The Common Approach to Sponsorship-funded Programming

Adolescent Development Module

Revised November 2010

Save the Children®

Contents

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Acronyms used in this module:

AD	Adolescent Development
ARSH	Adolescent Reproductive and Sexual Health
BE	Basic Education
CAC	Community Action Cycle
CAP	Country Annual Plan
CAR	Country Annual Report
CO	Country Office
CM	Community Mobilization
CRC	Convention on the Rights of the Child
DAP	Developmental Assets Profile
DHS	Demographic Health Survey
DIP	Detailed Implementation Plan
DM&E	Design, Monitoring and Evaluation Module
ECCD	Early Childhood Care and Development
FGD	Focus Group Discussions
FP	Family Planning
IR	Intermediate Result
MoH	Ministry of Health
M&E	Monitoring and Evaluation
NGOs	Non-Governmental Organizations
OVC	Orphans and Vulnerable Children
PDQ-Y	Partnership Defined Quality for Youth
PIT	Process Indicator Tool
RIPT	Results Indicator Planning Tool
RSH	Reproductive and Sexual Health
SDP	Service Delivery Point
SHN	School Health and Nutrition
SIP	Summary Implementation Plan
SO	Strategic Objective
STI	Sexually Transmitted Infections
STWG	Sponsorship Technical Working Group
TA	Technical Assistance
VCT	Voluntary Counseling and Testing
YCBDA	Youth Community-based Distribution Agent
YCYP	Youth Couple-Years of Protection

Introduction to the Common Approach Adolescent Development Module

About the Common Approach to Sponsorship-funded Programming

Funds raised through marketing sponsorship products (e.g. individual and representative child sponsorship) are allocated to specific country offices (COs) to implement sponsorship-funded programs. These programs aim to ensure that children are educated and healthy through the use of a proven approach to design, implementation and measurement, known as "The Common Approach to Sponsorship-funded Programming" or "the Common Approach."[1]

The goal of the Common Approach is for country offices to successfully design, implement, monitor and evaluate their sponsorship-funded programs. The Common Approach framework has seven key components:

1. A focus on select programs in which Save the Children has extensive experience and expertise, and that coincide with the age range of sponsored children.[2] These are called the sponsorship "core programs" and consist of:
    a. Early Childhood Care and Development (ECCD)
    b. Basic Education (BE)
    c. School Health and Nutrition (SHN)
    d. Adolescent Development (AD)
2. Guidance and tools for each of these programs documented in core program modules, including this one.
3. Standard supporting guidance and tools for design, monitoring and evaluation (DM&E), which are also documented in a module.
4. Adherence to a common program cycle (see Figure A).
5. The provision of consistent, quality program technical assistance (TA).
6. Mechanisms through which we can learn from experience and use this information to make program improvement.
7. Use of a proven approach for mobilizing communities, documented in the *Sponsorship Community Mobilization Compendium: Mobilizing Communities for Education, Health and Social Change*.

This module draws on all seven of these components and provides guidance on how to design, implement, monitor and evaluate your sponsorship-funded AD program.

Sponsorship-funded Programs and Innovation

At the heart of the Common Approach framework is the implementation of quality, evidence-based programs. However, there is flexibility within the framework to allow for innovation. Sponsorship funds can be used to pilot and evaluate cost-efficient innovative interventions and/or approaches that seek to best address children's positive growth and development. Successful innovations can then be shared with other Save the Children COs, and scaled up through hand-over to the government, additional donor funds, or partnership with others. The implementation of any innovation should be done in close coordination with the program's Sponsorship Technical Working Group (STWG) TA provider.

[1] The acronym "CASP" is sometimes also used to refer to The Common Approach to Sponsorship-funded Programming.
[2] Country offices must invest a minimum of 75% of their sponsorship program resources in one or more of these core program areas.

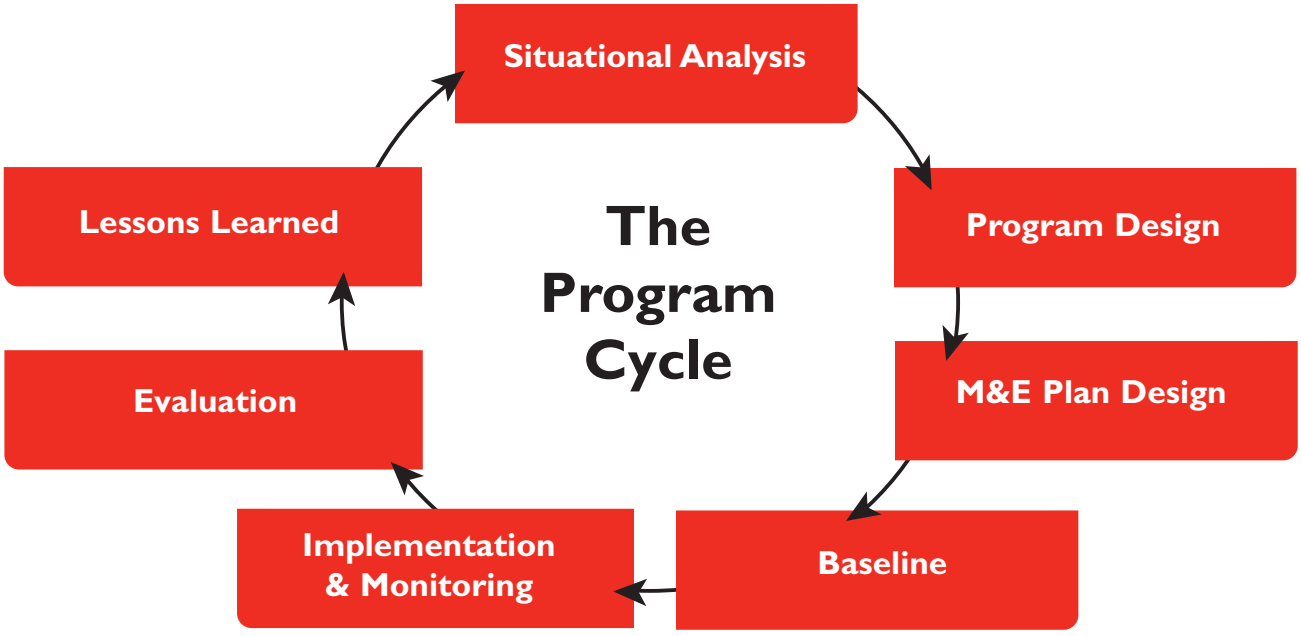
How to Use this Module

This module is intended to provide you with **step-by-step guidance** in designing, implementing, monitoring and evaluating your sponsorship-funded AD program. The module is divided into two main sections:

1. **About Adolescent Development:** This first section provides background on AD programming at Save the Children, including the key characteristics of any AD program. In addition, it outlines key principles that guide AD programming. The objective of this section is to establish a common understanding of AD programming at Save the Children.
2. **The Common Approach and Adolescent Development:** This second section walks you through each of the seven steps of the Common Approach program cycle (see Figure A), with AD-specific guidance provided for each step. Particular emphasis is placed on the situational analysis and program design steps.

This module is intended to serve as a reference and guide for CO program technical staff and is to be supplemented by technical assistance from the CO's STWG TA providers. In addition, the Common Approach DM&E Module and the Sponsorship Community Mobilization Compendium should be read alongside this core program module. The DM&E Module contains many helpful tools and in-depth explanations about each step of the program cycle, with a particular emphasis on the steps that follow the situational analysis and program design. The Sponsorship Community Mobilization Compendium provides detailed guidance on how to implement the Community Action Cycle (CAC). The phases of the CAC, and how they relate to each program cycle step, are presented in abbreviated form in this core program module.

Figure A



The Common Approach emphasizes that programs must be designed, monitored, and evaluated according to a standard process. This process is guided by adherence to a standardized program cycle.

About Adolescent Development

Adolescence, generally referred to as encompassing the age group from ten to eighteen years, is a turning point when young people are forming their identities and preparing to assume adult roles. If prepared, adolescents can acquire the attitudes, competencies, values and social skills that will carry them forward to successful adulthood.[3]

With the rapid developmental growth and maturity of adolescence comes increased vulnerabilities and risks. In many societies puberty, which usually occurs between ages nine to fifteen, is the point at which adolescents are seen to become adults and begin to take on adult roles, such as contributing to family earnings or preparing for marriage and parenting. These roles often come with lifelong compromises to the health and education of adolescents themselves, as well as of their future children.[4]

Adolescent development programs should provide opportunities in safe settings for young people to build on their developmental assets. These assets can help protect adolescents against potentially life-threatening or life-compromising risks, and offer them the potential to break the cycle of poverty with the appropriate skills, knowledge and support in place.

Assets

Developmental assets represent the relationships, opportunities and personal qualities that young people need in order to avoid risks and thrive. There is a direct correlation between asset development and the prevention of high risk behaviors including premature sexual activity and engagement in violence. An increase in assets has also been correlated to school achievement and attendance. Poor developmental asset outcomes can be related to health complications, chronic poverty and lack of parental support.

There is much anecdotal evidence that our AD programs make a difference in the wellbeing of young people and their communities, but it is not always easy to measure, outside of our specific indicators for adolescent health, education and livelihood development. For this reason additional information is provided in Annex 3 about measuring developmental assets using the Developmental Assets Profile (DAP). The DAP is a tool, developed by the Search Institute, that enables programs to track changes in categories of assets for young people over time, and which can serve as a higher level evaluation of the wellbeing of adolescents.

Adolescent Development at Save the Children

Adolescent Development programs at Save the Children target young people ages twelve to eighteen utilizing an asset-based approach. Given the diverse needs of adolescents, AD programs should strive to be multi-sectoral and work across activities related to adolescent reproductive and sexual health (ARSH), non-formal education, and/or adolescent livelihood development.[5] That said, depending on the context and resources, programs may focus on a particular sector or sub-theme, as well.

Whether multi-sectoral or not, the defining characteristics of any AD program are as follows:

1. **Builds assets:** Programs strengthen adolescents' developmental assets and clearly articulate how they contribute to the strengthening of young people's positive relationships with adults and peers.

2. **Develops skills:** Programs develop and build the skills of adolescents that will enable them to succeed. These skills are often referred to as "life skills" which help adolescents during this

[3] Board on Children, Youth and Families, 2002.
[4] Judith Bruce, "Reaching the Girls Left Behind: Targeting Adolescent Programming for Equity, Social Inclusion, and Poverty Alleviation," Population Council, (prepared for "Financing Gender Equality: A Commonwealth Perspective," Commonwealth Women's Affairs Ministers' Meeting, Uganda, June 2007).
[5] Several COs implementing sponsorship-funded AD programs have recognized the importance of a multi-sectoral approach to adolescent development and are currently implementing multi-sectoral AD programs. However, it is important to note that as of the writing of this module in November 2010, the STWG does not have education or livelihoods TA providers who focus on adolescence and are able to support these two aspects of the program globally. There are, however, STWG TA providers that support ARSH programming. For this reason, ARSH is addressed in greater depth in this module. COs needing TA for adolescent education and livelihoods development should seek that TA outside of the STWG.

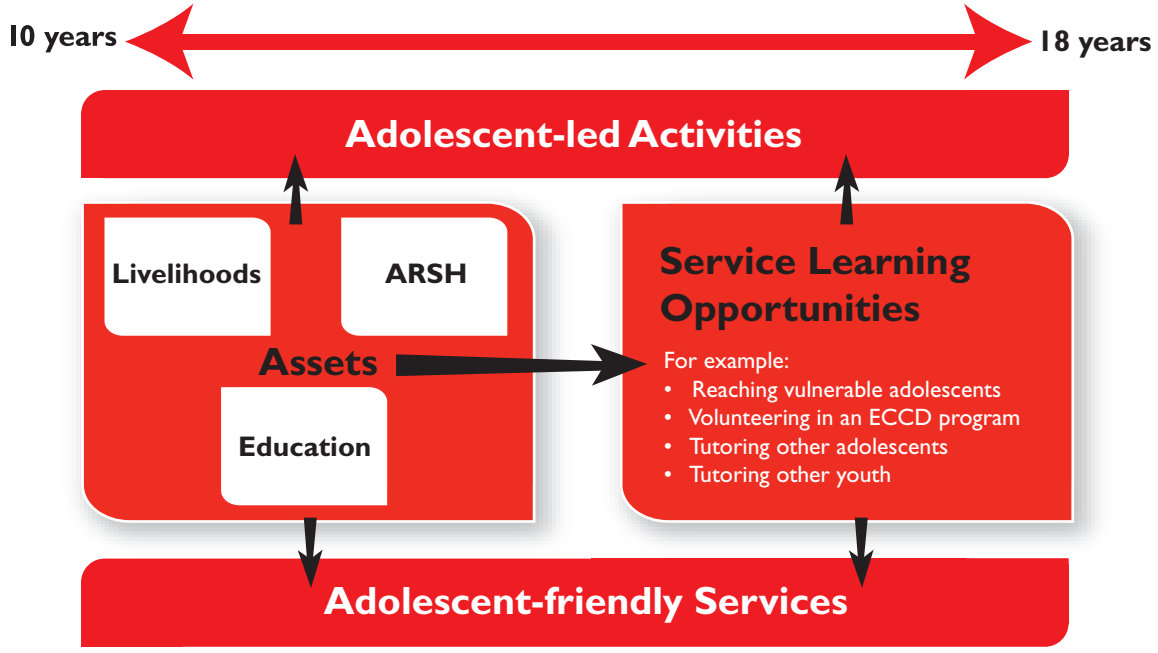
transition by preparing them to make complex decisions about their sexual and reproductive health (SRH), as well as for the world of work, amongst other things.

3. **Promotes adolescent-friendly services:** Programs work with institutions to make structural changes to attract adolescents and increase adolescent demand for information and use of services. These could include health, microfinance, vocational and non-formal literacy services. Changes might include training for service providers or local entrepreneurs to tailor their programs toward the needs of an adolescent user.

4. **Integrates adolescent-led activities:** Through the development of life skills, adolescents can become contributors to the wellbeing of their society through civic participation. This is often seen through activities designed and implemented by adolescents that contribute to the enhancement of community wellbeing and connectedness.

