young people)".

Tanzania Historically, UNFPA's contribution to policy reform and advocacy has centred around on the national population policy, family planning, and more recently on awareness-raising among senior policy-makers of the ICPD POA. UNFPA's contribution to stimulating an enabling environment for policy support to young people's reproductive health and rights has been limited. Despite advocacy and policy reform objectives in successive CPs, inherent flaws in design and implementation, and the weak capacity of key partners, has meant that UNFPA has made little difference to the policy environment for young people. The current AYA initiative to review laws and policies relating to or affecting young people's reproductive health and rights (for which UNFPA is the lead agency), and the review work undertaken for development of the draft AHD strategy, have increased UNFPA and partners' awareness of policy and legal issues. It remains to be seen how effective the CP and AYA will be in terms of translating increasing awareness into reforms. Some bilateral partners expressed the view that UNFPA's decision to remain outside the Health Sector Basket Fund set up under the health SWAp, hampers its policy advocacy role.

In Burkina Faso, Nicaragua, and Vietnam significant efforts have been made to support policy and legislative reform and to increase public awareness of young people's reproductive health and rights issues. In Vietnam 10% of the total CP budget is allocated specifically to policy and advocacy for young people's reproductive health and rights, despite political constraints to rights-based work (see 2.2.3 above). In these three countries, UNFPA has developed effective partnerships with key government agencies, including the provision of information and training to these partners in policy and legislative issues, and developing

relations of trust in politically sensitive milieu (notably in Vietnam). These partnerships have facilitated UNFPA's advocacy work. In Nicaragua the absence of effective partnerships with and support for civil society organisations has, however, limited the effectiveness of policy reform and advocacy efforts. Box 29 illustrates the effectiveness and impact of these three CPs on policy and advocacy for young people's reproductive health and rights.

Box 29: Policy and advocacy for young people's reproductive health and rights by UNFPA in Burkina, Nicaragua and Vietnam

Burkina Faso The legislative and political framework as it relates to the reproductive rights of young people has developed positively during the last two decades: the adoption of the Personnel and Family Code and particularly the rights and duties of spouses, the repeal of the law forbidding use and promotion of contraception, the promulgation of the law prohibiting FGM, and modifications to the law against abortions. UNFPA has contributed to these changes through direct advocacy with high-level authorities, and by supporting the creation of other lobbying groups (eg the National Advisory Group Against Excision), and sensitisation of parliamentarians.

Nicaragua Support for policy reform has been a key area of UNFPA's work. UNFPA has worked with Ministries of Health and Education and supported the formation of the Youth Secretariat (SEJUVE), now one of its key partners in government, and the Youth Ombudsman. UNFPA has played an important role in the development of legal structures to protect young people's rights. UNFPA has kept a low profile in advocacy work, preferring to promote policy change when opportunities arise (as illustrated by its recent work on sex education in schools). However, it has not used its technical and financial resources to strengthen civil society groups active in advocacy work on young people's rights, who could also increase the impact of UNFPA's work on public opinion change.

Vietnam UNFPA has been instrumental in establishing a UN Interagency Working Group on Youth, which aims to mainstream youth issues (including reproductive health where appropriate) into other UN programmes. Senior staff have a clear understanding of how policies are developed and implemented, and how to influence that process. Youth issues are arguably less clearly understood by partner agencies. Government has been opening up through the *doi moi* reform agenda, but advocacy and the introduction of "new" or "outside" ideas requires more sensitivity than in many countries; and UNFPA has demonstrated such sensitivity. All UNFPA partners - government, mass organisations, and UN agencies - recognise UNFPA's lead role in the development of national policies especially those associated with young people, including the Vietnam Population Strategy 2001-2010 (adolescents are a specific target group), the National Strategy on Reproductive Health 2001-2010 (the adolescent focus is more on provision of information than services), the National Standards and Guidelines for Reproductive Health Care Services 2003; and the recently approved National Youth Development Policy.

FPAs

As non-governmental organisations, the FPAs would be expected to be at the cutting-edge of advocacy for policy and legislative reform in relation to a vulnerable group like young people, in line with their IPPF-affiliation mandate (IPPF's *Vision 2000* proposes that its affiliates should be active advocates of reproductive rights). Table 2, however, shows that the FPAs are allocating very few resources to advocacy and policy generally. This represents one of the most disappointing findings of the evaluation. VINAFPA, EFPA, FPAB and PROFAMILIA are effectively doing nothing in the field of advocacy for legislative and policy reform in relation to young people's reproductive health and rights. ABBEF has, however, been engaged in important policy reform issues, and UMATI has a clearly articulated strategy for advocacy on young people's reproductive health and rights issues, but limited resource availability means that their work, while pioneering is not having as much impact as it could.

The paucity of advocacy efforts by the FPAs is in part the result of their failure to adopt rights-based programming, which in turn stems from the political and cultural sensitivity in some of the countries to the concept of rights. Box 30 shows that explanatory factors are locally specific: VINAFPA is constrained by its proximity to government where the Party

remains strong and civil society has little voice, while PROFAMILIA is effectively shackled by its dependence upon USAID. Broader lessons and recommendations which emerge from the country evaluations in relation to FPAs and advocacy are highlighted in chapters 3 and 4.

Box 30: FPA advocacy for policy and legislative development and reform

FPAB Advocacy and policy development are not part of FPAB's work. Staff and volunteers have a poor understanding of how laws affect reproductive rights, and lack interest and skills in advocacy. The proportion of the current budget allocated to advocacy and policy work on young people's reproductive health and rights is just 1%. No staff member has specific responsibility for advocacy and policy reform.

ABBEF has actively supported the reform of the law prohibiting use and promotion of contraceptives, and the law that permitted the expulsion of schoolgirls due to pregnancy. It is also engaged in advocacy to eradicate FGM through its membership of the National Committee Against Excision. Many volunteers and former staff of ABBEF work with government or international institutions and are responsible for advocacy and policy reform efforts.

EFPA does not engage in policy reform or advocacy. The country evaluation notes that EFPA has a "… tendency to respond to the interests of ministries rather than providing a clear, articulate and distinct voice from outside the government structure".

PROFAMILIA has not adopted an advocacy role vis-à-vis young people in the sensitive socio-political context of Nicaragua. Significant elements of IPPF's Vision 2000 are incompatible with the policies of USAID, and in order to safeguard its USAID funding PROFAMILIA signed the Mexico City Accord. However, PROFAMILIA staff are effective advocates for young people's reproductive rights at community level. PROFAMILIA has developed norms for its services that are generally of higher standard than those of the MOH. It has shared these norms with the MOH and professional bodies, but has not taken the lead in raising service quality standards at national level.

UMATI's advocacy activities are currently constrained by lack of funds and staff. The IEC and Advocacy Officer post is currently vacant. The first goal of UMATI's current strategic plan is to advocate for change to laws, policies and practices to empower youths to exercise their reproductive rights. Of the five strategies set out to achieve this goal, only two have been funded over the past three years because of resource constraints: small-scale projects raising community awareness on harmful practices, and increasing young people's knowledge on reproductive rights working with education authorities, district leaders, community leaders, the media, NGOs, lawyers associations, religious leaders and teachers.

VINAFPA. While staff and volunteers at head office demonstrate good understanding of the policy and laws that affect young people's reproductive health and rights, there are no human or material resources dedicated specifically to advocacy. Challenging state policy in Vietnam is actively discouraged, and although some local organisations undertake a challenge function, VINAFPA's proximity to government (through its membership of NCPFC) prevents it from doing so. At provincial level, VINAFPA has focused on creating an enabling environment in which their ARH work can operate more effectively. There is also little evidence of VINAFPA impacting on the development of national guidelines, norms and standards

2.5 Reproductive Health Services and Information

International consensus since the mid-1990s (see for example UNICEF, 1997) holds that the most appropriate and sustainable approach to reaching young people with services and information is through mainstreaming 'youth-friendly' services within existing health service delivery structures. UNFPA itself has highlighted that in poor countries, the greatest barriers to young people's use of public sector health services are lack of privacy and confidentiality, negative attitudes of providers, and inappropriate clinic opening hours (UNFPA, 1997). Tailoring existing health services to make them youth-friendly should not require significant

additional resources, but services which have "… attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their youth clientele for follow-up and repeat visits" (Senderowitz, 1999: 11). The table below sets out the key components of youth-friendly services from a wide range of documents published since ICPD.

The components of youth-friendly services
• Services geared to the specific needs of different groups of young people. • Young people involved in service management/monitoring. • Skills-based education and behaviour change communication (to enable young people to explore values/feelings and to assess and address risks) - combined with access to services. • Engagement with the wider community (including parents), presenting accurate and up-to-date information about the health problems faced by young people. • Service providers and educators who have a commitment to serving young people in a non-judgmental manner (with respect for individual rights and feelings); and who are technically competent, with good communication and counselling skills, trained to deal with young people's concerns around sexuality. • Services provided confidentially and in a way that maintains privacy. • Clear guidelines and service delivery protocols that ensure quality. • A comprehensive array of health services (to meet different needs of young people). • Clear information for young people on the types of health services being provided and the way in which they are delivered, through promotional materials and peers.

The evaluation considered young people's access to reproductive health information, education and services as a central rights issue. This section explores the extent to which both agencies are supporting the development and delivery of youth friendly reproductive health services and IEC/BCC as part of an effort to stimulate an enabling environment for young people's behaviour change in relation to their reproductive health. The analysis focuses initially on the resources allocated to providing and/or supporting services and information for young people. This is then followed respectively by an analysis of the attention paid to gender and reproductive rights issues by each agency in their work on service strengthening and IEC, and of the extent to which both agencies are improving the accessibility and quality of youth friendly services and information.

UNFPA

Resources allocated to services and IEC aimed at improving the reproductive health of young people.

Table 2 shows that all CPs allocated a significant proportion of their budgets to services/IEC (averaging over 60% across the six countries). In terms of allocation specifically to young people's services and IEC, the data are patchy at best. The CPs in Egypt and Tanzania have to date devoted very few of their resources specifically to youth services and IEC. In Tanzania, although there are budget allocations to youth services and IEC within the reproductive health sub-programme of the new CP, there has been no implementation to date. In Vietnam (8% of total budget) and Bangladesh (5%-10% of total budget), there is a clear but limited commitment of resources to youth services/IEC. In Nicaragua [5] and Burkina Faso over 18% of the total CP budget is allocated specifically to services/IEC for young people.