The model below demonstrates how adolescents can build their assets and life skills as they progress through a multi-sectoral AD program with the characteristics outlined above:

Figure B



In this multi-sectoral model, all young people entering the program learn from all three sectors:

- Skills in *livelihoods* include supporting a young person apply financial literacy by opening up an individual savings account or forming a savings' group.
- Skills in *ARSH* include puberty education and family planning (FP) and life skills.
- Skills in post-primary *education* include functional literacy, pre-vocational training, or links to vocational training.

This multi-sectoral approach enables programmatic synergies, which enhance the learning process. As they grow in their capabilities and knowledge, adolescents will also strengthen and build upon their *developmental assets*.

As adolescents mature, all along the age continuum, they are engaging in *adolescent-led activities* – such as savings clubs and child clubs – as well as accessing and promoting *adolescent-friendly services* – for example in clinics, school or financial services – which serve to further develop their assets, and those of other adolescents.

While early on in this model, the emphasis is on building adolescents' assets and skills, there is a transition into *providing service learning opportunities* for the adolescents as they become older where they can apply these skills. These opportunities promote their personal and professional development, while enabling them to continue building their assets. In addition, the entire community benefits from these service learning opportunities, which promotes the view that young people can and should take responsibility and be engaged in activities in the broader community.

Key Principles of Adolescent Development

The *Convention on the Rights of the Child* (CRC)[6] is the primary reference that should guide our programming. The CRC should be reviewed in detail by Save the Children country offices as part of their sponsorship program development.

The following principles of adolescent development programs build off of key rights in the CRC as well as generally accepted standards for quality in the adolescent development sector.

1. **AD programs are participatory and empowering.** Programs promote the meaningful participation of adolescents and communities. Programs are designed to increase the capacity of adolescents to become significant partners in the design, implementation, monitoring and evaluation of projects that promote their development. Close attention is also paid to developing community partnerships between adolescents and adults. Having a voice through participation is empowering for adolescents because it builds self esteem and connectedness to others.
2. **AD programs are gender-sensitive and inclusive of all children.** The CRC provides for the expression of the rights of all children and adolescents regardless of background and level of vulnerability. AD programs do not exclude or discriminate on the basis of difference. Instead, all adolescents are welcomed, treated equitably, and given equal opportunities. For this reason, AD programs target vulnerable adolescents to provide them with access to quality programming. To this end, a coverage exercise, which is described in Step 5 of this module, is a useful tool to better understand who our adolescent programs are reaching. In addition, AD programs make deliberate attempts to achieve gender equity by integrating gender into all phases of the program.
3. **AD programs are safe and protective of adolescents.** Programs promote the healthy physical, social and emotional development of adolescents in environments that are free from abuse and harassment. It is especially important to reduce and prevent the harassment to which adolescent girls may be subjected in school or in the community.
4. **AD programs are asset-based.** Programs utilize an approach that builds on the existing capabilities and assets of young people and their communities.
5. **AD programs are adolescent-centered and age-appropriate.** Adolescents' needs range across a broad spectrum, and vary and change as they develop. AD programs address these diverse physical, intellectual, social and emotional needs of adolescents to build lasting life skills. All programming are tailored to the developmental stage of adolescents, recognizing that twelve year olds are emotionally and developmentally very different from eighteen year olds. Save the Children acknowledges that young people are enablers of development and have skills and knowledge that can facilitate this process. Young people will be encouraged to enhance these skills and knowledge and create additional opportunities to improve their own wellbeing and that of their communities.
6. **AD programs seek to scale-up.** Programs will test, monitor, evaluate, document and disseminate lessons learned and best practices in adolescent programming in preparation to scale-up through partners and/or other funding sources. Replication and expansion of quality programs and/or interventions will be a priority to increase coverage and reach the most vulnerable adolescents.

[6] Convention on the Rights of the Child, available at http://www.unicef.org/crc/

In addition, all sponsorship-funded core programs, including Adolescent Development, adhere to the following practices:

1. **Programs are accountable for results.** Through regular assessment and monitoring and evaluation programs demonstrate how investments and interventions are contributing to improvements in reproductive and sexual health, life skills, livelihood development, learning and meaningful participation.
2. **Programs collaborate and partner.** Programs work with governments at the local and national level, as well as other partners to ensure that they complement and strengthen the government system and are not offered merely as substitutes. A memorandum of understanding (MoU) should describe the obligations of each partner.
3. **Program teams innovate and document.** Programs develop, test and refine new and/or better ways to address the key needs of adolescents. Save the Children will also explore innovation in measuring the impact of AD programming through adolescent-driven research, exploration of partnerships and use of new tools. Investing in innovation and documentation is critical to achieving positive, lasting change at scale.
4. **Programs are integrated.** Adolescent programs are not implemented in isolation, but are linked as appropriate to other programs (sponsorship-funded and others).
5. **Programs are sustainable.** It is critical that local governments, communities and other stakeholders continue to maintain and expand quality adolescent programs beyond Save the Children's intervention. From the beginning, programs are developed in partnership with government stakeholders while building their capacity to sustain programming. Non-governmental organizations (NGOs) that are led by adolescents or serve them should also be strengthened in the process. Programs are designed with time and resource limits. Strategies are developed to ensure that communities and institutions do not become exclusively dependent on Save the Children and its resources.
6. **Program interventions are cost effective.** Programs identify and prioritize interventions that produce the greatest impact for the least amount of resources – program outcomes justify the level of expenditure necessary to achieve them. This is determined by applying relevant evidence-based strategies and conducting operations research to compare and test different approaches. Cost effective programming is a key element in program sustainability.

Save the Children's Theory of Change

The Theory of Change should help guide the planning and implementation of all sponsorship-funded programs.

Links to Other Sponsorship-funded Core Programs

Country offices with sponsorship funding often implement more than one of the Common Approach core programs. It is important to ensure that the program teams collaborate on program planning and implementation, as well as think strategically about how programmatic linkages can be made between the sponsorship-funded programs. Some links to consider between AD programs and ECCD, BE and SHN are outlined below.

AD links to Early Childhood Care and Development

There are many opportunities to link AD programs with ECCD programs:

- Adolescents frequently maintain child rearing responsibilities for younger siblings at home. However, adolescents have rarely received any orientation on to how to rear children or what child rearing activities support child development. Thus, offering child rearing training or orientation to adolescents – even before they become parents – is strategic. This will also help prepare them to raise their own children later on.
- Similarly, adolescents who become mothers have needs not only for their own health information and services, but also for their newborns, younger siblings and parental roles as caregivers. Parenting education and training classes should reach out to adolescent mothers in the community with information on a variety of topics, including ways to strengthen care giving practices and to nurture development of their children, as well as information on family planning and birth spacing.
- In many communities, adolescents can play a critical role in supporting ECCD programs themselves. Adolescents may be trained and involved in running summer learning programs for children with no preschool experience, organizing community play groups for young children, after school learning circles, ECCD community events, volunteering at a health clinic or immunization campaign and many others. Adolescents are an incredible asset to a community-but unfortunately are often an under-utilized resource-to help young children obtain skills associated with robust human and community development. Involving them in programs and helping them learn about young children's needs are ways to strengthen not only ECCD programs but also to provide opportunities for adolescents to prepare for positive parenting practices later on.

AD links to Basic Education

Basic education programming encompasses primary school-aged children. The key link between BE and AD programming is in the preparation of children for adolescence by promoting gender-equal activities within an environment of safety and protection. Links include:

- Making school interesting and engaging to help keep girls in school. This may be one of the most important protective factors in preventing early marriage and reducing poverty.
- Including messages on gender norms and gender equity in the classroom. This can enable young people to consider different and potentially less rigid gender norms than currently practiced in their community.
- Incorporating age-appropriate messages on health and physical development in a safe and open dialogue so that young people can be more knowledgeable about their bodies and empowered to be responsible for their actions as they move into adolescence.

AD links to School Health and Nutrition

In the primary school years (age six to twelve) early adolescence begins. Young people who have the information and resources they need before puberty will be prepared for the physical, social and emotional changes that will soon happen. Save the Children's SHN programs can include specific sexual health components that will enable school-going adolescents to be better prepared for the transitions during puberty by:

- **Including sexual and reproductive health concerns in SHN curricula, and ensuring that they are addressed adequately and in an open and age-appropriate manner. Activities on puberty, gender, sexuality, sexually transmitted infections and HIV/AIDS prevention should a) answer young people's questions about body changes, including menstruation b) reduce teasing and encourage boys to respect girls as their bodies mature, c) remove misconceptions about HIV and discriminatory attitudes towards people living with HIV and d) plant seeds for positive and responsible sexual health behavior as children move into adolescence.**
- **Establishing separate latrines for girls so that they feel more comfortable in the school setting when they are menstruating.**

The Common Approach and Adolescent Development

The following section provides step-by-step guidance on how to design, implement, monitor and evaluate your sponsorship-funded AD program. The section is organized around the seven steps of the program cycle, with AD-specific guidance provided at each step. Particular emphasis is placed on the situational analysis and program design steps. As noted above, additional guidance can and should be obtained from the Common Approach DM&E Module, the Sponsorship Community Mobilization Compendium, as well as from your STWG TA provider.

Step 1: Situational Analysis

Goal of this step:

Identify problems and needs in the sponsorship impact area related to AD to inform program design.

What you will need:

- This module
- The DM&E module

The outputs of this step will be:

- A situational analysis report
- Completed Situational Analysis Summary Tool

Community Mobilization Action!

Effective community mobilization (CM) is integral to program success. Throughout this module, a summary of each phase of the Community Action Cycle will be presented alongside the corresponding step in the program cycle, beginning here with the Situational Analysis. For a full explanation of each phase of the CAC, please refer to the Sponsorship Community Mobilization Compendium.

Remember that during the time of the Situational Analysis there is work to be done within your own team, and partners to prepare the way for mobilizing communities around the sponsorship-funded core program. In particular you will need to develop a community mobilization team composed of key staff and partners and ensure they are prepared with the skills and abilities to mobilize communities using empowering community approaches. This is also the time to pave the way for greater understanding of the communities you will be working with. It will be important to gather key information about how communities are organized, existing social networks and groups with which we might work, key leaders and stakeholders, and how community decisions are made.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the Prepare to Mobilize phase. These key steps include:

Step 1: Put together a CM team.
Step 2: Develop your CM team.
Step 3: Gather information about community resources and constraints.
(Step 4 in this phase is undertaken during program design please see below).

The purpose of the situational analysis

Save the Children believes no one model works well everywhere, since values, expectations, needs and realities vary considerably in different locations. The situation analysis helps identify priority problems in each context, and also considers the underlying dynamics with a view toward identifying potential points of intervention. The information gathered and analyzed will be used to help facilitate the process of designing a program that successfully addresses the developmental needs and rights of all children and adolescents in the

impact area. In addition, a situational analysis ensures that the community communicates their needs. The situational analysis is a critical step in establishing a relationship with the community based on mutual understanding, and in promoting the involvement of community members in the planning and management of the program.[7]

Step 1: Review the questions in the situational analysis matrix

In the situational analysis matrix below, you will find a list of questions which the situation analysis can address. For each question, information sources and data collection methods are suggested to help you gather the responses. Review the matrix first and select the questions, data sources and methods that seem most relevant to your impact area and program needs. Make a plan for the data collection and create a report outline. As you undertake this step, keep in mind that the situational analysis should be conducted in collaboration with the other core program teams; it should not be done separately.

Step 2: Gather information

Gather the information you will need to answer the questions you identified in Step 1 from the suggested sources of information. The main data sources include:

- **Review of secondary data:** A review of documents from government agencies such as the ministry of education (MoE) or the ministry of health (MoH) in your country (including district and national levels) and other development partners, and a review of published papers specific to your country and issues.
- **Key informant interviews:** Conducted at the national and district level, these will include interviews with national level experts, national program managers and development partners involved in AD related activities, as well as Save the Children program staff. The choice of key informants will vary by country and depend on the program focus and existing connections with Save the Children. Key informant interviews should also be used to create and strengthen connections with partners, make sure they are aware of Save the Children's activities, identify possible links and gather recommendations for Save the Children's program focus (e.g. the role that Save the Children should play to contribute to national strategies/policy aimed at youth).
- **Primary data collection:** Conducted at the household, school and community level using participatory methods such as focus group discussions (FGD) and in-depth interviews.

You may need assistance from a qualitative research expert to help gather and analyze the primary data at household, school, and community levels. However, the key informant interviews at the national and district level, and review of secondary data should ideally be conducted by Save the Children staff to strengthen our relationships with partners and awareness of the content of AD related documents in country.

Step 3: Process the information and summarize findings in a report

The information gathered must be processed and summarized into a report. Findings from the review of secondary data, key informant interviews and primary data collection should be reported under separate sections and then pulled together in the conclusion with programmatic recommendations. The Situational Analysis Summary Tool in the Common Approach DM&E module (see Step One) can be used to prioritize the important findings from the situational analysis and identify appropriate strategies and interventions to address these findings.

Step 4: Share findings and use for program design

The final and most important step is to share the findings of the situational analysis with Save the Children staff and district level partners and use those results to guide the program design.

[7] Save the Children, 2001.

Key questions to guide a situational analysis

This following matrix contains seven sets of questions to help guide your situational analysis. The first six sets of questions correspond to the results framework you will construct in the next step of the Common Approach process. The seventh examines Save the Children's capacity to implement an AD program in your impact area.

You should select the questions from each list that are most relevant to your impact area. Some questions listed below may not be relevant for you and you may decide to include other questions based on your experience and understanding of the local context. Be sure to focus especially on the assets of adolescents in your impact area so that, in the following steps, you can build upon those assets to create a successful, sustainable program.