[5] Over 30% of the total Nicaragua CP budget is allocated to youth issues, an estimated 61% of which is to services/IEC

Attention to gender and reproductive rights issues in service strengthening and IEC

Poor understanding and application of gender issues in many of the UNFPA CPs has resulted in equating reproductive health service and information issues with meeting young women's needs, and limited attention to the reproductive health needs of men, and to their role in determining women's access to services and information. The Nicaragua CP has addressed the issue of services for young men through its differentiated services model (see box 46, case 1). The Nicaragua, Bangladesh and Burkina Faso CPs have made some progress, in terms of raising a broader awareness of gender issues among public sector service providers, and in articulating gender more effectively in the IEC materials and strategies that they support.

Reproductive rights – in line with the ICPD POA – are equated within many of the UNFPA COs evaluated with the right to services and information (as already noted reproductive rights do not feature in either the Bangladesh or Egypt programmes). UNFPA Nicaragua has been more successful than any of the other CPs evaluated in integrating a rights-based approach to the delivery of services and the development of IEC materials and strategies, with important work in public sector staff training, in higher education, ad in the development of service norms and standards (see box 31).

Box 31: UNFPA attention to gender and rights issues in reproductive health service strengthening and IEC

Bangladesh UNFPA has integrated gender issues into the reproductive health training of service providers. Pilot projects have demonstrated the need for the provision of services for males and females at separate times, which are now supported by UNFPA.

Burkina Faso UNFPA addresses key reproductive rights and gender issues in the IEC materials and strategies it supports. As a result of UNFPA information-based activities, health facility staff are gender sensitive and show high levels of awareness of the health problems associated with female circumcision and abortion and the corresponding laws associated with them.

Egypt Poor understanding and application of gender issues in the CP has resulted in limited attention to reproductive health service access for men, and no effort to date to raise awareness of male responsibility

Nicaragua Service delivery supported by UNFPA includes training for staff in rights and gender equity, concepts which are now incorporated in MOH norms for attention to adolescents (although monitoring of the application of these norms is missing). UNFPA support for development of a Masters in Reproductive Health (with modules on rights and gender) should ensure that rights and gender equity become integral in service delivery (including to young people), as most graduates are in management positions in the public and NGO sectors. UNFPA's work in the formal school education sector starts from the concept of rights to education and information in sexuality and reproduction, without which adolescents cannot take informed decisions. Rights have been included in many of the IEC/BCC materials produced by UNFPA's partner organisations.

Tanzania There is no framework within the CP through which to address gender issues related to service delivery. Resources focus mainly on women-oriented service and IEC activities, with no explicit strategy for addressing the specific service delivery needs of young men. The CP states that it aims to increase the rights of all individuals irrespective of age, marital status, and ethnicity to access reproductive health information and services, provided through the public sector. UNFPA has promoted reproductive rights through community-based sensitisation, with particular success in Zanzibar. The UNFPA CO recognises that a rights-based approach has not been internalised or operationalised within the CP.

Vietnam The CP defines gender equity in terms of supporting females. Addressing men's involvement in reproductive health is inadequate. UNFPA-supported government clinic utilisation data by age and

sex are not readily available. The CP's focus on rights relates to the right to access information and services; along with the rights to choice, and to participation.

Improving the accessibility and quality of services and information

Only Nicaragua of the six CPs evaluated has made a significant contribution to promoting accessible and quality services and information for young people. UNFPA Nicaragua (see box 32) has supported the establishment of models of youth friendly services (including IEC/BCC for young people), although it has missed opportunities for experience sharing and lesson learning with other agencies. Burkina Faso has also supported the development of public sector services for young people, through adaptation of the youth-friendly approach to government-run health centres and youth centres. The current phase of this initiative is still relatively new, but shortcomings with IEC/BCC are evident and are likely factors in the low service utilisation rates by young people.

Box 32: UNFPA improving the accessibility and quality of services and IEC

Burkina Faso UNFPA supported separate public sector youth-friendly centres until 2001, but since then has (for cost-effectiveness reasons) supported integration of services for youth into existing MOH health centres and youth centres run by the Ministries of Social Action and of Labour, Employment and Youth. UNFPA also supports a local NGO initiative, which adapts services to meet the specific needs of young people in 12 urban public sector health centres – using preset standards of services, such as adapted hours and fees, separate entrance, and "youth friendly services". However, in both the MOH government-run youth centres, and NGO initiative, there remains exceedingly low utilisation of services by young people. IEC material is often unavailable in health centres, and no study has been undertaken to determine the acceptability and effectiveness to young people of these IEC/BCC materials.

Nicaragua UNFPA's work in services and IEC for young people has been extremely effective (see chapter 3 on good practices; the major successes and some constraints and shortcomings are highlighted here). UNFPA has promoted the establishment of separate services for adolescents in MOH health units, and service norms for adolescents. Its principal demonstration projects have linked adolescent clinics - which improve supply of services - to youth clubs which are increasing demand. UNFPA-supported municipal youth clubs provide recreation, IEC and life-skills BCC; and deploy adolescent promoters for outreach and referral of young people to MOH clinics. Several organisations are supporting youth clubs of this type, and there are missed opportunities for collaboration, experience exchange, lesson-learning and analysis of cost-effectiveness. UNFPA is also working to promote reproductive health information and education in the formal education system, and has funded IEC material production, is yet to undertake any studies of the effectiveness of materials. Most organisations working in adolescent reproductive health in Nicaragua have produced their own IEC materials, often working from the same rights and gender perspective. Some of the most effective materials are those produced by adolescents themselves. Again there are clearly opportunities for collaboration, coordination and lesson-learning in this area, and UNFPA could use its comparative advantages to take the lead.

Of the other four CPs, Bangladesh and Egypt have made little or no attempt to promote youth-friendly services through the public sector. Vietnam and Tanzania propose in their current CPs to, respectively, develop support for youth-friendly corners in public sector facilities and the development of a minimum package of adolescent friendly health services for the MOH (see box 33). Chapter 3 discusses and analyses the factors which explain this lack of response to date by these UNFPA CPs. The current UNFPA Tanzania CP has supported a small-scale but innovative lifeskills BCC project with young people through an international NGO, but there are doubts about the capacity of district government to implement.

In those CPs where there is a range of organisations supporting young people's reproductive health services, youth clubs, and youth-focused IEC/BCC materials and interventions,

UNFPA seems to have missed opportunities for collaboration, experience-exchange, and lesson-learning. This is probably at its most stark in relation to IEC materials, where little has been done by UNFPA within its CPs to coordinate or lead on either the development of a coherent national IEC strategy or on the collation and centralisation of IEC materials.

Box 33: UNFPA shortcomings in improving accessibility and quality of services and information

Bangladesh Although the country evaluation notes that it is "virtually impossible for an unmarried girl to access reproductive health services" through the public sector, the recently-completed CP had no project focused on services for young people. The new CP has plans for training service providers, and a pilot project with NGOs to provide youth friendly services. IEC messages are generic and not audience-specific. IEC/BCC strategies supported by UNFPA for young people have been in-school (with a major input into curriculum development where reproductive health and rights have been incorporated); out of school; and youth clubs. The skills and competencies of the teachers and peer educators are still weak.

Egypt Despite evidence of pressing reproductive health needs, young people have been largely neglected in public sector services. UNFPA addresses the needs of married women. Information and education developed with support from UNFPA has not been tailored to sub-groups based on age, region, urban-rural residence, sex, or marital status.

Tanzania To date UNFPA has not supported the implementation of any activities relating to the delivery of young people's reproductive health services, although the current CP includes development of a minimum package on Adolescent Friendly Health Services. Constraints identified by UNFPA are lack of MOH capacity to prioritise and implement youth friendly services, weak coordination between UNFPA and AYA, and MOH resistance to including NGOs as implementing partners. In terms of IEC, UNFPA has been supporting family life education (FLE) in schools, but many of the modules have little relevance to the reality of young people's lives, linking sexual and reproductive health to population dynamics and moral debates on family life. UNFPA's support to training teachers in the FLE curriculum has a limited focus on addressing teachers' attitudes (despite high levels of sexual exploitation of pupils/students by teachers). There has been no involvement of young people in design or implementation of FLE. Young people cite local theatre, entertainment and dialogue with peer educators as their preferred sources of information, with very few indicating that knowledge on reproductive health issues had been acquired in school. UNFPA (see chapter 3) has supported a lifeskills project implemented by an NGO, which trained young people as peer counsellors, parents in parent-youth communication skills, and community members as para-professional counsellors, and led to changes in behaviour and attitudes among young people. Funding has now come to an end, and the approach is to be implemented by the MOH at district level, although there may be insufficient capacity to take the approach forward .

Vietnam Little effort has been put into making public health services youth friendly. UNFPA is proposing support for youth-friendly corners in government facilities, targeting out-of-school youth, ethnic minorities, and street children. It remains to be seen how youth will participate in implementation, monitoring, and evaluation of youth-friendly services. UNFPA has sponsored the development and dissemination of a plethora of IEC materials focused on young people, including books, booklets, leaflets, posters, videos. While these address a wide range of issues and focus on providing accurate information on issues such as puberty, HIV/STI transmission and prevention, and drug abuse, they are not developed with behaviour change in mind, and young people report the information is too superficial. None of the materials address risk perception or other barriers to behaviour change. There is still duplication of efforts, different partners producing similar materials.

FPAs

Resources allocated to services and IEC aimed at improving the reproductive health of young people.

As with UNFPA, the budget allocation data for FPAs set out in table 2 are indicative only. All the FPAs devote the majority of their programme budgets to reproductive health services and

IEC (indeed in some cases, the FPA allocates its entire programming budget to services/IEC). The percentage of these budgets which are specifically targeted at young people is difficult to discern from the available data. Most FPAs continue to devote only a very small proportion of their overall programme budgets specifically to young people's reproductive health. UMATI in theory devotes 100% of its programme to work with young people in its new paradigm shift (85% of which is for services/IEC), but as noted this paradigm shift is far from operationalised and a large proportion of budget and staff time remains devoted to general services/IEC. EFPA has since 1999 allocated no funds specifically to youth programmes (pre-2000 it was between 3% and 8% annually), and around 4% of the PROFAMILIA budget is specifically allocated to young people. In contrast, FPAB devotes around 14% and VINAFPA around 16% (expenditure on which has increased threefold over the last ten years) specifically to young people's activities.

Gender and rights in service delivery and IEC

Gender and rights are not well-incorporated into the FPA strategies for the delivery of reproductive health services and information to young people.

FPA shortcomings with defining and operationalising reproductive rights in their programmes have been highlighted in 2.2.3 above. An crucial element of youth-friendly services - the right to privacy and confidentiality– is insufficiently addressed by many of the FPA services evaluated. Overall, the evaluation findings were also disappointing with regards to the extent to which the FPA IEC/BCC materials and approaches address priority rights issues, with EFPA and FPAB particularly constrained. The evaluation of FPAB for instance notes that "reproductive rights are not incorporated into FPAB's approach to service delivery… No IEC materials contain any reproductive rights information". However, with regards to rights-based IEC, PROFAMILIA has shown (see box 34) that appropriate TA and institutional commitment can facilitate the development of rights-based IEC.

Box 34: PROFAMILIA'S rights-based IEC

PROFAMILIA has received TA in IEC and communications from Johns Hopkins University and now has in-house capacity to design good quality materials. The manual used for training youth promoters and for work with mini-club members has a comprehensive chapter on rights that provides details of a wide range of rights as they relate to young people's reproductive health, based on IPPF's *Vision 2000*. The information is easy to understand with appropriate examples and there are games and participatory exercises that the youth promoters carry out with their club members. Youth clubs also have other materials such as a poster produced by IPPF that spells out young people's rights and a video that takes each right in turn and provides an example from a different part of the world. These materials are shared with all young people visiting the clubs. The majority of young people (including those not involved in PROFAMILIA or other youth clubs) are aware of their human and reproductive rights, even though they experience obstacles in exercising them.

With regards to addressing gender issues, FPA service delivery strategies remain overly focused on meeting women's reproductive health needs, and lack strategic approaches to address effectively the needs of young men, as is illustrated by VINAFPA and PROFAMILIA below (box 35). The shortcomings with STI services for young men is of particular concern in the context of emerging HIV epidemics.

Box 35: Gender and service delivery in VINAFPA and PROFAMILIA

Despite most PROFAMILIA service outlets running male clinics once a week (offering a wide range of services) the numbers of clients is low, and there is no particular effort to encourage young men and boys to attend. The marketing of male clinics is not integrated with IEC for the youth programme and the number of young male clients attended is not recorded.

VINAFPA is failing to address gender issues in its service delivery. Service statistics indicate clearly that more young women are being reached than young men – indeed, a snapshot of STI treatment statistics showed 100% of clients were women. This is a serious concern. Either the youth service is totally unsuitable for young men and they seek treatment elsewhere, or VINAFPA is not undertaking 'partner treatment' action, despite having trained its service providers in STI diagnosis and treatment protocols. Despite programme data/records clearly showing the significant lack of male involvement in ARH service provision, VINAFPA has not yet developed a strategy aimed at addressing the needs of young men, beyond engaging in condom social marketing.

Where innovative rights and gender based IEC and service projects are successfully piloted, the FPAs (eg UMATI, see box 36) have been constrained by lack of human and financial resources, and lack of capacity for lesson learning and dissemination of best practice, in their efforts to scale up.

Box 36: Rights and gender in services and IEC. UMATI's pilot projects

The main focus of UMATI's approach is on the rights of the client, and the rights of all young people to access reproductive health information and services. Gender-specific strategies have been piloted through a project designed to address issues related gender, power and sexuality and to reach young men with strategies to support behaviour change and increase their access to services. Gender integration has been one of the important aspects of the project, and the Tanzania Gender Networking Programme (TGNP) provided training of trainers on gender issues. Other small-scale projects are directly addressing issues related to reproductive rights, using a range of media (billboards, leaflets etc) with reproductive rights messages. As with other innovative projects run by UMATI, the challenge (which UMATI is losing in the context of resource constraints) is how to scale up from these small pilots. Absence of capacity for lesson learning and dissemination of best practice further constrains scaling up

Accessibility and quality of information and youth-friendly reproductive health services

Only two of the FPAs (UMATI and ABBEF) have developed and are implementing youth-friendly services. ABBEF's strategy is based on its four - exclusively urban-based – youth centres, which although operating through the component principles of youth-friendliness identified above are not reaching young men with services and information (see box 38). UMATI's approach to youth-friendly services includes a wide range of service delivery strategies (clinics in youth centres, peer education, community-based services), but is faced with the challenge of how to scale-up to reorient its core clinics (which focus on adults) to reach young people as their primary clients.

Box 37: UMATI's youth friendly services and shift to BCC

UMATI's service delivery strategy for young people consists of a range of small-scale, geographically-dispersed approaches including the integration of youth-friendly clinic services into multipurpose youth centres, peer education linked to youth centres, integration of an ARH component into community-based services, and pilot approaches linking peer education to government dispensaries. UMATI's integrated reproductive health approach includes STI diagnosis and treatment, sexual and reproductive health counselling, and HIV/AIDS Voluntary Counselling and Testing (VCT), which is available in two UMATI youth centres. UMATI is however constrained by lack of financial and human resources in its efforts to scale-up its service delivery to young people, and to reorient its 12 core clinics (which currently focus on adults) to reach young people as their primary clients, and has had to postpone the renovation of these clinics and the training of service providers in youth friendly services. Internal UMATI lesson learning on best practice – a basic necessity for any scaling-up approach - has been undermined by lack of data from which to analyse trends in service utilisation by young people and the relative cost-effectiveness of different service delivery approaches. UMATI recognises this limitation.

Efforts have been made at project level to respond to the diversity of service needs: youth friendly service components have been integrated into projects reaching refugees; and differentiated

strategies have been adopted to reach in-school and out-of school youth (through school-linked interventions in some sites, and peer education to reach out-of-school youth), to address the needs of married and un-married youth (integrated youth centre-clinic services largely target unmarried youth, while married youth access core clinics), and to reach rural young people (CBD agents are trained in ARH, peer educators are incorporated into the rural CBD programme).

UMATI for some time relied upon rather conventional IEC approaches, but in recent years has supported innovative youth-focused BCC initiatives. However, it has been unable to scale-up this innovative work. IEC materials have been produced with young people's participation and address a range of priority issues identified by young people. However, materials have not yet been developed to address the differing age-specific needs of young people. A small project developed a BCC approach, and UMATI is currently developing a lifeskills manual and has undertaken training of trainers. Peer education has been an important component of UMATI's reproductive health education approach since the late 1980s. A recent evaluation of the peer education programme indicates that peer educators have been effective in making referral to services, but noted that they focus on information giving and need further training in counselling skills. The challenge for UMATI is to scale-up and integrate these different project-based approaches into an IEC/BCC strategy for the overall programme. However, coordination and capacity to take this forward is currently constrained by no IEC/Advocacy Manager.

Youth friendly service strategies are at various stages of development in the other four FPAs (see box 38). FPAB has recently started youth friendly services, but clinic staff have not been adequately trained, and the introduction of user fees is limiting access for poorer young people. EFPA and PROFAMILIA also charge for services and neither provides youth-friendly services. EFPA clinics are women-focused, "unfriendly to men", and do not cater specifically for young people. PROFAMILIA maintains that service quality in adult clinics should be sufficient to attract young people. PROFAMILIA's service user group is middle-income, with no attempt to reach the poor or marginalised. VINAFPA has to date not focused on provision of services for young people, focusing instead on IEC and counselling.

The quality and availability of the FPAs' IEC materials and strategies is generally poor. FPAB programme sites lack IEC materials, and one-stop educational sessions run by youth organisers are inadequate. ABBEF relies heavily on written materials with moralistic messages which require secondary school education and familiarity with French to comprehend. EFPA targets educated groups, with a heavy focus in its IEC on family planning. VINAFPA has taken a strongly IEC based approach as opposed to BCC, and its IEC materials and outreach strategies do not specifically differentiate between different age and social categories of young people. Although PROFAMILIA's IEC materials and methods are of high standard, clear and easy to understand, there is little focus on BCC. Only UMATI (as illustrated in box 37 above) has made a serious shift from conventional IEC to support for innovative youth-focused BCC initiatives, but human and financial resource constraints mean that it has been unable to scale-up this work.

Box 38: Strengths and weaknesses in selected FPA efforts to improve accessibility and quality of information and services for young people

FPAB clinics focus mainly on the provision of contraceptives to married women. Recently-introduced youth friendly services in clinics once a week are constrained by inadequate staff training and user fees (affecting access for poorer young people). FPAB's IEC materials are easy to understand, but not produced in sufficient quantities and many programme areas do not have materials. FPAB's reproductive health education to youth is not effective: trained youth leaders conduct one-stop educational sessions that are inadequate in the absence of regular refresher sessions for the target group. Retention of messages is low, and young people express a desire for more visual materials and repeated sessions.

ABBEF runs four centres, based on principles of youth friendly services: easy access to educational and leisure activities, financially accessible services adapted to the needs of young people, and a youth-to-youth approach using peer educators to sensitise young people and introduce them to the

centres. Over 10 years the number of young people visiting the centres has increased, and the range of services offered has grown. ABBEF support ensures high motivation among staff and volunteers. However, the centres are based in town centres, and cater more to the needs of young women than young men. IEC materials are evident in the centres, but the dominant medium is the written word (in French), and many messages are moralistic. There has been no evaluation of young people's response to or recall of messages.

PROFAMILIA provides services for young people in its adult clinics, maintaining that high service quality is sufficient to attract young people (despite only 10% of clinic users being aged under 24). Young people have to pay for services, and there is little outreach to the marginalised or extremely poor. IEC materials and methods are of high standard, clear and easy to understand, and effective for community outreach work. Young people participate in the development and testing of materials, but as respondents to questionnaires rather than protagonists. PROFAMILIA has provided effective adolescent-to-adolescent IEC in the school system through youth promoters.

VINAFPA does not focus on service provision for young people, emphasising IEC and counselling instead. Strategic approaches have tended to respond to young people as a homogenous group, but VINAFPA is gradually developing programmes to meet the needs of diverse and vulnerable groups (including HIV/AIDS prevention among young commercial sex workers in hotels and restaurants, and work with street children/youth). The needs of young men are not addressed. VINAFPA has taken a strongly IEC based approach as opposed to a BCC approach, of which there is limited conceptual understanding. IEC materials dedicated to young people's reproductive health needs are centrally-produced, with limited youth involvement (pretesting only), and not rooted in Vietnamese culture. VINAFPA is unable to measure the effectiveness of its IEC approaches, as it does not undertake baseline and final evaluation surveys: it is difficult to assess how VINAFPA has contributed to young people's knowledge and understanding of reproductive health issues.