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
Understanding determinants of behavior *AD is a multi-sectoral core program whose overall goal is to improve adolescent development in aspects of reproductive and sexual health, non-formal education and livelihoods.* *Therefore it is important to understand the determinants of SRH behaviors and related economic and educational barriers. It is also critical to understand the broader environment within which adolescents live that may keep cultural, social and gender norms in place.*	**Methods** • Review of secondary data and published papers • Key informant interviews • School/community level FGDs **Sources of information** • Ministry of Health (MoH) statistics (national and district level) • Health reports published and unpublished (MoH and partners) • Interviews with MoH personnel at district and regional level • Health facility and school level statistics in sample schools • FGDs with children, teachers and parents	**Data on determinants of behavior** • What are the key determinants of adolescents' sexual and reproductive health behaviors? • What are the motivations that determine whether and how adolescent s seek out RSH information and services? Do these factors vary by age, sex, ethnicity and other socio-demographic determinants? • What level of awareness do adolescents have about reproductive health and HIV/AIDS? How does that knowledge link with their behavior? • What keeps adolescents from staying in school? To what degree are the reasons economic, social, cultural? How do adolescents continue to learn if they do not attend formal schooling? • Where do adolescents get their key information to transition into adulthood (basic life skills?)? What are the risks young people face in this community if they do not get those life skills? • Who are the vulnerable adolescents in the community and how are their needs being met? • How do adolescents perceive their own risk taking behavior? **Key informant interview** If there is not secondary data available to answer these questions, you may need to rely on key informants in the community. **Community/school level FGDs** This will provide general consensus and support any possible trends identified.	**Goal**
Reproductive and sexual health and status of adolescents *What are the most significant reproductive and sexual health issues adolescents face in this community?* *How are these linked with economic and educational indicators?*	**Methods** • Secondary data • Key informant interviews • FGDs with children, teachers and community members • Baseline survey can confirm findings and fill missing gaps in info **Sources of information** • Published papers (search websites) • MoH statistics, Demographic Health Survey (DHS), agency reports and unpublished survey reports • Interviews with national level experts in the field • Interviews with regional, district and community level health workers • FGDs with teachers, parents, adolescents	**Reproductive and sexual health data** a) What are the key health problems among adolescents? What is the pregnancy rate? What is the couples rate of protection among adolescents? What is the unmet need for family planning? What percent of adolescents do not have a job? How many married adolescents are in the community? What percent of the population under 18 is married? What is the age of sexual debut? Report differences between the sexes, age group and other socio-demographic determinants if available. Note the gaps in information which can be filled in during the baseline survey. b) Is there any country level evidence of the impact/associations between health and education? Have there been any studies that attempt to link education attainment with delaying marriage and childbirth? Do girls go back to school after giving birth? c) How does RSH link with poverty alleviation? Are there any studies that link educational achievement with attainment of job skills for adolescent girls?	**Goal**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
Availability and accessibility of adolescent friendly services and opportunities *Do adolescents have access to basic health services to address the most common health problems identified? Are any of these health services provided at school? Do they have access to livelihoods opportunities and non-formal education programs? In the community? Are these services being used?*	**Methods** • Secondary data • Interviews with key informants • FGDs with school and community members, health providers, peer educators, parents **Sources of information** • ARSH policy/strategy document and program reports • Any existing statistics on health, youth development or educational programming, if available • Interview with national program coordinators: ARSH, health, youth, sports, etc. • Discussion with UNFPA and other stakeholders who may have population based data including trend data. • FGDs with teachers, parents, children	**Data about adolescent access to services/resources** • What barriers to ARSH services, livelihood development and non-formal education opportunities exist? • What barriers to health care exist? • What kinds of economic activities are adolescents involved in? • Do young people use financial services? If so which and how? • Do young people access livelihood preparation programs? Which? • What kinds of financial resources do adolescents access already? • What are the main successes and challenges faced with the implementation of ARSH, education and livelihoods services at school, community, district and national level? • What other services are available to adolescents? • Are there community or health center-based health campaigns targeting adolescents? Is there voluntary counseling and testing (VCT) for HIV/AIDS? • Are there other health services such as sexual and reproductive health services, and information and counseling for FP services? • What sources of data and information are available to adolescents • What ARSH, education and livelihoods services are being provided in the schools and in the community? • Are all adolescents using and benefiting from these services? If not, why not? Are certain groups of adolescents less likely to use them (children living far from service delivery, girls/boys, younger/older children, children from certain socio-economic groups, orphans and vulnerable children (OVC)? • Are out of school adolescents also targeted by particular services? If so, which ones and how are they targeted?	**Strategic Objective and Intermediate Result 1**
Quality of services and opportunities *Are health facilities and livelihoods and education services/ opportunities adolescent- friendly? Are they of good quality and safe?*	**Methods** • Review secondary data available • Interviews with key informants • FGDs with school and community members, adolescents **Sources of information** • MoH statistics or/and ARSH statistics • Interview with AD coordinator and reproductive health and nutrition national and district level • Interview with partner agencies UNFPA, other NGOs, UNICEF, • FGDs with students, teachers and parents	**Secondary data** • What is the status of services currently being provided for adolescents? • Where do they go for RSH information and services? • Is poor health a significant problem among adolescents? What health issues do adolescents face? • What is the prevalence of HIV/AIDS among adolescents in the country and/or project site? • What is the prevalence of Sexually Transmitted Infections (STIs) among adolescents in the country and/or project site? Which STIs are most common? • Are adolescents and households facing significantly hard decisions in balancing income generation and investments in skill and knowledge development? To what extent and what are the risks, vulnerabilities, and opportunities? • How do adolescents contribute to the family income? • What level of education do most adolescents reach? **Ask service providers (health worker, youth worker, etc.)** • Are there tools to assess the school environment, financial institutions, and clinic facilities for youth-friendliness? • Are there adolescent-run organizations (e.g. clubs)? What is their purpose? What do they do?	**IR2**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
		Ask adolescents • Do adolescents feel that education, livelihood (preparation or financial), and health services are youth-friendly? • Do adolescents feel that education, livelihood (preparation or financial), and health services are of good quality?	**IR2**
Capabilities, skills and knowledge of adolescents *Are children practicing the key health behaviors to ensure that they stay healthy? What are schools/community programs doing/not doing to provide adolescents with the knowledge, skills and attitudes needed to practice these behaviors?*	**Methods** • Secondary data review • Key informant interviews • FGDs with school and community members **Sources of information** • Reports of health behavioral studies, including DHS • School curriculum and information education and communication materials used in schools (including by development partners) • Interviews with national level experts (STI/HIV/AIDS, hygiene, nutrition) and development partners • FGDs with student, teachers and community members	**Ask service providers** • Is there demand from young people to address AD needs? **Ask adolescents** • Is there demand from young people to address AD needs? • What do adolescents say are the biggest contributions they can make to community development? • Do adolescents feel good about themselves? And feel life has a purpose? • Are they optimistic about the future? • Do adolescents believe it is important to help others? • Can adolescents plan ahead and make decisions? • Do adolescents want to do well at school or in other learning programs in which they may be involved? • Do adolescents care about their education? • Are they good at making friends? • Are they comfortable with other young people of different cultural/racial/ethnic backgrounds? • Can they resist negative peer pressure and dangerous situations? Can they resolve conflicts non-violently? • What kinds of skills and knowledge do adolescents develop through existing livelihood activities? • How do young people and families prepare to withstand shocks? • Where adolescents work, what kinds of skills and knowledge are they developing? **Ask parents** • How do young people and families prepare to withstand shocks? • What do adolescents say are the biggest contributions they can make to community development? **Ask community leaders** • Is there demand from young people to address AD needs? • What do adolescents say are the biggest contributions they can make to community development? **Key informant interviews (school based health education)** • What are the strengths and weaknesses of the existing school curriculum and system in promoting healthy behaviors amongst school children, including HIV/AIDS prevention? What effort is being done to improve it or add extra curricula health promoting activities to the school agenda? • Are teachers trained in skills-based health education, particularly sexual education and HIV/AIDS prevention? Is it included in the pre- or in-service teacher training? What are the plans or needs for improving teachers' capacity to provide skills-based health education? **Community/school Level** • Do children, teachers and community members know what health behaviors they should practice to stay healthy (e.g. to avoid getting HIV/AIDS)?	**SO, IR3**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
		• Are adolescents learning about ARSH in the schools? Is it effective or could schools (and school children and teachers) do more to promote healthy behaviors? If so, what and what support do they need? • Do teachers feel they have enough training and materials to promote healthy behaviors, including sexual health? If not, what more do they need?	**SO, IR3**
Social and policy environment *How can Save the Children engage with communities, government and other partners to improve health, education and livelihood services for adolescents?*	**Methods** • Review secondary data • Key informant interviews • FGDs with teachers, children and parents, and religious leaders and other key stakeholders **Source of information** • Government documents and data • National RSH, education, economic policy or strategy document or other related documents (meeting reports, draft documents, etc) • National program strategies (10 year plans) for health, HIV/AIDS • Interviews with national program coordinators (health, sports, youth, nutrition, HIV/AIDS, etc.) • Interviews with development partners involved in the development of the national ARSH, education strategy • FGDs with students, teachers and parents • Interviews with local and national leaders and policymakers	**Secondary data** • What particular policies or guidance exist in regard to key areas of Adolescent Development? • Are there policy barriers preventing successful AD activities and programs? • What ministries and government bodies are involved in Adolescent Development issues and related policies? Do they have recognition of the inter-sectoral nature of AD? • How open are local or national governments to Adolescent Development? To non-governmental organization interventions and collaboration in the sector? Is there local level and national support for adolescent development initiatives, and from whom? What type of support? • Who else is working on Adolescent Development? Are there suitable partner organizations at the local and national level that Save the Children could work with to influence policy? • Does the government adequately fund and allocate funding for adolescent development activities? • Does a national adolescent reproductive health policy or strategy exist? If so, what are the main elements of this policy and what are the gaps at all levels? • What is Save the Children's role in the policy development or strategy implementation? What is the coordinating mechanism for the national ARSH strategy at national, regional, district and school level? Have the roles of each stakeholder been clearly defined? Have the communities role been defined and a mechanism identified to engage communities? **Ask adolescents** • Do adolescents receive high levels of love and support from family members? • Can adolescents go to family members for advice and support and have in-depth conversations with them? • Who are the non-parent adults adolescents go to for advice and support? • Do adolescents feel valued by their community? • Do parents and adults model positive, responsible behavior? Do peers model positive, responsible behaviors? • Do parents/guardians/teachers encourage adolescents to do well? • Are adolescents invited to participate throughout the relevant advocacy and policy-creation processes? **Ask parents** • Do adolescents receive high levels of love and support from family members? • Can adolescents go to family members for advice and support and have in-depth conversations with them? • Based on experience to date, what has been the reaction from the community to adolescent-focused activities currently or previously implemented (including ARSH programming)?	

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
		• What kinds of traditional ceremonies and/or rites of passage are practiced? What are the impacts of these? • Is female genital cutting commonly practiced? • What is the average age of marriage (both legal and customary age)? Of first birth? Is marriage considered an economic necessity/alternative? • How are families able to address the varied needs of the household? • Is there demand from key adults/the community to address adolescent development needs? **Ask community leaders** • Do adolescents receive high levels of love and support from family members? • Can adolescents go to family members for advice and support and have in-depth conversations with them? • Based on experience to date, what has been the reaction from the community to adolescent-focused activities currently or previously implemented (including ARSH programming)? • Has there been community support for adolescent development programming? • What kinds of traditional ceremonies and/or rites of passage are practiced? What are the impacts of these? • Is female genital cutting commonly practiced? • What is the average age (both legal and customary age) of first birth? Is marriage considered an economic necessity/alternative? • Are adolescents invited to participate throughout the relevant advocacy and policy-creation processes? **Ask service providers** • Do adolescents receive high levels of love and support from family members? • Can adolescents go to family members for advice and support and have in-depth conversations with them? • Based on experience to date, what has been the reaction from the community to adolescent-focused activities currently or previously implemented (including ARSH programming)? • What local and national adolescent policies and structures exist that may support or hinder intervention efforts (e.g. policies that promote or hinder adolescents obtaining reproductive and sexual health information and/or services)? What policies or guidelines are not in place that would support program efforts? • Are there policies that help young people have appropriate paperwork to protect financial assets, especially young women?	
Save the Children's capacity *An awareness of Save the Children's capacity and experiences in the specific context can you help plan more effectively.*	**Methods** Interviews with Save the Children staff and review of documents that record the organization's experience in the program areas. **Key informants:** Save the Children staff	**Ask key informants** • Does Save the Children currently have programs for adolescents in any of the following areas: adolescent reproductive and sexual health, education, and adolescent livelihood development? If so, is SC staffed to provide technical advice to counterparts implementing these programs? • If not, what capacity exists for developing these program areas? • Does Save the Children staff have adequate training and capacity to work with government officials and stakeholders to advocate for policy change and to collaborate with national governments and stakeholders?	

Processing the situational analysis

As you gather information to answer the questions above, you may want to record your most important findings in the Situational Analysis Summary Tool, found in the Common Approach DM&E Module. You will then need to process the information you gathered, identifying problems that your AD program should address, and the assets of adolescents in your impact area that could be built upon by your program.

Below are some questions that may help you process your findings.

Processing your access findings:

- **Are there enough health facilities, alternative and/or higher learning centers (formal and non-formal education) and vocational training opportunities?**
- **Are there ways to address barriers to adolescent-friendly health care?**
- **Do adolescents receive adequate livelihood preparation?**

Processing your quality findings:

- **Are existing adolescent programs of high quality? Do they empower young people?**

Processing your knowledge, skills and capability findings:

- **What assets do young people in your impact area possess?**
- **How can you build on these assets to empower adolescents and increase the success and sustainability of your program?**

Processing your policy/context findings:

- **Are the local and national governments supportive of AD?**
- **What policies exist or don't exist that are supportive of AD, and what are particular policy barriers that are preventing successful AD initiatives and programs?**
- **What are the local gender norms and traditions that need to be considered when designing the program?**

Processing your Save the Children capacity findings:

- **Does Save the Children have health, education or livelihoods development activities in your impact area that target adolescents? Could they be made more holistic?**
- **Does the local Save the Children staff have an adequate understanding of AD issues?**

Step 2: Program Design

Goal of this step:

Understand the Save the Children AD results framework, and document your own. Choose strategies that will best address the needs you identified in your situational analysis and enable the program to achieve the desired results. Develop a summary implementation plan.

What you will need:

- This module
- The DM&E module
- The situational analysis report

The outputs of this step will be:

- A results framework for your program
- A summary and/or detailed implementation plan

Now that you've gathered information about the needs and context of your impact area, you are ready to begin using that information to design your program. The two central elements of this are documenting your results framework, and selecting the strategies that best address the gaps between what you found in your situational analysis and what you are seeking to achieve as reflected in the results framework.

Community Mobilization Action!
Program Design

During the time of program design a community mobilization plan for Save the Children staff and partners will provide a needed roadmap for beginning work with selected communities. The community mobilization plan is a description of how your CM team intends to mobilize communities around the core program goal in the designated area you will be working. As such, the community mobilization plan should serve as a detailed roadmap for you and your team. Note: This is not a community action plan. This will be developed by communities themselves later in the process.

Your team's mobilization plan should focus on the overall core program goal and objectives and identify a process that will help interested communities achieve them. As you create this plan, you should always keep the two overriding goals of community mobilization in your mind:

1. **To achieve the core program goal of the community, including those *most affected* by the issue.**
2. **To improve the community's capacity to address the issues and sustain their effort over time.**

Developing a community mobilization plan provides an opportunity to harmonize efforts between sponsorship operations and program staff so that communities are not bombarded by multiple meetings for similar purposes. The mobilization plan should be widely shared to see if community-based efforts might be integrated. For example, if other core programs are being newly initiated, coordinating community orientation meetings could be time-saving (and appreciated by communities).

Additional detail on the key CM step to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Prepare to Mobilize* phase. This step is: Step 4: Develop a CM Plan.

What is a results framework?

The results framework (RF) is a diagram that shows how your sponsorship-funded AD program will produce positive change for children by identifying the goal, strategic objective and intermediate results of the program. There are four major pieces in a results framework, which are causally linked.

1. **The Goal:** The goal sits at the top of the RF and represents the "big picture" positive change or result you are aiming for. In general we think of goals as being the long-term outcome that we would like to see. In the short-term, though, it is recognized that an individual program may not be able to achieve this outcome on its own.
2. **Strategic Objective (SO):** The measurable behavior or status change that is needed in order to reach your goal. It is important to note that the SO is at the heart of our results framework and is the standard by which AD programs are judged. All program staff need to focus on the SO during the program cycle in order to best assess what can realistically be achieved within a given time frame and set of resources.
3. **Intermediate Results (IRs):** Measurable, lower-level results that must occur in order to reach the Strategic Objective. Each IR may be supported by several strategies, or kinds of activities.
4. **Indicators:** Indicators are measures used to assess progress made towards achieving the goal, SO and IRs. There are two broad kinds of indicators: those that are quantitative (i.e. things that can be counted, percentages that can be calculated, etc.) and those that are more qualitative (i.e. descriptive and somewhat more subjective). Indicators are mentioned in this section because objectives should be stated with an awareness that indicators will be used as the basis for monitoring and evaluation of the program. A list of recommended indicators is included as an annex in this module.

A results framework is a very important tool for designing your program and for monitoring it. In the program design process, the RF can help your team build consensus around shared objectives and strategies, and communicate those ideas to partners. As you implement your program, the RF will help you gauge your progress and adjust activities that are not producing the results you hoped for.

Documenting your results framework

On the following page, you will see a results framework that has been developed by Save the Children AD specialists. It represents the state-of-the-art for a multi-sectoral AD program. While you will select strategies and indicators that address the unique contexts, issues and needs of your impact area, you should use the Goal, Strategic Objective and Intermediate Results included in this model results framework (the Strategic Objective may be tweaked if you are not implementing a multi-sectoral program).

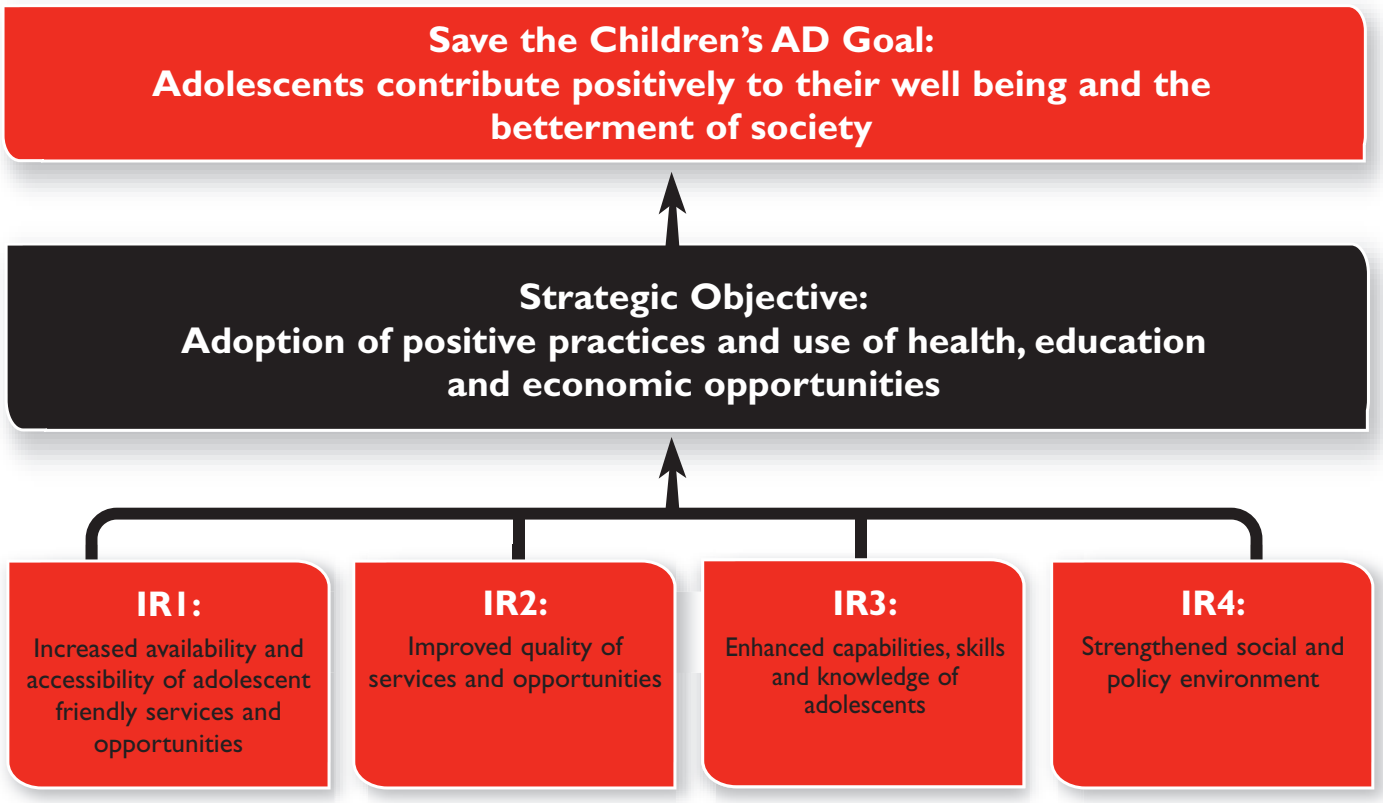
On the pages following the results framework, you will find a more detailed description of the Strategic Objective and each IR. You will notice that the SO and four IRs correspond to the categories of questions in the situational analysis matrix. This should help you begin to consider the findings of your situational analysis and choose strategies for each IR that best match the needs and resources of your impact area.

For each IR, you will need to use the findings from your situational analysis to consider:

- What are the highest priority needs in the impact area, based on gaps in each IR identified in the situational analysis?
- What assets do adolescents in the impact area have that might help address this IR?
- What kinds of solutions are cost-effective and likely to work?
- Does your CO have the capacity to implement these programs with help from any partners you've identified?

Figure C

Adolescent Development Results Framework



About the strategic objective

The specific components of the strategic objective result include:

- **Use of positive practices:** This should be focused on the adolescent's individual behaviors. It should be locally defined according to the country context, and the needs and assets identified. Examples of positive practices include delaying sexual debut, delaying marriage, remaining in a monogamous relationship, using condoms at last sexual experience, abstaining from drugs and alcohol, using resources for improving skill development, acquiring financial management skills, completing an education program or undertaking life-long learning, adopting positive gender norms, etc.
- **Use of opportunities:** Examples of using opportunities include completing an educational program, participating in financial readiness services, initiating a savings account, and utilizing sexual and reproductive health counseling and services, such as family planning, HIV testing, reproductive health counseling, etc.
- **Asset development:** Refers to the internal and external building blocks of healthy development. Some examples include constructive use of time, involvement in community development through adult-adolescent partnerships, commitment and motivation to learn, and developing a sense of personal power to resist negative peer pressures.

The AD strategic objective offers a holistic and integrated approach to programming. *However, progress should still be tracked based on sector-specific objectives and activities.* Where appropriate, initiatives will use cross-sector indicators to monitor results. The sector specific objectives address:

Health (ARSH)

ARSH objectives are: increasing the quality and utilization of reproductive and sexual health services, including the use of family planning counseling and services, STI diagnosis and treatment and voluntary counseling and testing for HIV. Objectives for improved ARSH behaviors include use of contraception and condoms, delaying

sexual debut and marriage, practicing abstinence and remaining in monogamous relationships.

Education

Education objectives are: increasing participation and completion of formal and non-formal educational/training programs. They also focus on transitions-including the transition from primary to secondary school or school to work-and encourage life-long learning. Such options may include accelerated learning for out-of-school adolescents, with emphasis on relevant curricula, life skills education, and literacy and numeracy training.

Programming will also focus on creating adult-adolescent partnerships to build skills through service in their communities. Information and communications technology may also be used where necessary, feasible and appropriate to improve learning.

Livelihood development

Livelihood development goals include: increasing livelihood preparedness through financial management, literacy and life-long skills that improve youth livelihood options in the present or future. These livelihood options include self-employment, formal employment, household support, reduction of household expenses, and investment in ongoing professional and technical education.

About Intermediate Result One: Access

The first IR addresses the problems of availability and accessibility of adolescent-friendly services and opportunities.

Strategies for IR1 may include:

- Provision of educational opportunities (formal and non-formal, vocational, literacy and numeracy).
- Livelihood preparation and opportunity programs.
- Making formal and informal sources of adolescent-friendly reproductive and sexual health services more attractive to adolescents through popular mobilization.

Issues related to IR1 include:

- Approaches will need to be age appropriate according to needs and assets of younger (10-14 years) and older (15-18 years) adolescents.
- Reflect upon when to set up programs in rural settings and when to in urban settings to reach vulnerable populations.
- Orphans and vulnerable children in communities affected by HIV/AIDS and/or conflict will need to be targeted for provision of educational, economic, and reproductive services.

About Intermediate Result Two: Quality

The second IR addresses the quality of services in the areas of education, reproductive and sexual health and livelihood development.

Strategies for IR2 may include:

- Training of service providers on state-of-the-art methodologies in livelihoods, reproductive and sexual health, and education.
- Improving and updating curricula and materials for relevancy.
- Monitoring, mentoring/coaching for staff, partners and service providers.

Issues related to IR2 include:

- Save the Children will need to consider internal as well as external capacity building (i.e. NGOs) to program effectively for and with adolescents.
- Follow-up monitoring should be conducted to ensure that relevant issues/concerns are addressed, such as HIV/AIDS, trafficking of adolescent girls, early marriage, etc.

About Intermediate Result Three: Capabilities, Skills and Knowledge

The third IR addresses the capabilities, skills and knowledge of adolescents.

Strategies for IR3 may include:

- Empowering young people to gain enhanced capabilities and improved knowledge, attitudes and skills related to their holistic wellbeing (ARSH, education and livelihoods). This would include child clubs, use of adolescent learning centers and peer education programming.

Issues related to IR3 include:

- A significant commitment both in financial and human resource terms will need to be made to build the capabilities, skills and knowledge of adolescents, and influence behaviors. If this is not planned for, programs are unlikely to be effective.

About Intermediate Result Four: Social and Policy Environment

The fourth IR is related to support systems and the policy environment.

Strategies for IR4 may include:

- Promoting a positive social environment that supports young people's adoption of positive reproductive health, educational and economic practices.
- Working with key decision-makers, such as parents, teachers, government and religious leaders to influence policies and practices that enable adolescents to thrive.

Issues related to IR4 include:

- Of particular importance are detrimental cultural and social practices that influence girls' and boys' health and welfare such as early marriage, child trafficking and labor, female genital cutting and gender-based violence.
- Maintain linkages with government and other partners to ensure inclusion and ownership every phase of the project, from design to evaluation.
- Partner with adolescents to promote genuine participation and leadership so that their voice is heard and respected at all levels of society.

Sponsorship-funded programs and advocacy

Save the Children's firsthand experience through our work on the ground positions us well to advocate for change. In order to increase the reach and sustainability of our work, we must endeavor to develop and document program interventions that can be implemented and sustained at scale by local and national governments and partners. In areas where we come across policy barriers that hinder our work and Save the Children believes that government policy is inadequate or not being effectively applied, we may decide to advocate if we assess that we are well-placed to do so and see a chance for success. In these cases, the program team should identify an advocacy objective(s) and a strategy to achieve the objective. The advocacy strategy should be informed by results from our sponsorship-funded programs and the evidence base we create through their implementation.

Selecting strategies for your program

After documenting the results framework, the next step in designing your program will be selecting the strategies that best address the gaps between what you found in your situational analysis and what you are seeking to achieve as reflected in the results framework. Ideally, you will select strategies that address all four IRs in a holistic way. When this is not possible, your team should work with technical staff in your country office, regional office or in headquarters to choose strategies based on available resources and community needs.

Some possible strategies that could be used to address the problems related to each IR have already been presented above in the Results Framework section; however, a menu of strategies, called the Key Strategies Matrix is presented in Annex 1. This matrix lists many of the key strategies that have been found to be effective when implementing a multi-sectoral AD program, but it is not comprehensive. The information included in the matrix will help you assess the applicability of strategies by giving you some basic rationale, as well as information about the issues related to each of them.

Not all strategies listed in the matrix will be appropriate for your program (particularly if you are not planning on addressing all three areas of education, adolescent livelihoods development and ARSH) or impact area. Remember to base your strategy choices on the results of your situational analysis, as well as the resources available, while keeping in mind the objectives of your AD program.