CHAPTER 3: CONCLUSIONS

This chapter draws out the main conclusions of the overall evaluation focusing on the performance of the UNFPA country offices and the Family Planning Associations in the six countries in promoting the reproductive rights and reproductive health of young people since ICPD; in doing so it identifies examples of good practice.

What progress have UNFPA and IPPF made since ICPD in promoting the reproductive rights and health of young people in these six countries? Answers to this central question are hampered by the inability to establish retrospectively a 1994 baseline against which to measure progress. However, using the proxy indicators developed at the methodological stage of the evaluation[6], the overall conclusion is that progress has been limited. This is due, in part, to the political and cultural sensitivity surrounding young unmarried people's sexuality and reproductive behaviour in the countries evaluated, and in part to the decline in financial resources available, especially to the Family Planning Associations since ICPD[7]. In addition, there is an absence of effective monitoring and evaluation systems and consequent lack of serious attention to lesson learning by both agencies in the six countries. And while some of the UNFPA Country Offices and the FPAs have new, embryonic initiatives on young people's reproductive rights and health, there is a paucity of examples of good practice which have gone to scale and been widely disseminated.

This concluding section is organised around key themes in the country evaluations: contextual specificity, diversity and vulnerability, building partnerships, lesson-learning, advocacy, and services and information. These are also key themes upon which consensus was reached internationally around good practice in the period immediately after ICPD, and on which one would thus have expected to see evidence of progress in the programmes of UNFPA and the IPPF-affiliates.

Contextual specificity

Efforts to develop or strengthen reproductive health services and information for young people and to advocate successfully for relevant policy and legislative reform require political support. This evaluation recognises that building such political support for the delivery of youth friendly services and for the realisation of young people's reproductive rights is a necessarily slow process, constrained by cultural sensitivities and stigma. Despite such constraints, UNFPA in Vietnam and Nicaragua – who operate respectively in politically and culturally constraining contexts - have been able to translate awareness and articulation of priority issues around young people's reproductive health into successfully focused programme interventions (see box 39). The same is true for the Burkina Faso UNFPA programme, but impact has been constrained by overall deficiencies in health infrastructure and government capacity. The cultural challenges are more profound in Bangladesh and Egypt, where public resistance to unmarried sexuality precludes explicit delivery of reproductive health services to unmarried youth. In Bangladesh, UNFPA's cooperation with NGOs has provided some limited entry into educational outreach and service provision for young (unmarried) people. In Egypt, there have been limited opportunities to date to create points of access for the unmarried.

Notwithstanding issues of effective UNFPA country-level leadership on policy issues, UNFPA's support for socio-cultural research into the issues facing young people's reproductive health and rights not only provides the evidence base for better designed

[6] See the *Inception Report* and the individual country reports for a checklist of the key questions addressed and data sources consulted.
[7] Globally, financial resources available to population and reproductive health programmes in developing countries since ICPD have declined in real terms by over 36% since ICPD

programmes, but raises public (especially government) awareness and goes some way to facilitating work within otherwise constraining political and cultural milieu.

Box 39: Good Practice
UNFPA programmes address context-specific issues

Nicaragua Since ICPD, UNFPA has focused on adolescent pregnancy, STIs and HIV/AIDS. Research commissioned by the CO into the socio-cultural and economic determinants of adolescent reproductive health, and of factors that constrain their adolescents' ability to exercise reproductive rights has informed UNFPA's strategy for working with young people, including a growing emphasis on the development of lifeskills (to address *inter alia* low self-esteem among young people), and a focus within service provision on low-income groups who use public sector services (to address the economic constraints on young people's access to services).

Vietnam UNFPA has commissioned research into the socio-cultural and other factors that influence young people's reproductive health and rights in Vietnam. This research has allowed the CP to articulate the priority reproductive health and rights issues facing young people.

The FPAs, with some notable exceptions (see box 40 on FPAB's work with the Islamic Research Cell for instance), have been far less effective when it comes to working with or addressing political and cultural sensitivities.

Box 40: Good Practice
FPAB and sex education in Bangladesh

FPAB's collaboration with the Islamic Research Cell (IRC) is addressing the sensitive issue of reproductive health education for young people in schools. The IRC works with religious leaders and students in the religious education system (Madrasah schools) to support reproductive health education through peer educators (both male and female) drawn from Madrasah students who provide such education either in classes or in local youth clubs, using verse from the Holy Quarn and Hadith. However, to date the project has not been evaluated or documented in depth.

Shortcomings and deficiencies with surveys of knowledge, attitudes and practices (KAPs) have been well-rehearsed, and include *inter alia* failure to draw on young people's experience in the design of questionnaires, dealing inadequately with context, and young people's reluctance to admit to behaviour which adults censure when asked direct questions. Nevertheless we see from these six country reports that when data are collected for planning and/or monitoring (admittedly not consistently or regularly), there remains a continued reliance on KAPs. Interventions need to be designed using in-depth social analyses and localised needs assessments[8], which analyse the specific epidemiological and cultural contexts of young people's sexual and reproductive rights and health needs (see section on vulnerability below). One of the key findings of the evaluation is that carefully-designed and professionally-managed socio-cultural research – evident in the UNFPA programmes in Burkina Faso, Vietnam and Nicaragua – supports a much more strategic approach to dealing with the priority reproductive health and rights issues facing young people.

Vulnerability and diversity

For some time it has been evident (see Price *et al*, 1998) that generalised statements create a stereotypical view of young people's sexual behaviour and vulnerability. For example, the traditional distinction between in-school and out-of-school youth leads to a stereotyping of in-

[8] For example, WHO has designed the *Narrative Research Method* (WHO, 1993), an experiential needs assessment approach premised on the importance in project design of understanding contemporary patterns and determinants of young people's sexual behaviour. The method involves young people role-playing a story, which they consider typical of young people's sexual and reproductive experiences and needs. The story is then converted into a questionnaire which is piloted before large-scale implementation.

school youth as less vulnerable, and out-of-school youth as highly sexually-active and prone to 'anti-social' behaviour. Concern with this false dichotomy led UNAIDS in 1996 to adopt an approach which prioritises vulnerable groups on the basis of local analyses, and which recognises that vulnerability is highly context-specific. However, the country evaluations reveal repeatedly that many programmes continue to address "diversity of needs" almost exclusively on the basis of differentiated approaches to in and out of school youth.

The evaluation also illustrates a sustained lack of attention to the sexual and reproductive health needs of male youth. The paucity of programme efforts directed to young males suggests a cultural hesitation (or a general confusion about how) to engage young men and to address their sexuality. In light of explicit ICPD aspirations to make males more responsible, the uniform lack of programme activities for males in the six countries is of concern.

Building partnerships

The limited capacity of government to implement effective youth reproductive health and rights programmes through the educational and health sectors is evident from this evaluation. Some of the FPAs, who have taken a lead in small-scale pilot approaches, are grappling with the issue of how to scale-up in a sustainable way where there is little or no government commitment, and in the face of declining core IPPF funding. UNFPA at country-level seems to have devoted inadequate resources to building the capacity of its government partners to evaluate, identify, disseminate and scale-up successful programmes. UNFPA's recent initiative with the MOH in Tanzania (see box 41), however, serves as an example of good practice.

The development and nurturing of partnerships with public and private (including civil society) sectors are pivotal for effective programming, as evidenced from UNFPA Bangladesh (box 41). The inadequate attention to dissemination of lessons learned and good practices among most of the UNFPA COs and the FPAs is in part due to weak M&E systems, but also to lack of effective partnerships, as illustrated by PROFAMILIA:

> "PROFAMILIA has worked independently and to some extent in isolation from other organisations concerned with young people's reproductive health and rights. As a result it has not had an identifiable impact on lesson-learning or identification of best practice in the field of young people's reproductive health and rights". (p14 of the Nicaragua Country Evaluation)

A strategic opportunity that should not be missed is the chance for young people's reproductive rights and health to be incorporated into expanding HIV/AIDS-related initiatives. While the financial resources available to reproductive health programmes have declined in real terms since ICPD, HIV/AIDS-related funding has increased over the same period. Effective integration of reproductive health and HIV/AIDS programmes has been insufficient to date in much of the developing world, and there was limited evidence of existing partnerships between youth-related and AIDS-related projects in the six countries. Just as a multi-sectoral approach is needed to improve young people's reproductive health, so HIV/AIDS control will be enhanced by investments in young people's reproductive health. UNFPA COs and FPAs should be able to capitalise more substantially on AIDS-related funding for condom promotion, STI care, VCT, health infrastructure, and BCC for young people.

Box 41: Good practice in capacity building and partnerships

1. UNFPA Tanzania capacity building in the MOH
A major constraining factor to the implementation of activities planned under the current UNFPA Country Programme is limited capacity within the Reproductive and Child Health Section (RCHS) of the Ministry of Health. UNFPA is partly addressing this through fully-funding for a fixed period of time a new post of Adolescent Reproductive Health Training and Service Delivery Officer in the RCHS. The Officer will be responsible for supporting planning, implementation and evaluation of UNFPA supported activities related to adolescent reproductive health services. The RCHS Director expressed her hope that this post would be incorporated into the MOH staff complement on cessation of UNFPA project funding for the post.

2. UNFPA Bangladesh working with NGOs
NGOs in Bangladesh are recognised by government as being able to work effectively on a number of key issues relating to young people's reproductive health, which because of their sensitivity government is reluctant to support directly. UNFPA recognises this opportunity and has made NGOs important implementing partners in the CP. UNFPA has developed a compendium of NGOs, listed by competencies and areas of focus, which is an important source of data when UNFPA, in consultation with the relevant Ministry, identifies partners and implementing agencies for its sub-programmes.

> "In the recent review of ICPD+10, carried out for UNFPA with representatives [of government and NGOs], best practices in the work of implementing the goals of ICPD POA included UNFPA's involvement with civil society and NGOs." (direct quotation from the Bangladesh Country Evaluation Report)

Young people's sexual and reproductive health is determined by a range of interconnected economic, political, social and cultural factors. UNFPA COs and the FPAs recognise that poverty, lack of educational and employment opportunities, gender inequalities, harmful traditional practices, and lack of protection of rights combine to bring about contexts in which young people experience poor sexual and reproductive health outcomes. A consensus emerged in the 1990s that young people's sexual and reproductive health needs cannot be addressed through single-sector (notably health sector) strategies or interventions. Despite the increasing recognition that a multi-sectoral approach (involving health, education, community development, social welfare, workplace, sport, recreation and the arts) is essential, the country evaluation studies show that at best multisectoralism is symbolic, and that the health and education sectors remain the main partners for UNFPA and the FPAs in their work on reproductive health and rights. However, UNFPA's support in Nicaragua for municipal youth clubs (box 42) demonstrates an effective multisectoral approach to supporting behaviour change and meeting young people's reproductive health and rights needs.