With regard to the key ARSH strategies listed, Save the Children has recently placed an emphasis on family planning within the context of ARSH adolescent development programming. Additional guidance on how to integrate family planning strategies into your AD ARSH program can be found in Annex 2 of this module.

Completing the Summary Implementation Plan

Once you have chosen the strategies that will best address the objectives of your program and the needs of adolescents in your impact area, within the context of your sponsorship program budget, record your choices in the Summary Implementation Plan (SIP), which you will find in the DM&E Module. Where countries use a Detailed Implementation Plan (DIP) for planning purposes, this can be substituted for the SIP as long as all of the information in the SIP is included. The implementation plan should be reviewed and updated on an annual basis.

STWG review needed!

Before moving on to the next steps in the program cycle, it is critical to seek a technical review of what you have developed in Step 2 of this module (program design). Do not move on to the next step of designing your M&E plan before sharing your results framework and Summary Implementation Plan with your STWG TA provider for their review and input.

Step 3: Monitoring and Evaluation Plan Design

Goal of this step:

Develop a monitoring and evaluation plan after careful selection of AD indicators.

What you will need:

- This module
- The DM&E module
- The completed Results Framework
- The Summary Implementation Plan
- The Common Approach AD Indicator Reference Sheets

The outputs of this step will be:

- A Results Indicator Planning Tool (RIPT) for your program
- A completed Process Indicator Tool (PIT)

It is now time to design a monitoring and evaluation (M&E) plan for your AD program, determining which process and results indicators you will track.

Community Mobilization Action!
M&E Plan Design

During or around the time the M & E plan is being developed your team can formally approach the community and invite their participation in the core program(s). If the steps in this phase of the Community Action Cycle are undertaken prior to the baseline, community members can be involved and assist in data collection efforts, analysis and dissemination of results. Remember – sharing the outcomes of the situational analysis with communities will help build interest and participation in the core program.

Key to communities getting organized around the core program is ensuring that communities are fully oriented to Save the Children and our partners and understand the core program issue and how sponsorship-funded programming works. Inviting those most affected and interested in the core program to participate, and ensuring they will have a central role, voice, and will benefit is also critical.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the Organize the Community for Action phase. These key steps are:

Step 1: Orient the community.
Step 2: Build relationships, trust, credibility and a sense of ownership with the community.
Step 3: Invite community participation.
Step 4: Develop a 'core group' from the community.

Process indicators measure progress in program implementation, to assess whether activities are being implemented as planned. Process indicators and targets are set every year, based on your implementation plans, and are documented and submitted annually with the Country Annual Plan (CAP) using the **Process Indicator Tool (PIT)**. Process indicators relate to program inputs (materials, goods or actions to carry out the program) and outputs (services provided). For AD programs, process indicators typically include:

- **Supplies data (e.g. number of adolescent learning centers equipped with books; number of teaching/learning materials developed).**
- **Services data (e.g. number of training sessions; number of peer educators trained; number of health providers trained; number of religious leaders oriented; number quality improvement teams formed).**

Results indicators measure higher-level changes that we believe our program activities contribute to. Results indicators should be the same from year to year: they are established when a program or new intervention is designed. The **Results Indicator Planning Tool (RIPT)** is the template for sponsorship results indicator planning, and includes the information usually contained in a monitoring and evaluation plan. It contains the definition for the indicator, an explanation of how it is calculated, as well as the source, data collection tool, the frequency of data collection and a target. It also names who is responsible for ensuring that the data are collected. When you are filling out the RIPT, it is important to consult the AD Indicator Reference Sheets, in Annex 6 of this module, which contain the recommended indicators for Common Approach AD programs. For the monitoring and evaluation of Common Approach Adolescent Development programs, most results indicators are collected on an annual basis.

Annual Results Indicator data collection includes:

- **Data collected from *all* program schools, adolescent/youth clubs or groups at the beginning and/or end of the year. This is used to calculate indicators such as number of new and repeat users of RSH information and services at service delivery points (SDPs), number of child clubs formed, or percent of adolescents who successfully complete an apprenticeship. Knowledge attitudes and practices surveys are conducted to gauge change in students' learning and attitudes regarding marriage, pregnancy, contraception, STI/HIV/AIDS and life skills over time. Similar measures are used in non-formal settings in the community.**

More guidance on selecting results and process indicators and reporting on them, as well as the tools used for M&E planning, can be found in the Common Approach DM&E module.

Beyond the process and results indicators described above, it is important to consider the evaluation design and plan for your program. The minimum requirement for all sponsorship-funded programs is a baseline to endline evaluation. In addition to this, there are other possible approaches that program teams can consider in light of their evaluation capacity, available resources and evaluation objectives. In all cases, technical assistance must be sought. More information about evaluation is provided in the Common Approach DM&E module.

Time to document the Impact Area Presence Plan!

Once you have completed the first three steps in the program cycle, it's time to document your long-term plan for sponsorship-funded programs in your designated impact area. This includes: the rationale for program implementation; the program design (including the results framework(s) and key strategies); the M&E plan design; your community mobilization plan; as well a the exit strategy. The plan should be submitted to your STWG TA providers before moving on to the baseline step. For more information about this plan, please see the DM&E module.

Step 4: Baseline

Goal of this step:

Gather baseline data on the health, education and livelihood status of adolescents in the impact area.

What you will need:

- This module
- The DM&E module
- The completed Results Indicator Planning Tool

The outputs of this step will be:

- A baseline survey report

Community Mobilization Action!
Baseline

Around the time of the baseline activities, the Explore and Set Priorities phase of the Community Action Cycle is undertaken by community members. The Explore Phase aims to help community members, explore their own knowledge, beliefs, and practices related to the core program issue and the perspectives of the broader community. The community core group, which was formed earlier, learns how to carry out participatory activities that will better inform them and the community about the core program issue in order to help them set their priorities. The Explore Phase can be easily integrated into the baseline study, especially if qualitative data is being collected.

Helping communities analyze the underlying issues affecting change, local barriers and strengths, and set their own priorities is key to engaging communities in actions that are relevant to their reality. What should you do if communities do not prioritize issues that might in be in the core program design (for example, work with adolescents and service providers to ensure youth-friendly services in an AD ARSH program)? Remember: core programs will have some overall strategies that are best addressed at the national/district levels and others that are best addressed at community level. Therefore, aspects of each core program may *not always* be community-based and might be achieved through work with partners at different levels.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Explore and Set Priorities phase*. These key steps are:

Step 1: Explore the core program issue with the Community Core Group.
Step 2: With the Community Core Group, explore the core program issue with the broader community.
Step 3: Analyze the information.
Step 4: Set priorities.

Prior to beginning program implementation, you need to collect baseline data for AD program results indicators. Baseline data will act as the main point of comparison to measure progress in key indicators over the life of the program. Baseline data are also important because they:

- **Provide additional information and insight on educational attainment, reproductive and sexual health knowledge, attitudes and practices among adolescents in the impact area.**
- **Identify and/or confirm the issues that are most critical to address, and whether there are particular geographic areas and/or populations that require greater support.**
- **Help us confirm and further refine the interventions needed for the AD program.**

For AD programs, the baseline will be the first time you collect the annual results indicators outlined in Step 3. This will provide an important point of comparison for annual program monitoring in subsequent years, documenting the status of the indicators prior to program implementation. As with the situational analysis, plan and conduct the AD baseline survey along with the other sponsorship-funded core programs. Data should be collected through coordinated surveys with key target groups.

At baseline, you may also decide to collect additional survey-based data that will only be gathered at a set interval determined by your program team. You will need to design the survey to fit with the overall evaluation plan for the program, and will need to seek assistance from your STWG TA provider to determine the best design. Conducting a survey at baseline is particularly important for ARSH since there is a need to assess changes in behavior, which can only be done through a survey. There are many standardized survey tools that already exist that you can use. These tools should be reviewed and, with assistance from your STWG TA provider, questions should be selected based on the objectives of the program. The type of information captured in these surveys could include the following:

Reproductive Health Status

- Adolescents' marital status
- Pregnancy status of the adolescents after marriage
- Knowledge on menstrual hygiene
- HIV/STI knowledge
- Knowledge of family planning
- Awareness of RSH SDPs
- Formal and informal SDPs for RSH services
- Condom use at last sex

Educational status

- School attendance and enrollment by gender
- Reasons for school dropout
- Non-formal education activities for extracurricular learning (adolescent/youth clubs, etc)
- Participation level by out of school/dropout adolescents in non-formal education activities

Livelihood development status

- Information about local business opportunities for adolescents
- Skill level of adolescents related to livelihoods
- Ways in which adolescents would like to be engaged in the workforce
- Stability/sustainability of adolescent employment

Community-based data. This may include any population based indicators. You may also decide to collect more qualitative information such as those relating to religious and cultural norms and practices through focus groups with parents, religious leaders, parents and other community members.

You should write a report that encompasses all of the sponsorship-funded core program baselines, and which includes the following information:

- **Introduction:** A summary description of the planned program.
- **Methodology:** A description of the overall evaluation approach, how the data was collected, the sampling method, and the tools applied to generate the results.
- **Results Indicator Planning Tool:** The RIPT can be annexed to show data sources and how indicators were calculated.
- **Findings:** A detailed description of the results presented in tables showing results by sex, age group and geographical area. Include sample size (n), means and percentages with standard deviations for each result.
- **Conclusions and recommendations:** The interpretation of the results and recommendations for future programming.

Step 5: Implementation and Monitoring

Goal of this step:

Implement program activities and regularly monitor the progress of the program.

What you will need:

- This module
- The DM&E module
- Your Summary Implementation Plan
- Your Process Indicator Tool
- Your Results Indicator Planning Tool (RIPT)

The outputs of this step will be:

- A Results and Process Indicator Report (RPIR) and Progress Narrative
- A report(s)/action plan(s) from the Results Review meeting(s)

Community Mobilization Action!

Implementation

Communities take part in the implementation of core programs in many ways based on the overall core program design. One important way communities participate is through the development of their own action plan, implementing their planned strategies and activities, and monitoring their own success. The Plan Together phase of the Community Action Cycle helps the community core group develop their community action plan to address the core program issue. It is important to ensure that those most affected by the core program issue have a central role and voice in developing the community action plan.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Plan Together* phase. These key steps are:

Step 1: Determine who will be involved in planning and their roles and responsibilities.
Step 2: Design the planning session.
Step 3: Facilitate the planning session to create a community action plan.

The *Act Together* phase of the CAC also takes place during implementation, and helps communities implement their community action plans. The role of the sponsorship CM team is now to strengthen community capacity in areas necessary to effectively carry out the strategies and activities the community core group defined in their action plans. This may include skills in leadership, planning, conflict resolution/decision-making, and resource mobilization and management. At this point, there are often volunteers and community groups working together to carry out activities. Helping communities monitor their own progress, and using data for decision-making is essential in motivating ongoing collective action.

Additional detail on the key CM steps to be undertaken during the Act Together phase can be found in the Sponsorship CM Compendium. These key steps are:

Step 1: Define the CM team's role in accompanying community action.
Step 2: Step 2: Strengthen the community's capacity to carryout its action plan.
Step 3: Monitor community progress.
Step 4: Problem-solve, troubleshoot, advise and mediate conflicts.

Implementing your program

You are now ready to implement the AD program. For more guidance on how to implement the various interventions and recommended strategies, please consult with your STWG TA provider.

Monitoring and Reporting on your progress

During implementation, you will regularly monitor both process and results indicators, according to the plans and timeframes set out in your PIT and RIPT. All AD indicators should be tracked in a program database, and should be reported on in a summary document which allows program staff and STWG TA providers to view current values and trends over time. A Results Review should be held at least every six months to discuss if the program is on track and to identify areas for improvement.

The Results Review offers the opportunity to examine questions such as:

- **Do you need to adopt different strategies to more effectively achieve your objectives? Do the strategies complement each other in achieving your results?**
- **Are there barriers to achieving results that are not addressed in the program design, which must be addressed to make the program successful?**
- **Do you need to reorganize the field team or make other changes to Save the Children/partner implementation to better achieve targets? For example, are there adequate supervision and quality assurance mechanisms?**

Detailed guidance on how to conduct a Results Review can be found in the Common Approach DM&E Module.

Both process and select results indicators are reported through the Country Annual Report (CAR) once a year using a Results and Process Indicator Report (RPIR) along with an explanation of the findings, which is called the Progress Narrative.

Reaching vulnerable adolescents: conducting a coverage exercise[8]

A coverage exercise is a recommended part of the implementation and monitoring program cycle for AD programs. It is a monitoring tool, just like the Results Reviews, that helps assess current programming and how to use data to make decisions about changes in program implementation.

Sponsorship-funded Adolescent Development programs often reach a diverse set of adolescents, including sponsored adolescents who are progressing through secondary school, as well as adolescents in the impact area who are out-of-school. These out of school adolescents are very diverse: married girls, adolescent mothers, day laborers, adolescent affected by HIV, working adolescents and illiterate adolescents. This diversity often makes it hard to design appropriate strategies to reach our beneficiates, but even harder to articulate *who we are reaching*. Unlike the other core programs, where BE and SHN are reaching primary school children and ECCD is reaching children 0-8 years old and their caretakers, the Adolescent Development program beneficiaries are much more heterogeneous. With this reality comes a desire and obligation. But how do we know if we are doing so, even if our strategies were designed to reach the most vulnerable? A coverage exercise is a quick methodology to help program managers evaluate who is actually being reached by their programs with an aim to articulate the demographic of those currently being reached and identity other vulnerable groups that could be reached in future programming.

What is a coverage exercise?

A coverage exercise is a simple, low-cost, rapid assessment tool that can be used during program implementation to profile who is being reached by Adolescent Development programs within the impact area. It can be used for a range of services, both those based in a facility (health facilities, adolescent/youth clubs, non-formal education groups) and those conducted on an outreach basis (through peer educators or other community based components of AD programs). A coverage exercise collects data on a variety of characteristics including gender, schooling status, living arrangements, work status and marital status of those benefiting from a program or service. It also enables program

[8] Adapted from Population Council, *How to Conduct a Coverage Exercise: A Rapid Assessment Tool for Programs and Services*, July 2006.

staff and managers to take a systematic look at which services they are actually providing, where exactly they are being provided, and whether program beneficiaries are repeat customers or not. The ultimate purpose of the tool is to determine:

1. Whether services offered are reaching the intended beneficiaries.
2. If services are appropriate for those receiving them.

Understanding whether programs are reaching intended beneficiaries or not helps AD program managers focus their activities and funding to reach the most in need.

Using a coverage exercise to determine involvement by vulnerable adolescents

Acknowledging that adolescents with different characteristics, such as age, gender and marital status have different needs is sometimes overlooked when designing Adolescent Development programs. Yet these differences in characteristics and needs are essential for understanding adolescents' vulnerabilities. For example, a 12-year old unmarried, out-of-school girl, living away from her rural home with distant "cousins" in an unfamiliar urban area as a domestic worker has markedly different needs from a 19-year-old, educated, engaged girl living with both of her parents – and both have needs that differ from a 16-year old boy in a semi-rural area who has been orphaned by AIDS and is trying to attend school while supporting and caring for his younger siblings.

National data, like those collected in the Demographic Health Surveys, can help describe proportions of adolescents in a country that fall into these different types of categories. A coverage exercise illuminates which adolescents are being reached by programs targeting them, as well as which are not. It allows AD managers to see the internal diversity of those they serve, and identify the proportion of adolescents as broken down by subgroups: age, gender, schooling status, marital status, and living arrangements (and other relevant categories). With data thus generated through a coverage exercise, organizations can decide if their program objectives are being met and/or if they want to shift their approach and outreach to serve a different group of adolescents and/or offer different services to those whom they already serve.

Phases in a coverage exercise:

A coverage exercise is done in five main phases:

1. Setting a common format and framework
2. Sensitizing staff and overall planning (4 weeks)
   - Finalizing the data collection tool
   - Creating a schedule
3. Conducting the training and data collection (4-6 weeks)
   - Training workshop
   - Collecting data forms
4. Entering and analyzing data (4-6 weeks)
   - Packaging preliminary results for dissemination
5. Dissemination of data, dialogue with partners/implementers, program redesign
   - Dissemination workshop with all program implementers (Peer educators, service providers, etc)

If program teams are interested in conducting a full coverage exercise, contact your STWG TA provider for assistance and/or download the Population Council's coverage exercise guidance.[9]

Benefits of a coverage exercise:

- Allows program managers and service providers (like peer educators or adolescent/youth center staff) to know who they are and are not reaching.
- Acts as both a monitoring and evaluation tool.
- Builds future capacity for monitoring and evaluation of programs.
- Is easy to use (does not require high literacy or sophisticated data analysis skills).
- Is low-tech and replicable.
- Is low cost.
- Allows for ownership of data.
- Uses those who deliver services to collect data as part of normal work routine.
- Provides a feedback mechanism for workers who rarely have one.

[9] *How to Conduct a Coverage Exercise: A Rapid Assessment Tool for Programs and Services*, Population Council. Accessed October 25, 2010. http://www.popcouncil.org/pdfs/CoverageExerciseGuide.pdf.

Step 6: Evaluation

Goal of this step:

Evaluate the program to assess its effectiveness.

What you will need:

- This module
- The DM&E module
- Guidance from your STWG TA provider and an M&E specialist

The outputs of this step will be:

- An evaluation report

Community Mobilization Action!
Evaluation

The evaluation of core program(s) provides a unique opportunity for communities to learn about the success of their collective action, and what work remains to be undertaken. The Evaluate Together phase provides an opportunity for community members to participate in the evaluation process, learn how to evaluate, analyze results, share results with the community, and apply lessons learned to future program efforts.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Evaluate Together phase*. These key steps are:

Step 1: Form a representative evaluation team with community members and other interested parties.
Step 2: Determine what participants want to learn from the evaluation.
Step 3: Develop an evaluation plan and evaluation instruments.
Step 4: Conduct the participatory evaluation.
Step 5: Analyze the results with the evaluation team members.
Step 6: Document lessons learned and provide feedback to the community.

The minimum requirement for the evaluation of a sponsorship-funded program is baseline to endline, including a mid-term evaluation, with annual monitoring of key indicators. Other evaluation designs may also be considered. For example, evaluations may seek to examine both program processes (the quality of implementation) and impact (what changes result from the program). When you enter into a new impact area, you will need to establish your approach to evaluation as you design the program, so that the methodology and baseline allow for a strong evaluation. Generally speaking, program results should be evaluated at three to four-year intervals (baseline, mid-term, and endline).

Evaluations allow implementers to observe any changes that have occurred throughout the course of implementation and in some cases to assess whether this change was a result of Save the Children programming. Depending on the objectives of your AD program and evaluation design, some of the questions that could be

answered by an evaluation include:

- Are adolescents more knowledgeable about ways to avoid HIV /AIDS transmission and unwanted pregnancy than at baseline?
- Do adolescents feel more capable of negotiating condom use? Are adolescents more able to resist peer pressure to have sex?
- Are adolescents initiating sexual debut later? Are adolescents using condoms consistently? Are adolescents getting married later than at baseline? Has the number of adolescents in peer education programs increased?
- Are health services more adolescent-friendly than they were at baseline?
- Are more adolescents acquiring skills that will help them become employed than at baseline?
- Have adolescents' literacy and numeracy skills improved?
- Has the quality of teaching/learning on reproductive and sexual health, and the overall quality of the enabling environment, improved over the life of the program?

In addition to baseline to endline evaluation, you may wish to evaluate the impact of particular interventions, as you design and test new and innovative approaches, for example. This may be done at a different interval from the impact area evaluation cycle. In this case, we recommend working closely with a researcher and/or your STWG TA provider to come up with the best evaluation design possible. The evaluation design should be tailored to help you answer specific questions and to generate the evidence needed for advocacy and replication of the approach. Conducting a longitudinal study, which tracks a cohort(s) of children over time, is another evaluation option that sponsorship-funded programs can consider undertaking.

More information on evaluations can be found in the DM&E module.

Step 7: Lessons Learned

Goal of this step:

To reflect and learn from program implementation and evaluation, in order to inform future programming and improve effectiveness.

What you will need:

- This module
- The Lessons Learned guidance in the DM&E module

The outputs of this step will be:

- Documented Lessons Learned

Community Mobilization Action!
Lessons Learned

Communities have a unique role to play in sharing lessons learned. In particular, community-to-community sharing of promising practices (and lessons learned) provides important learning between and amongst communities themselves. The ability for communities to share and see each other's work, innovation and success generates rapid uptake of approaches and strategies. Analyzing and documenting lessons learned also provide important guidance on how best to scale-up approaches.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the Prepare to Scale-up phase. These key steps are:

Step 1: Identify communities of promising practice.
Step 2: Provide opportunities for community-to-community exchange and learning.
Step 3: Utilize lessons learned to consolidate and refine the approach to prepare for scale-up.
Step 4: Develop a scale up plan including roles and responsibilities of implementing partners.

Sponsorship-funded programming constantly generates learning that is relevant to future implementation and to other, non-sponsorship, programs. This learning may be technical – for example, which strategies are most effective to accomplish an objective – or they may be related to partnering or reaching a particular target population. It is critical to take the time to reflect on and document this learning, so that it can feed into future programming.

In order to document and use this information, you should undertake a Lessons Learned process after each evaluation (i.e. midterm, endline), at least. [10] Here, Save the Children staff, government officials, program participants and donors have the opportunity to reflect on past programming and provide feedback to inform future work. This review should look at both the strengths of the program and areas that need improvement. By the end of the session, there should be a common understanding of and agreement on the lessons learned. Lessons should be clearly documented and widely shared, so that they can be used to improve current and future programming. Documenting and sharing evaluation results and lessons learned enable sponsorship-funded programs and innovative practice to be leveraged to achieve impact at a larger scale.

More information for conducting a Lessons Learned workshop can be found in the Common Approach DM&E Module.

[10] A Lessons Learned exercise can be undertaken at other stages as well, depending on the situation. For example, it can be very useful to undertake a Lesson Learned exercise *prior* to a final evaluation when a CO is phasing over into a new impact area, if the phase-in is to take place before the final evaluation in the "old" impact area. In this case, conducting the lessons learned "early" would ensure that these lessons learned from the old impact area inform the program design and implementation in the new area from the outset.

Annexes

Annex 1: Key Strategies Matrix

Intermediate Result 1: These key strategies address problems of access

Key Strategy	Frequency	Costs	Issues/Comments
ARSH Creating new service options	Once – with regular monitoring	Medium to high depending on who manages the program. Initial start-up costs (includes training, negotiations, contracts) also vary from low to high	• Involves establishing outreach services as part of an existing Service Delivery Point; and/or adding a cadre of adolescents to an ongoing community-based distribution agent program; and/or establishing referral systems among clinics, youth centers/clubs, VCT services, etc. • Because young people tend to prefer to seek care from non-formal sources (such as pharmacies, shops, kiosks, community-based health workers and peers), it is important to consider service options that are not clinic-based. • Partnership Defined Quality for Youth (PDQ-Y, see below) findings should be used to determine the need for and the appropriate service option to create. • Integration with education and livelihood opportunities: referral networks between safe spaces, and youth and community centers.
Education Securing safe spaces	Once	Low, since existing space will be utilized	• Involves identifying and obtaining permission and setting hours for use of space, such as youth centers, community centers and schools. May involve advocacy with education ministries or other government bodies or officials. • Location, design and hours of program must take cultural concerns (including gender) into consideration. • Integration with ARSH and livelihoods: integrated activities and curriculum at the safe spaces.
Education Provision of learning materials	Once	Low if local materials are used	• Includes teaching aids, such as desks, blackboards, and notebooks. • Maintenance and security during non-learning hours must be organized.
Education Establishment and use of flexible learning calendars	Once at the outset; adjust as necessary after the first "semester" or year	Low	• Learning program schedules need to take into account seasonal work demands and other priorities that may serve as barriers to participation. Specific activities include: meetings with parents, communities, local officials, or workshops specifically on this topic. • Input from the community, participants and other stakeholders is critical. • Takes into consideration cultural norms and practices. • Integration with ARSH: flexible hours for health SDPs.
Livelihoods Development Creating access to technical institutes in high demand areas	Ongoing	Low to high depending on whether Save the Children or partners are providing the infrastructure	• Ensure that technical skills training is both relevant and in demand. • Those working with adolescents often need to be informed about the kinds of technical skills services available in the community before establishing more services.
Livelihoods Development Creating access to "business practicums"	Dependent on the project cycle		• Adolescents are given the opportunity to translate skills into practice and knowledge by either running small businesses or through internships. • Youth often ask for practical experience; this is key in any kind of employment programming.
Livelihood Development Linking adolescents to micro-finance savings Linking adolescents to formal and informal savings Creating peer saving programs	Economic assessment twice a year	Moderate to high depending on time available from local teams	• While many claim otherwise, young people do have access to resources. Understanding the sources and use of these resources is important in order to support links to services.

Intermediate Result 2: These key strategies address problems of quality

Key Strategy	Frequency	Costs	Issues/Comments
ARSH Partnership Defined Quality for Youth (PDQ-Y)	One initial PDQ-Y cycle, with periodic sessions for monitoring Timing for strategies that result from PDQ-Y process will vary	Low cost initially (for dialogues), but cost of strategies that result will vary	• Involves facilitated dialogues among adolescents and providers separately, and then together to determine characteristics of quality and to develop a service improvement plan. • Providers involved in PDQ-Y should be those from whom adolescents prefer to seek care (most often informal providers, such as pharmacists, private doctors, traditional healers) and/or those sources that are able to provide for adolescents with ARSH/social services. • It is important to involve adolescents who use and don't use services in the PDQ process. • Sessions conducted by skilled facilitators are the key to success. • Integration with livelihoods development and education: Innovative applications of PDQ-Y can be used to design adolescent-driven quality education programs and livelihoods opportunities.
ARSH Improving existing services	Once with regular monitoring	High for service expansion Medium to high for separate hours and space Low to medium for materials provision (low if materials exist)	• Involves expanding the range of available services at existing SDPs (e.g. pre/post natal care, STI diagnosis and treatment, counseling, contraception, VCT); establishing special hours or separate space for adolescents in existing centers; providing informational materials targeted at adolescents. • PDQ-Y findings and secondary health statistics (adolescent pregnancy rate, STI prevalence rate, etc.) should be used to determine the need for expanded services and which services are desired. Adolescents should be involved in the design of these services. • Adolescent Participation: Adolescents should be involved in both planning and in monitoring service improvements. They can also develop informational materials through information education and communications workshops if no relevant materials are available. This ensures local relevance and appeal to target population.
ARSH Service provider training	Once with regular monitoring	Medium to high, depending on how much an existing curriculum must be adapted to the context and the PDQ for Youth findings.	• Involves developing and implementing a training curriculum for providers that improves their ability to offer "adolescent-friendly care" (e.g. treating adolescents with respect, ensuring confidentiality and privacy). In recognition of young people's preference for non-formal care, "service provider" includes clinic staff, pharmacists, shop keepers, traditional healers, etc. • Training curriculum should be based upon issues of quality that adolescents define as well as quality service standards. Even if informal providers, such as pharmacists, are focus of training, health ministries and other government bodies could be engaged as trainers/participants.
Education Teacher/facilitator training	Pre-service: once (usually 1-2 weeks, unless facilitators have never taught) In-Service: As needed, but at least 3 times per year (3-5 days each time), based on needs	Low to moderate Costs increase if training done with smaller groups covering disparate geographic areas	• Training on topics to be covered in the curricula include active learning, adolescent and girl-centered methodologies and adolescent development, and to a lesser degree preparation, record and grade keeping, continuous assessment, classroom management techniques, and curriculum implementation. • Training should also be given for curricula localization, adaptation and enrichment. • Teachers/facilitators chosen from the community can be successful because they are likely to be trusted by parents. However, they are likely to have no prior teaching/facilitation experience and therefore will require additional training.