Box 42: Good practice
Facilitating behaviour change through a multisectoral approach
UNFPA support for youth clubs in Nicaragua

UNFPA in Nicaragua has developed a model of motivation and education in reproductive health and rights through municipal youth clubs. These clubs are seen as the demand-side of UNFPA's adolescent work, complementing the supply-side of MOH adolescent clinics. Youth club projects were designed by UNFPA and are implemented through AMUNIC, the local government association of Nicaragua. The clubs provide a space for adolescents to develop recreational activities, and motivate participation in IEC/BCC activities. Young people are trained as reproductive health and rights promoters and work in their communities using adolescent-to-adolescent contacts and a wide range of media (newsletters, radio spots, theatre, puppet shows, talks, one-to-one discussions, etc). Promoters refer young people to an MOH adolescent clinic if one exists in their municipality (see box 40). UNFPA is trying to coordinate its demand-side and supply-side projects to cover the same municipalities and ensure differentiated services are available for adolescents.

The clubs started in 2001, and are aimed at adolescents up to 19 years of age, although some 20 year olds participate. The first generation of promoters is currently training new recruits. Promoters

interviewed during the evaluation had good communication skills and a thorough knowledge of reproductive health and rights themes. A comparative evaluation of the knowledge and attitudes of promoters, young people contacted by promoters and young people who had no contact with the programme showed that the promoters had a significantly higher level of knowledge than other participants, who in turn had a significantly higher level than non-participants. Parents have also received training and are supportive of the work, and commented to the evaluation team that the programme " has had a real impact on the youngsters' development…. If we'd had these opportunities things would have been different for us… Now they [young people] sit down and talk to us, we were embarrassed to talk to them before"

Clubs have been set up in 18 municipalities with varying levels of success. AMUNIC and UNFPA have analysed the key factors in success or failure of the scheme, and the second stage of the project (just starting) has taken these lessons into account. Several other donors are funding similar youth clubs, and some valuable lessons could be learnt from a joint evaluation of the model. The project has successfully raised awareness within local government of the importance of youth development schemes, and local governments have improved their public image through involvement in these social development projects. AMUNIC has now included youth development work as a cornerstone of its strategic plan. This augurs well for sustainability of this initiative.

Monitoring, evaluation and lesson learning

Limited commitment and capacity within both agencies to monitor progress and to evaluate impact has been highlighted several times in this synthesis report. While they are often able to articulate strengths and weaknesses, both agencies are rarely able to substantiate these with documentation or data. Lack of documented evidence of what works in young people's reproductive health programming has been extensively highlighted (see for example DFID, 2001; Price *et al*, 1998; McKaig *et al*, 1996). The persistent inadequacy of monitoring and evaluation in both UNFPA and the FPAs across the six countries confirms lack of attention to this issue. The inadequate monitoring highlighted in some of the country evaluations appears to be leading at country-level to widely-varying quality of care being provided, and lack of standardised approaches to key policy issues such as paying for services and client confidentiality (as illustrated by Vietnam).

Identification of good practice needs to be evidence-based, selecting proven models for dissemination, scale-up and/or adaptation by other agencies. The absence of effective M&E clearly undermines such a process. Two examples from Tanzania illustrate what is fairly widespread across the two agencies in most of the six countries, namely lost opportunities for building on good practice. In an NGO-led lifeskills project funded by UNFPA (see box 47), significant lessons for best practice were produced, but because of MOH resistance to working with NGOs, potentials for scaling-up and sustaining the approach were lost. In the second example (see box 43) UNFPA has not undertaken a systematic assessment of the strategic value and effectiveness – or the impact on young people's reproductive health behaviour or status – of its family life education (FLE) initiative in Tanzania, despite UNFPA's involvement in this work for nearly 13 years. A further example is the lack of a baseline assessment by UNFPA in Nicaragua during development of the new sex education curriculum, missing an opportunity for subsequent evaluation of impact.

Box 43: A lost opportunity for lesson-learning - UNFPA Tanzania's support for FLE

UNFPA has been supporting the development of school-based Family Life Education (FLE in Mainland) and Moral Ethics and Environmental Studies (MEES in Zanzibar) since the early 1990s, including training of trainers, teachers and peer educators; and the development of curricula and teaching and learning materials. The curricula and teaching guides integrate issues related to population, sexual and reproductive health and gender into host subjects (geography, biology, civics, home economics), and the FLE/MEES component of these subjects is now examinable.

Despite significant investment of human and financial resources in FLE/MEES, no detailed evaluation of the strategic value, effectiveness, or impact has yet been undertaken, although surveys undertaken in 1999 with support from UNFPA now provide a baseline from which effectiveness could and should be monitored, to guide UNFPA's support for future behaviour change communication initiatives. In focus group discussions with young people in four sites undertaken as part of the evaluation, only 10% indicated that knowledge on issues related to reproductive health had been acquired in school.

Advocacy for legislative and policy reform

A critical problem in making public sector health services youth-friendly and addressing key reproductive rights issues as they affect young people, is the existence of restrictive laws and policies. Even when laws and policies have been promulgated, such as those which are aimed to prevent traditional harmful practices like early marriage and FGM, these are often not enforced. Likewise, supportive policies are often ignored or misunderstood (as evidenced in a number of the country evaluations). UNFPA's proximity to government would appear to partly explain the lack of a significant contribution to legislative and policy reform in some of the countries evaluated, although the UNFPA programmes in Nicaragua, Vietnam and Burkina Faso have made notable progress in their work on legislative and policy reform (see box 44 below). However, with the exception of UMATI and ABBEF (see box 45 for ABBEF), the FPAs have chosen not to engage in advocacy work for young people's reproductive rights, which is surprising given their non-governmental status. Although there is no evidence within the country evaluations to attribute level of young people's participation in the FPA programmes to the level of engagement by the FPAs in advocacy for young people's rights, it is worth noting that UMATI and ABBEF are the only two FPAs with both a high degree of young people's participation and any engagement in advocacy.

Box 44: Good Practice
UNFPA's advocacy for young people's rights

1. UNFPA Nicaragua
UNFPA's work in the formal education sector is potentially one of its major contributions to reproductive health and rights for young people in Nicaragua and will have a far-reaching impact if carried to a successful conclusion. Socio-political forces in Nicaragua have kept education in sexuality and reproductive health out of the school curriculum for the last 25 years, although this is a pressing need and may be an important factor behind the high rate of adolescent pregnancy and STI transmissions. UNFPA has successfully advocated for the development of a National Population Policy Action Plan that includes provision of sex education in and out of schools, and has used the opportunity created by this Plan to provide high quality technical support (and financial support) to the Ministry of Education to develop a school curriculum in sex education and sexuality[9]. A further illustration of UNFPA's far-sighted and strategic approach is its support for a module on sexual and reproductive rights in the human rights course of the University of Central America law degree, that will impact on future generations of lawyers.

2. UNFPA Burkina Faso
There has been significant legislative and policy reform on issues that affect reproductive rights of young people over the last two decades, including promulgation of the Personnel and Family Code (which concerns *inter alia* the rights and duties of spouses), the repeal of the law forbidding use and promotion of contraception, the promulgation of the law prohibiting excision (FGM), and modifications to the law against abortion (still illegal except for specific circumstances). UNFPA has been a major player in these reforms through its direct advocacy with high-level authorities, and by supporting the creation of other lobbying groups, and sensitisation of parliamentarians.

3. UNFPA Vietnam

[9] Since the evaluation in May 2003, the introduction of the new curriculum has resulted in a highly visible national debate with conservative political powers campaigning for its withdrawal. The final curriculum is likely to be a much weaker version of that originally proposed and supported by UNFPA.

With 10% of its total country programme budget allocated specifically to adolescent reproductive health policy and advocacy, UNFPA Vietnam devotes by far the largest amount of its CP to this area of work of the six countries. UNFPA is credited by other UN agencies as putting young people's reproductive rights on the UN Interagency agenda and for the creation of a UN Interagency Working Group on Youth to mainstream youth issues in other UN programmes. UNFPA's partners (government, NGOs/mass organisations, and UN agencies) recognise UNFPA's lead role in assisting the government with the development of reproductive health policies and strategies in general, and especially with those associated with young people's reproductive rights.

Box 45: Good Practice
Advocacy by ABBEF in Burkina Faso

ABBEF has actively supported the reform of the law prohibiting use and promotion of contraceptives, and the law that permitted the expulsion of schoolgirls due to pregnancy. It also plays an key role in efforts to eradicate FGM through its membership of the National Committee Against Excision. Many volunteers and former professional staff of ABBEF now work with government or international institutions and are responsible for developing new policies.

Neither UNFPA nor the FPA in any of the countries evaluated has demonstrated that it is monitoring adherence to laws and policies. However, both agencies have a better track record of supporting ministries of health in the development of service delivery protocols, standards and guidelines for the provision of sexual and reproductive health services to young people - an important strategy for improving access to services (as is the training of public sector health personnel in service delivery protocols).

Youth-friendly services

Development of service delivery protocols and standards for the provision of sexual and reproductive health services to young people needs to be accompanied by an increase in the number of public sector service delivery outlets providing youth-friendly services, which is clearly not the case in these countries. Progress with the development, promotion and implementation of youth friendly services has been slow in most of the six countries. In particular, the evaluation notes the paucity of efforts directed to males, and the difficulty of providing services for unmarried females (especially in Bangladesh and Egypt). The evaluation underscores how challenging the components of youth friendly services (see section 2.5 above) remain. The only UNFPA country programme which has provided support to the public health system to reach a standard of service delivery to young people that could be termed genuinely youth-friendly is Nicaragua (see box 46). Small-scale initiatives from UMATI in Tanzania (box 46) and ABBEF in Burkina Faso demonstrate service characteristics that are youth-friendly, although as noted in box 38 above, the ABBEF services suffer from inadequate IEC and an exclusive urban bias.