Key Strategy	Frequency	Costs	Issues/Comments
Education Teacher/facilitator supervision/ follow-up and/or mentoring/coaching	Systematically (every couple of weeks at the outset and spreading out with time)	Low to moderate depending on the system chosen (individual supervisors, cluster supervisors, etc.), and geography/ accessibility	• Observations are useful for gauging behavioral and technical improvements, such as technical interaction with learners, presentation and lesson plan organization, continuous assessments of learners' progress, classroom management, cooperative learning progress. • Follow-up monitoring should be conducted to ensure that relevant issues/concerns are addressed, such as HIV/AIDS, trafficking of adolescent girls, early marriage, etc. • The learning environment provides a wealth of information on the needs in the community and the needs of adolescents. • Observation of the teacher/facilitator is a crucial part of monitoring and tracking investments made and checking results. Feedback should always be 2-way (from monitor to teacher/facilitator and vice versa).
Livelihood Development Identification of most relevant service provider	Once with annual review	Medium	• In the case of livelihood development, both technical institutes and the private sector can play a role; this needs to be informed by market labor assessments that can be undertaken by young people themselves. • Appropriate financial service use can be determined by young people and their families along with service providers.
Livelihood Development Practitioner training	As with teachers and facilitators in education	Low to medium	• Financial and market literacy facilitators need skills similar to adult learning educators – able to incorporate active learning techniques, build on existing experience, use real life situations/case studies.
Integrated Curriculum and materials development or strengthening: curricula updating or modification for practical, relevant learning.	Once with modifications annually, as needed	Costly: complete curriculum development; less expensive: curriculum adaptation, strengthening, or supplementation	• In addition to literacy and numeracy, the education program is meant to address the daily life needs of adolescents, to ensure they have the capacity to participate in their communities, and to promote their life-long development. Curricula should address these objectives.

Intermediate Result 3: These key strategies address problems of capacities, skills and knowledge

Key Strategy	Frequency	Costs	Issues/Comments
Integrated Educational training: (formal and non-formal)	Continuous	High initial cost for program materials development (medium cost if adapting existing materials); medium costs for program expansion and maintenance	• Curricula could address all ARSH topics (see behavior change education below), literacy and numeracy, legal literacy, vocational training, financial management and education, conflict resolution, basic computer skills, business development, entrepreneurship skills development, communication skills, and other adolescent development topics. • Adolescents will benefit from a comprehensive learning approach. Curricula should address specific needs of adolescents determined during situational analysis, qualitative, and baseline studies. Learning approach should be participatory, and focus on skills and behaviors. • Training may also be linked to other programs and strategies: for example, training adolescents to be able to run a summer learning program for young children as part of ECCD, or being able to volunteer at a local health clinic. • Learning spaces and/or adolescent centers must be created or secured. Requires advocacy, institutional capacity building (see IR 1). • Training does not guarantee employment.

Key Strategy	Frequency	Costs	Issues/Comments
Integrated Community service	On a regular basis/ Continuous	Low depending on materials needed for solution	• Programs should involve opportunities for adolescents to identify problems in their communities and to develop and implement solutions. • Community service helps not only build adolescents' problem solving and critical thinking skills, but also increases their visibility in their communities and promotes active participation and citizenship.
Integrated Team sports	On a regular basis/ Continuous	Low to medium as costs can include sports equipment and clothing (e.g. shoes, warm-up suits)	• Team sports, rather than individual sports, strengthen self-confidence, impart general knowledge, and improve a range of important skills such as teamwork, communication, numeracy and help-seeking behavior. • Boys tend to benefit more than girls from team sports programming. It's important to proactively engage girls. • Adolescent clubs are a mechanism for bringing adolescents together for learning, recreation, community service, etc.
ARSH Behavior change education (Behavior centered education and training to address high-risk behaviors related to sexual activity, violence, drugs, and alcohol.)	Continuous	High initial cost for program materials and development; medium costs for program expansion and maintenance	• Effective programs and materials demand a process that will permit the identification of ideal behaviors, current behaviors and opportunities within, feasible behaviors, major barriers and major motivations for practicing behaviors. • A significant commitment both in financial and human resource terms must be made to implement the process since it requires time and a number of activities with the community and beneficiaries. If the process is short-changed, the program is unlikely to be effective. • Behavior is the bottom line for long-term changes among adolescents. • Adolescent clubs and peer education are delivery mechanisms for behavior-centered educational activities.
ARSH Awareness raising	Periodic	Costs vary; costs of traditional methods are minimal; medium to high costs for modern media formats, unless air time or other aspects are donated	• Activities may include: campaigns (traditional and modern media: e.g. street drama, radio shows, television spots, video productions, posters), special meetings, social mobilization/marketing events, and tournaments with ARSH focus. • Messages should be based upon common knowledge, attitudes, and behaviors, and should be developed by going through a similar process for behavior centered educational programming.
Livelihood Development Practice based employability skills development	Ongoing	Moderate	• All adolescents develop cognitive skills of planning and management by practice and employment programs should be characterized this way. Adolescents need to be accompanied in their decisions for livelihood opportunities and learning enhanced whether they fail or succeed. • This is a critical link to education. The experience adolescents bring to programs, particularly economic ones, need to be acknowledged and strengthened by enhancing skills through practice-based opportunities such as internships and business practicums.
Livelihood Development Support adolescents to identify livelihood pathways that build assets and capabilities	Ongoing	Low: enhancing existing strategies Moderate: building on existing strategies High: developing strategies	• Adolescents are supported to identify the appropriate mix of work and education so that they are building on experience, investing in relevant education and creating positive livelihood avenues (self employment, household support, employment). • Adolescents can demonstrate enhanced skills, knowledge and attitudes in this area at three levels: adoption (they have tried using new skills); adaptation (they have used these skills in other areas); and appropriation (demonstrates behavior change).

Intermediate Result 4: These key strategies address problems of policy and social environment

Key Strategy	Frequency	Costs	Issues/Comments
ARSH Advocacy	Especially important at start of project, then continuous	Low for meetings with policy makers to high for data collection, analysis and dissemination	• Policy advocacy is a good way to ensure that a government is designating efforts and resources towards adolescent development and also to scale up programs that work. Policies have a wide impact and help ensure that our programs are sustainable. • Advocacy can be done via sensitization dialogues, documenting and presenting data. The sensitization dialogues are particularly important at the beginning of the project. • Policy-makers are encouraged to implement or enforce relevant legislation, e.g. age of marriage; service guidelines allowing married and unmarried adolescents access to contraception; prohibitions and disciplinary procedures for sexual harassment and abuse of minors; prohibiting sales of alcohol and tobacco to adolescents. • It is helpful to engage local leaders and other key adults in data collection so they learn first hand the need for ARSH programming. • In advocacy efforts it is important to identify a specific policy change objective (what you want to achieve), and develop a strategy of how to get there. Please refer to the resources section for more tools and resources on advocacy planning.
Livelihood Development Advocacy	Especially important at start of project, then continuous	Low for meetings with policy makers to high for data collection, analysis and dissemination	• Policy advocacy is a good way to ensure that a government is designating efforts and resources towards adolescent development and also to scale up programs that work. Policies have a wide impact and help ensure that our programs are sustainable. • Policy makers need to see young people as existing contributors and citizens that have a stake in the development of their community. • Involves promoting policies that help empower adolescents, such as policies that help young people, especially women, have the appropriate paperwork to protect financial assets. • In advocacy efforts it is important to identify a specific policy change objective (what you want to achieve), and develop a strategy of how to get there. Please refer to the resources section for more tools and resources on advocacy planning.
Education Advocacy	Once at beginning and periodic for follow-up, as needed	Low for meetings with policy makers to high for data collection, analysis and dissemination	• Policy advocacy is a good way to ensure that a government is designating efforts and resources towards adolescent development and also to scale up programs that work. Policies have a wide impact and help ensure that our programs are sustainable. • Involves dialogues and advocacy with government officials and local leaders to identify, obtain, and improve learning spaces. Can involve national level dialogues if proposed learning space is part of a national program (e.g. youth centers, schools) • Government or local officials need to acknowledge, act upon their responsibility and develop and implement relevant legislation for providing adolescents who otherwise wouldn't have access to learning opportunities, a safe and viable space to learn. • In advocacy efforts it is important to identify a specific policy change objective (what you want to achieve), and develop a strategy of how to get there. Please refer to the resources section for more tools and resources on advocacy planning.

Key Strategy	Frequency	Costs	Issues/Comments
ARSH Behavior change education for key adults	Continuous	High initial cost for program materials and development; medium costs for program expansion and maintenance	• Behavior centered education/training focused on building key adults' ability to communicate with adolescents on sensitive topics (e.g. romantic relationships, marriage partner and age), and to engage adolescents in decision making. • Effective programs and materials demand a process that will permit the identification of ideal behaviors, current behaviors and opportunities within, feasible behaviors, major barriers and major motivations for practicing behaviors. • Requires a significant commitment in financial and human resources since it requires time and a number of activities with the community and beneficiaries. If the process is short-changed the program is unlikely to be effective.
Livelihood Development Behavioral shift and adults			• Policy makers need to see young people as existing contributors and citizens that have a stake in the development of their community. • Financial service organizations should view adolescents as a potential market and invest in market development, specially with regards to savings mobilization. • It is important for adults to be able to understand that not withstanding the information provided to adolescents, they will still take a livelihood pathway of their own choosing. • Adults need to be able to make a shift in their approaches and access more tools that enable them to improve their practice such that young people are productive citizens from early on in their adolescence, which does not mean they necessarily take on economic activities but begin to understand family economic dynamics and place value on any part-time work that leads to ongoing education. This investment will in turn support young people to build internal assets that lead them to thrive in their livelihood endeavors.
Integrated Community awareness raising	Periodic	Costs vary; costs of traditional methods are minimal; medium to high costs for modern media formats, unless air time or other aspects are donated	• It is critical to raise community awareness of adolescents' need for access to quality reproductive health information and services, importance of adolescent learning, need to improve employability skills and adult-adolescent partnerships. • Activities may include: campaigns (traditional and modern media can be used to convey integrated messages: e.g. street drama, radio shows, television spots, video productions, posters), special meetings, social mobilization/marketing events, and tournaments with ARSH, learning, and livelihoods development focus. • Messages should be based upon common knowledge, attitudes and behaviors and should be developed by going through a similar process for behavior centered educational programming.
Livelihood Development Community awareness raising	Periodic	Costs vary; Costs of traditional methods are minimal; medium to high costs for modern media formats, unless air time or other aspects are donated	• Adolescents participate in the economy whether by virtue of their part-time support to the household while they study, or by taking on work on a full-time basis in their older teen years. Awareness of the economic options that young people make is necessary and needs to be raised in schools, clinics, youth clubs, sports and other places young people participate. The more aware adults are about how young people earn a living, the better positioned we are to accompany them towards more positive choices.

Annex 2: Family Planning for Adolescents

Introduction

Why was this family planning annex developed?

This annex to The Common Approach Adolescent Development Module represents the work of a 27-month project to integrate family planning (FP) into sponsorship programs, funded by USAID/ Flexible Fund. This family planning annex includes tools to help sponsorship program managers overseeing Adolescent Development (AD) programming to include family planning interventions. This model was conceptualized after an Adolescent Reproductive and Sexual Health (ARSH) program review revealed that interventions have provided broad reproductive and sexual health information, including HIV prevention, for general youth populations with little focus on family planning services or community efforts to delay marriage and motherhood. Moreover, the needs of the most vulnerable out-of-school, married girls have often been overlooked. This annex will help program managers include family planning-specific interventions into their Adolescent Development results frameworks, and overall ARSH programming to meet the family planning needs of both the general youth populations as well as adolescent mothers and young married girls.

How to use this annex

This annex is designed to be used along with The Common Approach Adolescent Development Module. Unlike the core program modules, this annex does not lead you step-by-step through the Common Approach program cycle. Instead, it offers supplementary information to help you plan, implement, and monitor family planning strategies for adolescents. You will need to refer to the information in the Adolescent Development module and The Common Approach DM&E Module to get complete information on all the steps in the program cycle.

Why focus on family planning?

Current data from sponsorship countries

Country	% ever married 15-19 (female)	% women giving birth by age 18
Bangladesh	48	46
Bolivia	12	19
Egypt	10	8
El Salvador	22	24
Ethiopia	20	23
Guatemala	20	24
Honduras	32	28
Malawi	37	30
Mali	49	45
Mozambique	43	42
Nepal	42	26
Nicaragua	30	28
Philippines	9	7

Source: PRB: world's youth 2006 data sheet, No data for Haiti, Afghanistan, Bhutan.

Program Cycle Step 2: Results Framework

Family Planning for Adolescents Results Framework

For more information on the strategies for each Intermediate Result, see the Key Strategies Matrix of this annex.

Save the Children's Adolescent Development Goal:

Adolescents contribute positively to their well-being and the betterment of society

Family Planning Strategic Objective:

Improved use of family planning services and delaying early marriage to prevent young motherhood

Intermediate Results (IR):

IR One: Access

Increased access and availability of family planning information and services for target youth

IR One Strategies

- Provision of family planning services by youth community-based distribution agents (YCBDAs)
- Trained traditional birth attendants promote lactational amenorrhea method among teen mothers
- Referrals to health facilities by YCBDAs and trained traditional birth attendants
- Facility-based activities by youth focal point person
- Outreach services supported by YCBDAs

IR Two: Quality

Improved quality of community and facility based family planning services

IR Two Strategies

- Youth-friendly health services
- Partnership-defined quality for youth
- Improve capacity building of YCBDAs (on the job training, supervision)
- Improve record keeping
- Clinical assessment of health providers
- Capacity building of health providers to provide family counseling and services
- Improving contraceptive logistics through logistics management workshops

IR Three: Capabilities, Skills, & Knowledge

Improved knowledge, acceptance of & ability to use contraceptive methods

IR Three Strategies

- Information, education and communication (IEC) activities: youth could create their own materials
- Peer drama
- Youth clubs
- Teen mother sessions within youth clubs (supportive meetings once a week to discuss goals and fertility desires)
- Male motivators to promote family planning among men married to adolescent girls

IR Four: Policy

Improved social and policy environment for contraception use to prevent early motherhood

IR Four Strategies

- Sensitization of gatekeepers using village structures (chiefs and chief councils)
- Working with parents to understand importance of attaining education
- Working with initiation counselors to integrate messages about delaying marriage and early pregnancies

Program Cycle Step 3: Choose Family Planning Strategies

These strategies are meant as a supplement to the key strategies in the Common Approach AD module. Choose from this list if you feel your program needs to include family planning strategies for adolescents.