Clearly, efforts to integrate youth friendly services into public health services are likely to be more successful when such services are already functional and of reasonable quality, and when IEC/BCC approaches are effective and closely linked to service delivery. Both such advantages were evident in Nicaragua. But the *relative* success in Nicaragua underscores the point that health infrastructure is a necessary, but not sufficient, condition for success in serving youth. In Vietnam and Egypt, which also have reasonably better-developed health infrastructures compared to the other three countries, politico-cultural factors continue to limit service access for youth. In the other three countries, health systems are extremely weak, undermining prospects for low-cost youth-oriented interventions, such as counselling, and physical structures to ensure privacy.

Young people in all the countries continue to seek reproductive health care and services from informal sources (kiosks, pharmacies, clandestine abortionists, traditional providers), and from the private sector where affordable (eg among middle class youth in Egypt). Health-seeking

from informal and private providers confirms the importance of privacy and confidentiality for young people, and the potential gains in youth service utilisation rates in public services if this aspect of care could be guaranteed. The youth-friendly services described below highlight the importance *inter alia* of confidentiality and non-judgmental attitudes in service provision for youth.

Box 46: Good Practice
Youth friendly services

1. UNFPA's differentiated services model in Nicaragua
To help address the lack of youth-friendliness in public sector services, UNFPA has been supporting the development of "differentiated services" for young people. The first stage in 1995 was the establishment of a special adolescent clinic in a Managua hospital, with a separate street entrance for young people. Initially the clinic had a medical focus and most clients were pregnant girls. Since 1997 the introduction of counselling, IEC, community outreach work, and a focus on lesson-learning has led to a more integrated and preventive approach, and services are now used by a range of clients, including young men. The clinic has become a reference centre for other MOH units and NGOs, and currently trains about 60 MOH staff each year in adolescent counselling. The model has been adopted in a number of MOH health centres throughout Nicaragua. While some of these MOH adolescent clinics may not have separate entrances, they all have a defined space where adolescents only are attended by specially trained staff. The clinic staff spend time on counselling and IEC work as well as medical consultations. Some clinics have set up clubs for adolescents with different needs (eg pregnant girls' clubs, post-partum clubs, asthmatics' clubs, diabetes clubs). A few clinics have adolescent promoters for community outreach. All clinics visited during the evaluation showed dramatic increases in female adolescent users since their establishment, with male adolescents also now using the clinics.

2. UMATI's youth-friendly services in Tanzania
Focus group discussions (FGDs) carried out for the Tanzania evaluation indicated that young people are confident in the skills and capabilities of UMATI staff in providing quality services. Young people specifically highlighted UMATI youth centres, VCT services in UMATI clinics, and peer educators as their main source of reproductive health information and services. UMATI youth centres were perceived to offer services in a friendly and conducive environment, which observed confidentiality, privacy and were responsive to young people's needs and problems. Services provided at UMATI youth centres are free of charge. Gender, age, ethnicity and marital status are not constraints to accessing UMATI peer educators and youth centres, according to the FGDs. Key factors influencing utilisation were that services were youth friendly, affordable, and responsive to youth problems and concerns. An independent assessment of one of UMATI's youth centres indicated that staff were delivering a high standard of care, as indicated by good history-taking, proper examination of clients, and STI diagnosis through laboratory testing. Youth clients felt that the information exchange with providers was good and that providers were approachable and non-judgemental, and that confidentiality was maintained.

A key component of any effective approach to the delivery of youth friendly services is the provision of information, education and behaviour change communication. The evaluation indicates that the quality and effectiveness of the IEC materials strategies of both agencies in the six countries is generally poor. Furthermore, with the exception of the UMATI programme in Tanzania (section 2.5), a small-scale NGO initiative supported by UNFPA also in Tanzania (box 47), and UNFPA's support for lifeskills through municipal youth centres in Nicaragua (box 32), there has been a persistence with the conventional didactic IEC approach that focuses on providing information, with little or no understanding of - or attempt to address - risk perception or other barriers to behaviour change. Indeed, behaviour change communication (BCC) is seen by many representatives of the two agencies as synonymous with IEC, reflected in both the dominant IEC medium (the written word) and the language and messages adopted in IEC materials messages (abstention, not engaging in pre-marital sexual activity, condemnation of homosexuality etc – examples of which are evident in many of the country reports). While young people in many of the countries appear to have high information levels, they are not being equipped with the ability to translate this information

into behaviours that will safeguard their reproductive and sexual health. This is a generalised problem throughout the international health sector, with several recent studies indicating that youth have gained knowledge of sexual and reproductive health issues in recent years, but show limited evidence of behaviour change. The evaluation offers what may be, in part, an explanation for this paradox, that the format and approach of much IEC still fails to incorporate a BCC approach. In the context of established or emerging HIV/AIDS epidemics in the six countries, such a shortcoming has serious implications for the current generation of young people, and locating examples of effective IEC/BCC becomes all the more critical. A further dimension of successful IEC/BCC, which has been largely overlooked by both agencies, is the need to focus on parents and other community-level “gatekeepers” and opinion-leaders, without whose support behaviour change among young people will be further constrained.

Box 47: UNFPA support for a lifeskills project in Tanzania

Working in a peri-urban district in Tanzania with UNFPA support, an international NGO (AMREF) applied community-centred participatory learning and action tools to understand problems faced by young people, and to design lifeskills interventions directly relevant to the young people in the district. The project sought to empower young people with skills that would enable them to adopt positive behaviours. The educational component was based on skills for “psychosocial competence” identified and developed by WHO. IEC materials were also developed through participatory approaches (message identification, pre-testing and implementation all involved young people) and focused on specific issues/problems identified by local young people, notably HIV/AIDS, drug abuse, STIs, and early pregnancy. The contextual relevance of the approach was evidenced by groups of peer educators establishing their own CBOs, and setting up small community booths that made IEC/BCC materials available for young people. While the IEC materials were only accessible to literate youth through the CBOs, trained peers also provided lifeskills sessions and community theatre to reach literate and non-literate young people. Youth involvement was central to the approach: in addition to design and implementation, young people participated extensively in project evaluation. The 2003 external evaluation of the project pointed to significant impact on young people’s attitudes and behaviours. Positive benefits identified by young people and community members included reduction in visible groups of youth taking drugs, increases in school attendance, visits for VCT, and enhanced self-confidence and communication skills among young people, as well as improved communication between parents and children. The evaluation indicated, however, that the benefits had been largely limited to those directly involved in the project (only 20% of the total youth population). Significant lessons for best practice have been produced by the Lifeskills project. UNFPA have made efforts to ensure that these lessons will be sustained through integrating lifeskills activities into MOH district level ARH plans, including training of peer educators, parents and community members (para-professional counsellors) in lifeskills, and awareness raising through community theatre. However UNFPA expressed concerns that the sustainability of the approach will be constrained by lack of capacity within the MOH and the districts to implement participatory and community based approaches. UNFPA has been unable to influence AYA to adopt the approach under its BCC component, and unable to influence the MOH to collaborate with AMREF as an implementing partner in the current CP. As a result important potentials for scaling-up and sustaining the approach appear to have been lost.

CHAPTER 4: RECOMMENDATIONS

This short final chapter highlights the main recommendations emerging from the six country studies. It is organised into three subsections that provide recommendations respectively for UNFPA, IPPF/FPAs, and in relation to improving collaboration between UNFPA and FPAs at country-level. Given the range and diversity of strengths/weaknesses and successes/failures raised by the six country evaluations, the recommendations here are those which emerge as the most common across the countries and agencies, and do not necessarily apply to both agencies in all six countries. Where there are context-specific or notable exceptions to the recommendations these are highlighted. It has not been possible within the constraints of the evaluation to assess the resource implications of implementing and sustaining these recommendations. Furthermore, as the sample of countries was not selected to be representative of UNFPA and IPPF globally, the recommendations cannot be generalised beyond the six countries (except perhaps in relation to the quality and nature of support from UNFPA Country Support Teams and the IPPF Regional Offices). Generalisation will thus require a broader analysis of the global operations of the two agencies.

4.1 Recommendations for UNFPA

4.1.1 Contextual and Strategic Focus

Operationalising Diversity: Most UNFPA COs have demonstrated a good grasp of the factors that constrain young people's reproductive health and rights, and the diversity of needs among a range of groups. However, and especially in Burkina Faso and Egypt, greater effort needs to be made to translate this awareness into programme strategies which target not simply married/unmarried, in-school/out-of-school, urban/rural, but also marginal and vulnerable young people like sex workers, street youth, and ethnic minorities, as well as young males.

Conceptualising and Promoting Young People's Reproductive Rights: UNFPA Country Offices and the Country Programme implementing partners need a clearer understanding of the concept of young people's reproductive rights, and the implications of such an understanding for rights-based programming. The latter requires firmer commitment to working with civil society, eg in the form of NGOs as implementing partners, especially in support of policy and legislative reform advocacy. This overall recommendation applies particularly, but not exclusively, to Bangladesh, Tanzania and Egypt. Where reproductive rights is a particularly sensitive concept for cultural and/or political reasons, then focusing on issues where there is consensus between government, key stakeholders and civil society groups (such as the Burkina Faso programme has done in relation to FGM) is likely to be more effective than trying to directly address controversial issues like unmarried young people's sexuality.

Strengthening Gender Sensitivity: Country Programmes need a strengthened framework for analysis of, and more strategic focus on, gender issues as they affect young people's reproductive health and rights. Greater efforts are needed to increase government partners' strategic understanding of gender issues in young people's reproductive health programmes. Gender remains overly associated with women: more attention needs to be given to the role of men. International resources for gender mainstreaming, in part supported by UNFPA, should be promoted at country level.

4.1.2 Institutional Capacity and Arrangements

Enhancing CO Capacity in Young People's Reproductive Health and Rights Issues: Some COs (notably Tanzania, Egypt and Vietnam) need to increase and enhance their expertise in

reproductive rights, gender, advocacy and service issues as they relate to or affect young people's reproductive health. In addition to appointing staff with appropriate expertise and sensitivity, training and awareness-raising courses for existing staff and greater support from the CST (and/or international consultants) in adolescent reproductive health, rights and advocacy should be considered as strategies for enhancing CO capacity and expertise.

Improving Monitoring and Evaluation and Lesson Learning for Best Practice Scale-Up: There have been promising attempts to improve M&E in country programmes, following the introduction of LogFrame programming in UNFPA in 1997 and the adoption of results-based monitoring in 2000. Many COs have recently established detailed baselines for their CP LogFrames, and the appointment of M&E officers. However, these should be seen as the first step in a long-overdue reform of the M&E system. Much needs to be done – including more technical assistance to the COs - to improve systems for, and to develop a culture of, lesson learning and best practice identification and sharing. Enhancing capacity for dissemination of lessons learned and best practice will require *inter alia* dedicated staff with information technology skills and expertise in synthesising evaluation data. The evaluations from Burkina Faso, Nicaragua, Vietnam and Tanzania illustrate clearly those programme areas where monitoring and evaluation could and should be providing important data and insights for the dissemination and adoption of lessons and best practice within the UNFPA CP and partner organisations working with young people.

Country Support Teams/International Technical Assistance: It is incumbent upon UNFPA HQ to address the current shortage of technical assistance generally, but especially in young people's reproductive health, rights and advocacy, available to COs through the CST system. A clear indication needs to be made about how much and what kinds of expertise will be available, and support for the development of registers of international consultants should be provided to COs.

Promoting the Participation of Young People: All the Country Programmes need a more strategic focus on empowering young people. Mechanisms should be developed to facilitate young people's participation in the CPs, including in the planning and design of CP component projects that are related to young people's reproductive health and rights (some CPs currently support limited youth participation in implementation and M&E). Such a shift in approach will require *inter alia* greater understanding among CO staff and government partners of issues around young people's participation, and specific participatory skills/competencies within the CO staff to promote such participation in their partner organisations. Without such skills UNFPA will be unable to explicitly demonstrate the value to government of such youth participation.

Enhancing Sectoral Leadership: In order for UNFPA to exert influence at national level (both within government and within donor-government forums such as the PRSP and SWAps), UNFPA's leadership role in reproductive health needs to be more visible and strategic. UNFPA HQ needs to provide clear guidance to its CPs with regards to key sectoral reform issues such as SWAp. The current position whereby UNFPA is a member of sector reform forums, yet continues to provide parallel funding when many donors are supporting sector basket funds, seems untenable and undermines efforts to ensure that adequate and appropriate resources are devoted to young people's reproductive health. A strategic re-articulation of young people's sexual and reproductive health needs is needed within the context of the HIV epidemic, and in relation to specific funding and policy initiatives such as the Global Fund and the Millennium Development Goals.

Strengthening Government Partners: More UNFPA CP resources need to be devoted to developing the capacity of government implementing partners in the fields of operationalising gender and rights, youth-friendly service design, IEC/BCC, monitoring and evaluation, dissemination of good practice, and effective integration with HIV/AIDS. Implementing

partners should be enabled to move beyond articulation of young people's reproductive health and rights needs, to the development of effective strategic approaches to addressing such needs.

Developing Civil Society Partnerships: Despite current government resistance in many countries (Bangladesh is the exception), UNFPA COs should make much greater efforts to develop sub-programmes and projects with NGOs as implementing partners (especially but not exclusively in Tanzania, Vietnam and Nicaragua). Even in sub-programmes and projects where government is the (appropriate) lead implementing agency, funds should be available to strengthen civil society work through the provision of TA and resources. The development of closer relationships with civil society organisations is particularly necessary in the field of advocacy.

4.1.3 Advocacy for Legislative and Policy Reform

There is widespread recognition within the COs of legislative and policy issues affecting young people's reproductive health and rights, and in a number of countries evidence that UNFPA has successfully supported legal and policy reforms. However, more effort is needed to support the development of mechanisms to implement such laws and policies (eg in Nicaragua, Burkina Faso); to enhance the capacity of UNFPA COs to work on policy and advocacy efforts (eg Tanzania); and to better collate the work of, and coordinate, the wide range of actors engaged in advocacy around young people's reproductive health and rights (eg in Vietnam, Bangladesh).

4.1.4 Youth Friendly Reproductive Health Services

Young people in most of the six countries are not accessing public sector services, and do not perceive such services to be youth-friendly. Within the UNFPA CPs evaluated there has been a disappointingly limited focus on support for government-led youth friendly services. Activities relating to services for young people should be prioritised and given much greater prominence (Nicaragua and Burkina Faso are the exceptions here). Greater effort needs to be made in advocating for youth friendly services, and identifying for public sector providers and policy makers the key components of such services. Given the high utilisation of NGO, informal and private health providers by youth in several countries, more explicit attention should be given to exploring effective partnerships with these sectors.

UNFPA COs should explore strategies to scale up some of their more innovative youth focused IEC/BCC activities. Partnerships with NGOs and an increased emphasis on lesson learning and dissemination would address this to some extent. UNFPA should lead on coordinating the production (including consistency and appropriateness of messages) and distribution of IEC materials for young people's reproductive health, to avoid *inter alia* duplication, contradiction and shortages of materials. Support for testing validity and relevance of messages and media should also be one of UNFPA's key roles.

4.2 Recommendations for IPPF and Affiliates

4.2.1 Contextual and Strategic Focus

Recognising Diversity of Needs: The FPAs (except UMATI) all focus too much upon married young women and/or school-based youth as their target groups. There is insufficient recognition of the diversity of needs of different groups of young people and interventions to address these. Differentiated strategic interventions are needed to more appropriately address the specific needs of vulnerable, poor, and unmarried young people (and the

marginal, including those not easily reached, eg through schools). The needs of young men, and their role in influencing the reproductive health of young women, is inadequately understood and addressed.

Conceptualising and Promoting Young People's Reproductive Rights: Most FPAs need to invest time and resources in establishing a clearer understanding of the concept of reproductive rights among their staff and volunteers, as it applies to work with young people in their country context.

Addressing Gender: Gender balance within FPA organisational and governance structures needs to be addressed at all levels as a matter of urgency (notably in Bangladesh and Egypt). Strategic understanding of gender issues as they affect young people's reproductive health also needs attention in many FPAs, as there remains a tendency to equate gender equity with providing services and IEC to young women.

4.2.2 Institutional Capacity and Arrangements

Strengthening FPA Capacity in Young People's Reproductive Health and Rights Issues: Current capacity problems within FPAs relate to lack of human resources in general and to the absence of key posts (in IEC, advocacy, M&E etc) in particular, as a response to declining resource bases. FPAs need technical support from IPPF to re-establish capacity, but also need to undertake human resource audits to produce organograms based on available material resources and strategic priorities of the programmes. An agency that is supposed to be the lead NGO in young people's reproductive health clearly cannot function without adequate expertise in advocacy, adolescent reproductive health, rights-based programming, IEC/BCC, and M&E.

Improving M&E and Lesson Learning for Best Practice Scale-Up: M&E, and thus lesson learning and best practice sharing, is woefully inadequate in all the FPAs evaluated. It is imperative that FPAs strengthen their M&E systems and capacity to *inter alia* allow for analysis of trends in service utilisation by young people and to enable the FPAs to assess programme effectiveness in bringing about sustained behaviour change among their target populations of young people. No FPA should be failing to collect and analyse service utilisation data that are not disaggregated by age and sex (as was the case in this evaluation). FPAs need to institutionalise the documentation and analysis of lessons learnt and good practice from pilot and small-scale projects, as a basis for scaling-up and integrating pilot projects into a coherent programme approach to addressing young people's reproductive health and rights needs.

Increasing Youth Participation: In line with IPPF constitutional recommendations[10], FPAs should institute mechanisms for young people's full participation in policy and decision-making, and ensure that these mechanisms are operational at all levels of the decision-making structure (at national, regional, branch and ward levels). Young people should be involved not just in project activities, but as decision-makers sitting within project steering committees and in the governing structure, not just for reasons relating to rights of participation, but also to improve the quality and appropriateness of FPA responses to youth needs.

Developing Partnerships: FPAs need to develop more strategic partnerships with other civil society groups – both for sharing experience and for increasing coverage (ABBEF, EFPA and PROFAMILIA are particularly weak in this respect; UMATI is the notable exception). Diversifying funding bases at a time when IPPF support is declining, means fostering

[10] 20% of the membership of boards should be young people

relationships and partnerships with a range of international donor agencies. Explicit attention should be given to exploring avenues for effective use of HIV/AIDS-related resources.
IPPF Regional Offices should facilitate in-depth sharing of experiences and lessons learnt between FPAs in their respective regions, provide ongoing and consistent technical support, and ensure that there are no bottle-necks in fund-flows to FPAs, to enable them to recruit the necessary staff and to implement their programmes.

4.2.3 Advocacy for Legislative and Policy Reform

FPAs as the leading civil society organisations working in the field of young people's reproductive health and rights in their respective countries must take a much more proactive advocacy stance on policy, legal and rights-based issues.

4.2.4 Youth-Friendly Reproductive Health Services

Most of the FPAs (notably EFPA, FPAB, VINAFPA, PROFAMILIA) need to enhance their understanding of what it means to provide youth friendly services and then to develop adequately resourced packages to deliver such services. As part of this reorientation and strategy development, FPAs are recommended to explore methods of strengthening service provision for young people, through further research on the feasibility of alternative models of delivering youth friendly services, including peer-promotion, mobile services and linkages to government services. Those FPAs that have embarked on strategies to deliver youth-friendly services, need to strengthen internal capacity to implement service provision, with a particular focus on training of existing service providers on youth-friendly services in core FPA clinics (eg UMATI, where best practice on youth friendly services is in evidence, but needs to be rolled out). Lack of comprehensive awareness of available IEC materials within countries and regions, and the absence of a centralised archiving of BCC/IEC materials and approaches need to be addressed. Technical capacity in IEC also needs to be enhanced in some FPAs.

4.3 Recommendations regarding collaboration between UNFPA and FPAs at country level

As the two lead agencies in young people's reproductive health and rights – both globally and in their country contexts – it is incumbent upon UNFPA and IPPF to demonstrate their complementarity and (more importantly) to coordinate and collaborate more effectively at country level. With the exception of Bangladesh and Burkina Faso, the evaluation concludes that complementarity is more by accident than design, and coordination, collaboration and communication between UNFPA COs and the FPAs is poor (except in projects where UNFPA is funding the FPA as an implementing agency, as in Vietnam).

The key, country-specific recommendations regarding collaboration and coordination are summarised below (further details can be found in the respective country reports). These recommendations are specific to five of the countries (in Egypt the paucity of work on young people's reproductive health and rights by EFPA makes it inappropriate at present to develop recommendations). As the UNFPA and IPPF members of the Evaluation Steering Group have pointed out, these countries are not representative of the enormous number and range of national programmes, and therefore recommendations cannot be made at or focused on UNFPA and IPPF HQ level.

Recommendations regarding collaboration between UNFPA and FPAs at country level

Bangladesh: The good collaboration between UNFPA and FPAB should be continued in its present form where both organisation recognise the strengths of the other and work together in the promotion of young people's reproductive health and rights. UNFPA could be more pro-active in supporting the training needs of FPAB, eg through collaborative training of peer educators. Examples of good practice in FPAB and UNFPA should be jointly shared with other agencies for possible scaling-up.

Burkina Faso: Despite complementarity, gaps are evident in addressing maternal mortality, mother-child transmission of HIV and STI information. This is due to the lack of a systematic way of coordinating efforts in the area of IEC/BCC activities, which should be addressed.

Nicaragua: Carry out a joint analysis of the costs and benefits of the two models of service provision for young people (separate services for young people in comparison with use of normal adult services). Promote more information-sharing and institutional coordination for identification and analysis of lessons learnt in work with young people.

Tanzania: Despite complementarity of approaches, coordination and lesson learning between the two organisations have been limited. There is great potential for scaling-up best practice through improved coordination between UNFPA and UMATI, and through including NGOs such as UMATI as implementing partners in UNFPA's Country Programme (although government resistance appears to be a major constraint to NGOs acting as CP implementing partners).

Vietnam: UNFPA's selection of VINAFPA as an executing agency in its programme was based on comparative advantage and geographical reach, not on demonstrated expertise. UNFPA (and others) needs to provide more support to VINAFPA in capacity building.

ANNEX 1: TERMS OF REFERENCE FOR THE EVALUATION

The following TORs are extracted (verbatim) from the document "Addressing reproductive rights and health needs of young people after ICPD: the Contribution of UNFPA and IPPF" issued at the time that bids were invited for the evaluation.

Short description of the evaluation
The Ministry for Economic Co-operation and Development (BMZ) of Germany, the Danish International Development Assistance (DANIDA), the Department for International Development of the United Kingdom (DFID), the Netherlands Ministry of Foreign Affairs and the Norwegian Ministry of Foreign Affairs intend to jointly sponsor an evaluation of a number of key aspects of the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD) by (i) the United Nations Population Fund (UNFPA) and (ii) the International Planned Parenthood Federation (IPPF).

The evaluation is geared to those key issues of the ICPD Programme of Action and the ICPD + 5 review, which have not been extensively covered by recent evaluations, i. e. in the area of reproductive rights and health for young people.

The primary purpose of the planned evaluation is to assess the performance of UNFPA country offices and member associations of IPPF (FPAs) in selected countries in promoting reproductive rights and health, with the aim of achieving behavioural change and with particular emphasis on adolescents and youth. The ultimate goal is to contribute to a better understanding of the conditions for the success of such work (best practices) and to draw strategic lessons for the future.

The evaluation will be based on an empirical approach, by undertaking up to six country studies, three in Africa, two in Asia and one in Latin America. The country studies will serve as a basis for a final synthesis report.

The intended audience for this evaluation includes the donor community at large and especially those donors supporting this evaluation; the governing bodies as well as management and staff of UNFPA and IPPF, both at central as well as decentralised levels; governments and other development partners; and the general public interested in questions of population and development.

Key questions
The primary purpose of the planned evaluation is to assess the performance of UNFPA country offices and FPAs in selected countries in promoting reproductive rights and health, with the aim of achieving behavioural change and with particular emphasis on adolescents and youth. The evaluation will hereby clarify how UNFPA and IPPF contribute to implement key aspects of the ICPD Programme of Action.

The evaluation will consider the whole range of reproductive rights and health needs of adolescents and youth as defined in the ICPD Programme of Action and in the policies of UNFPA and IPPF. However, as not all issues are of the same importance in all countries, each country study will be focused on priority issues, which will be identified at a later stage.

The following general questions will guide the evaluation:

- The extent to which UNFPA country offices and FPAs promote the concept and practice of reproductive rights in the respective countries
- The extent to which both organisations take into consideration the different cultural interpretations of reproductive rights and the influence of socio-cultural, gender-specific, religious and political factors on the practice of reproductive rights.

- The extent to which both organisations are effective in promoting behavioural change of and towards male and female adolescents and youth, in particular safe and healthy sexual behaviour.
- The extent to which both organisations are effective in stimulating an enabling environment for policy development in the field of reproductive rights and health of young people.
- The extent to which the work of both organisations is characterised by a strategic approach in contributing to the response of governments and civil society to the reproductive rights and health needs of young people.
- The extent to which both organisations contribute to the development of policies, strategies, and programmes responding to the needs of male and female adolescents and youth, in particular unmarried, out-of-school, poor and rural young people.
- The extent to which both organisations have the competencies and skills in order to provide high quality technical support and to promote lesson learning and best practice in the field of reproductive rights and health of young people.
- The extent to which both organisations promote the participation and empowerment of male and female adolescents and youth.
- The extent to which both organisations are gender sensitive in addressing reproductive rights and reproductive health needs of young people.
- The extent of complementarity and coherence of the approaches of UNFPA and FPAs and the extent of co-operation between both organisations.
- The extent of relevance, scope and effectiveness of co-ordination arrangements and partnerships between both organisations and other actors in the field of reproductive rights and health.

Once specific terms of reference for the country studies have been developed and agreed upon, these general questions will be reviewed. As part of the process of their further elaboration, a regrouping of questions under the evaluation criteria of relevance, efficiency and effectiveness will be given full consideration.

Methodology

The evaluation will be based on an empirical approach, by undertaking up to six country studies. The case studies will be followed by a final report, synthesising best practices identified and the strategic lessons learned.

The consultant teams for the country studies should be composed of three to four professionals, recruited both locally and internationally. The teams should be gender sensitive and gender balanced. One younger professional of the age of under 30 years should also be included. The consultant teams should be familiar with the socio-cultural context of the countries selected, have experience in evaluating complex sets of issues, and represent a range of expertise from the following fields:

- Policy and programme design, management and evaluation in reproductive rights and health;
- Health systems analysis
- Organisational and institutional development; capacity development;
- Adolescent and youth reproductive rights and health;
- Advocacy;
- Gender;
- Behavioural change and Information, Education and Communication;
- Donor co-ordination.

Prior to the fieldwork, the evaluators will review important documents on reproductive rights and health needs of adolescents and youth, including policy statements of UNFPA and IPPF as well as previous evaluations. The evaluation teams should give the findings from earlier evaluations of UNFPA and IPPF due consideration.

Besides programme and project documents, the teams will review all available material related to the specific evaluation focus of each case study, such as Demographic and Health Surveys, Knowledge, Attitudes and Practices Surveys as well as policy and legal documents.

In case substantial country specific surveys reflecting the perspective of adolescents and youth on their reproductive rights and health needs are not available, and in order to ensure that the point of view of adolescents and youth is given full consideration in the evaluation, local research and other institutions should be contracted as far as possible to conduct stakeholder surveys prior to the arrival of the evaluation team. Such surveys should be designed and conducted in co-operation with the national FPA and the UNFPA country office.

During their field visits, the evaluation teams will methodologically follow a qualitative approach and use a broad range of methods, such as in-depth individual interviews, focus group discussions, and semi-structured interviews. The methodology required for each country case study will be laid out in the inception report by the respective consultant team.

Key interview partners for the evaluation are UNFPA and FPA staff and volunteers at different levels in the selected countries and in regional offices and headquarters; government officials, including parliamentarians; representatives of civil society, including denominational groups and non-governmental organisations; and bilateral as well as multilateral donor agencies. Site visits will be made to selected UNFPA and IPPF supported projects, including visits to rural areas. The consultant teams will also conduct interviews with the target groups.

In order to involve stakeholders in the evaluation process, short workshops should be held at the beginning and the end of the field studies to inform participants about the goals and objectives of the evaluation and to discuss the main findings with them before the evaluation team leaves the country.

Steering and supervision

A Steering Group consisting of representatives of Denmark, Germany, the Netherlands, Norway and the United Kingdom as well as of UNFPA and IPPF will be responsible for the oversight and management of the evaluation.

The Steering Group may decide to establish an advisory mechanism (Advisory Group of not more than five senior experts in the field of population and development) with a view to obtain additional quality assurance inputs for intermediate and final evaluation products.

The results of the evaluation will be discussed with the governing boards of both UNFPA and IPPF. A follow-up of the evaluation will be initiated, in order to ensure as far as possible that key recommendations will be acted on.

Tasks of consultant

The consultant will assume the overall responsibility for designing and implementing the evaluation, which includes the following tasks:

- Developing an overall work plan and evaluation strategy.
- Pre-selecting international and national evaluators for the country case studies.
- Developing detailed terms of reference for each country case study on the basis of the framework terms of reference outlined above. The country terms of reference should be sensitive to the country specific situation and identify priority issues in the area of reproductive rights and health of young people. The terms of reference will specify (i) the approach and methodology to be used in the country case study, including the stakeholder surveys to be conducted locally, (ii) the tasks of the evaluation team

members, including the international and national experts, (iii) the modalities for assuring the participation of the UNFPA country offices, the FPAs as well as national partners of both organizations, (iv) stakeholder workshops to be organised at country level, and (vi) the projected timetable.

- Co-ordinating and supervising the country case studies, including the management of in-country stakeholder surveys and evaluation fieldwork, the preparation and facilitation of in-country workshops, the presentation of preliminary findings and the oversight of country reports.
- Drafting of a detailed outline for the synthesis report.
- Drafting of synthesis report.
- Ensuring regular and systematic communication and consultation with and between the Steering and Advisory Group, if established. Between meetings, the communication will be carried out predominantly by electronic means.
- Establishing and managing a special web site for the evaluation.
- Preparing, servicing, and following-up workshops and meetings of the Steering and Advisory Group.
- Managing the pooled financial contributions of donors, securing a cost-effective financial and administrative management of the evaluation, including keeping of separate accounts and securing compliance with any conditions attached by donors to their contributions.

With regard to the range and complexity of the above-described tasks the main consultant will be authorised to sub-contract work to other consultants, subject to prior approval by the Steering Group.

Specific products of the evaluation

The consultant will assume the overall responsibility for drafting the following documents to be submitted to the Steering and Advisory Group:

- Overall work plan and evaluation strategy
- Country terms of reference (in English and as necessary in French or Spanish);
- Inception reports for country studies;
- Country study reports (in English and with executive summaries in French or Spanish as necessary);
- Outline for synthesis report;
- Final version of synthesis report, including the preparation of its publication;

ANNEX 2: BIBLIOGRAPHY

These references are those that are cited in the text of the synthesis report. Full bibliographies are available in all of the country evaluations.

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