IR1: These key strategies address problems of access

Key Strategy	Frequency	Costs	Issues/Comments
Creating new service options: Youth community-based distribution agents (YCBDAs)	Initial training followed by refresher training every 6 months. Periodic outreach campaigns and mobile services. Ongoing referrals.	High initial costs for one or two week training. Training of supervisors needed. Refresher trainings every 6 months needed. Ongoing supervision costs.	• Young people (usually 15–22 years old) are selected by their fellow youth club members and trained on how to counsel and distribute contraceptives (condoms and pills) to clients in their communities and make referrals to health centers for Depo Provera, Intrauterine Devices, and Emergency Contraception. Depo Provera can also be provided by other trained community health workers. • Brings services closer to youth in the community using peer outreach methods. • Training only 24 year-olds results in the need to retrain more YCBDAs due to the aging out of these service providers. • Special care must be taken for retention of YCBDA (have girls work in pairs) as well as aging out of YCBDA. Train a mix of ages of young people. • Policy environment must allow community-based distribution by young people. Ministry of health training curriculum should be used when available. • YCBDAs must be connected to the local health center where they will receive their commodities. • They must be supervised, preferably by someone at the hospital/health center. • Supervision of YCBDAs by health providers assures they will provide high quality services and have a medical professional to answer difficult questions. It also sets up a referral network at the health center. • YCBDAs undergo refresher training every 6 months after the initial training. • Monitoring form must collect data on the number of methods distributed, the number of new and total clients and they should be submitted monthly. • YCBDAs often are given bicycles as an incentive and job aid.
Creating new service options: Trained traditional birth attendants promoting lactational amenorrhea method.	Once with follow up as needed.	Low cost for a short training.	• This strategy is for countries where many girls deliver at home or outside the health center. • Improves the ability of traditional birth attendants to promote lactational amenorrhea method as a deliberate family planning method to young mothers when they give birth. • Involves the ability of traditional birth attendants to refer new mothers to available family planning services before child reaches 6 months so mother can transition to another family planning method. • Job aids need to be adapted for low literate populations which can be used by traditional birth attendants to explain lactational amenorrhea method to new mothers. • Monitoring forms should collect the number of clients counseled and initiated on the method. If traditional birth attendants are low literate, data collection through a supervision mechanism are needed.

These strategies are meant as a supplement to the key strategies in the Common Approach AD module. Choose from this list if you feel your program needs to include family planning strategies for adolescents.

IR2: These key strategies address problems of quality

Key Strategy	Frequency	Costs	CostsIssues/Comments
Service Provider Training Family planning training for health providers as a component for Youth Friendly Health Services	Once every 1–2 years.	High cost for extensive training	• Improves health providers' capacity to accurately provide high quality family planning counseling and services. • Ministry of health family planning curriculum should be used where possible, yet many other family planning training resources available. • Training should be competency-based and conducted by a health professional (i.e. someone with a clinical background such as a nurse, midwife, or doctor).
Improving existing services. Logistics management workshops	Once and as needed	Low cost	• Without a steady supply of contraception at the health facilities, family planning services will not be available. Logistics management workshops improve the contraceptive security and availability at health centers. • On the job supervision can help health providers analyze their actual service utilization in an effort to improve projected family planning needs.

IR3: These key strategies address problems of access

Behavior Change Education Teen mothers sessions within existing youth clubs.	Ongoing	Low to medium costs	• Improves outreach to young mothers and married girls who are often overlooked in general ARSH programs. • Can be added on to or created as an extension to existing youth clubs. • Allows teen mothers to receive information on family planning and reproductive health issues while receiving support from peers as well as encouragement to re-enter the formal school system. • Teen mothers can be linked up with another teen (non-mother) who is attending school to create another layer of support. • Can be created through existing youth network of peer educators, youth coordinators and leaders, youth community-based distribution agents. • Monitoring forms can be used to collect data on attendance and topics covered. • Provides an opportunity for multi-sector approaches such as linking with livelihood and education opportunities.
Behavior Change Education Family planning and HIV integration Trained traditional birth attendants promoting lactational amenorrhea method.	Ongoing	Low to medium initial costs	• Peer education is a very popular intervention in ARSH programs, yet peer educators often focus solely on HIV education and HIV-related life skills. • Peer educators can also make the links between dual protection, i.e., protecting against HIV and pregnancy at the same time. • Unlike youth community-based distribution agents, peer educators do not need to know about how to use every method, but they should be able to engage other young people in a discussion about the benefits of contraceptive use to delay early motherhood. • Although supervision is needed, well trained peer educators have the capacity to maintain programs and train others. • Monitoring forms can collect data on the number of sessions conducted with a focus on family planning.

These strategies are meant as a supplement to the key strategies in the Common Approach AD module. Choose from this list if you feel your program needs to include family planning strategies for adolescents.

IR4: These key strategies address problems of access

Key Strategy	Frequency	Costs	Issues/Comments
Advocacy for youth-friendly health services Advocating for improved youth-friendly health services which include family planning	Ongoing	Low cost	• Take stock of any existing national policies or frameworks for adolescent health. • Engage on national level dialogues concerning family planning to make sure a youth focus is included. • Engage on national level dialogues on youth-friendly health services. • Local level advocacy can be done via community dialogues, open days, focused meetings with education and community officials.
Behavior Change Education Family planning and HIV integration Trained traditional birth attendants promoting lactational amenorrhea method.	Ongoing	Low to medium initial costs	• Advocacy can be done via community dialogues, open days, focused meetings with education and community officials. • Key adults include parents, religious leaders, community leaders, etc. • Peer educators and youth community-based distribution agents can conduct open day activities where they sensitize communities about dangers of early marriage and teen motherhood. • Support teen mothers who decide to go back to school in terms of influencing readmission policy. • Sensitize health center staff about the important role family planning plays in teen mothers returning back to school, including the health and economic benefits this will have on her family.

Strategic objective Indicator

Youth Couple-Years of Protection (YCYP)

Note: This indicator can be found in the Common Approach AD indicator reference sheet in this module.

Definition

The estimated protection provided by family planning services during a 12-month period, based on the total volume of all contraceptives sold or distributed free of charge to clients (10–24 years old) during that period.

The YCYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The YCYPs for each method are then summed for all methods to obtain a total YCYP figure. YCYP conversion factors are based on how a method is used, failure rates, wastage and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that intrauterine devices (IUDs) and implants may be removed before their life span is realized.

How to Calculate

For a 12 month period, collect the total number of methods distributed for each family planning method to youth 10–24 years old. To calculate the total YCYP for each method, multiply or divide by conversion factor for that method in the table below. (The conversion factor represents the number of units needed to protect a couple against pregnancy for one year.) Total YCYP equal the sum of the YCYPs across all methods.

Methods that require multiplying by the conversion factor

Method	Conversion factor	CYP
Cu "T" 380-A IUD:	3.5	1 IUD = 3.5 CYP
Implant: Norplant	3.5	1 Norplant = 3.5 CYP
Implant: Implanon	2	1 Implanon = 2 CYP
Implant: Jadelle	3.5	1 Jadelle = 3.5 CYP
Standard Days Methods (SDM)	2	1 trained & confirmed adopter of SDM = 2 CYP

Methods that require dividing by the conversion factor

Method	Conversion factor	CYP
Condoms	120	120 condoms = 1 CYP
Oral contraceptives:	15	15 packs = 1 CYP
Injectable: Depo Provera	4	4 doses = 1 CYP
Injectable: Noristerat	6	6 doses = 1 CYP
Injectable: Cyclotem	15	13 doses = 1 CYP

Data Source

You'll need to collect the number of methods distributed to youth 10-24 year old for each method both at facilities and by community based distributors

Data Collection Method

Health Management Information System or health registers and Youth Community Based Distribution forms for a 12 month period (if calculated over a period of 12 months).

Data Quality Issues

Collect the number of methods distributed to youth 10–24 years old at the health facility *and* through community based distribution. Data should be disaggregated age and by place of distribution (i.e. facility or community). Be sure that data forms track the total number of methods distributed (specifically for condoms and pills). Tracking the total number of family planning users will not provide enough information to track YCYP.

Interpreting and using CYP data

Contraceptive Prevalence Rate, the percentage of women between 15-49 yrs who are practicing, or whose sexual partners are practicing, any form of contraception, is the best measure of family planning use but it is measured though costly population based surveys. In the absence of population based surveys, CYP is an easy and realistic indicator to measure the use of family planning services with data available from ongoing monitoring. It is important to understand the limitations of CYP. Unfortunately, for pill, condom, foam tablet and all other methods that are used by the client, CYP does not indicate if the people who took the method actually used it consistently and regularly or at all. In addition, for the IUD or Norplant, there is no indication that the client will keep the method inserted for the length of time measured by CYP.

Despite its limitations, CYP does enable family planning programs to track progress in contraceptive use through monitoring data. There is no good or bad level of CYP. But for measuring program progress, it is suggested to use a baseline CYP benchmark and any increase in the value would show a positive trend in family planning use. To measure a baseline, 12 previous months of service utilization data would be needed, disaggregated by age. Where data is unavailable for youth 10-24, a baseline benchmark will be unavailable. Program could use the first three months as a baseline benchmark to see if there are increased trends in family planning utilizations following these first three months.

Note that programs distributing shorter acting methods such as pills, condoms and injectables (which are the focus of most youth programs) will have a low CYP as compared to a program which is distributing longer acting methods such as IUD, implants and sterilization, that yield higher CYP.

Example of YCYP calculation

The following is example data from a health register at the health post in an impact area. Monthly data is collected and this is the summary of the past 12 months.

Method	# of methods distributed
Norplant	50 implants
Depo Provera (Depo)	1000 shots
Oral contraception	1500 packs
Condoms	12,000 condoms
Lactational amenorrhea method (LAM)	400 active users
Emergency Contraception (EC)	200 pills

Norplant	50 x 3.5	= 175 CYP
Depo	1000 ÷ 4	= 250 CYP
Pills	1500 / 15	= 100 CYP
Condoms	12,000 /120	= 100 CYP
LAM	400 / 4	= 100 CYP
EC	200 / 20	= 10 CYP
	Total CYP	**= 735 CYP**

Meaning: "During the past year, 735 young couples were protected from becoming pregnant over a period of 1 year. This has (increased or decrease) since last year showing (more or less) young people are accessing key family planning services and protecting against early pregnancies."

YCBDA Supervision checklist

Rationale for YCBDA supervision checklist

The use of youth community-based distribution agents is an appealing methodology to reach other youth and married adolescent girls because of the many barriers young people face in accessing facility-based reproductive health and family planning services. Adolescents already tend to talk about issues of sexuality in the community and they are better able to relate to their peers, being part of the same youth "culture." But because distribution agents are providing condoms and oral contraceptives in the community, the quality of this service provision is very important to program managers. Moreover, adolescents appreciate the connection to adult supervisors who can help them gain and improve upon newly learned skills. International experience from working with adolescent peer educators has also shown that adolescents respond best to immediate, on-site feedback. This tool is to be used as a quality standard checklist by supervisors of youth community based distribution agents.

Instructions for YCBDA supervision checklist

Observe the YCBDA interact with five clients. Assess the session and give marks as follows:

1 Activity not done
2 Activity done but there is need for improvement
3 Activity well done

Add up the score for each discussion topic after the 5 visits have been completed. Create an action plan together with the youth community-based distribution agent to improve upon the desired skill based on these scoring levels:

5–7 Need to re-learn skill
8–12 Okay but needs improvement
13–15 Excellent, continue as is

Supervision Checklist for YCBDAs

YCBDA name Supervisor name: Date:

Skills/Discussion topics	Clients					Total score	Action Step
	1	2	3	4	5		
Introduction							
Provided privacy by finding a place away from disturbances							
Greeted client politely							
Introduced self to the client							
Assured clients confidentiality							
Asked client's name							
Assess Client's Obstetric and Family Planning History							
Asked client's age							
Asked about number of pregnancies							
Asked about the number of living children							
Ask about number of children desired							
Asked if client is currently using or ever used a contraceptive method							
Taught about family planning methods as follows:							
Used teaching aids appropriately							
Gave client chance to touch the contraceptives							
Provided an explanation on all FP methods available (both from themselves and at the health center)							
Gave client opportunity to ask questions							
Responded to client's questions appropriately							
Helping Client to Choose a Family Planning Method							
Asked client about their method of choice							
Has ensured that client's choice is voluntary and not coerced							
Has also counseled client about STI/HIV/AIDS							
Discussed dual protection (i.e. protecting against HIV and pregnancy)							
Has provided a referral for methods only available at the health center							
Review the Chosen Method Together with Client							
Supplied client with the method according to protocol							
Has explained clearly on how to use the method and its side effects							
Asked client to repeat information about the method							
Provided client with missing information on the method							
Has given client leaflet on method (if available and desired)							
Has giving the client a follow-up date for a revisit/ refill							

YCBDA Monthly Reporting Form

Month & Year _____ Health zone: _____

Ref. Hosp. _____ Name of YCBDA: _____

New Clients

Record the number of new family planning users *(those who are using FP methods for the first time in their lives)*

Methods	Females			Males		
	10-14	15-18	19-24	10-14	15-18	19-24
Oral Contraceptive Pills						
Condoms						
Foam tablets/Spermicides						

Old Clients

Record the number of return family planning users *(those who have ever used FP methods in their lives)*

Methods	Females			Males		
	10-14	15-18	19-24	10-14	15-18	19-24
Oral Contraceptive Pills						
Condoms						
Foam tablets/Spermicides						

Stock outs and couple years of protection

Contraceptive Methods Distribution					
Methods	**Balance at beginning of month**	**Received during the month**	**Total**	**Total Distributed (use this column for CYP)**	**Balance**
Pills					
Condoms					
Foam					

Counseling	Individual			Group		
	F	M	TOTAL	F	M	TOTAL
Importance of Family Planning						
Modern contraceptive methods						
Sexually Transmitted Infections (STIs)						
HIV prevention						
Dual Protection						
Lactational Amenorrhea Method						

Did you run out of supplies this month? Yes ☐ No ☐

Did you receive supervision this month? Yes ☐ No ☐

Key Indicators that can be tracked with this form: 1) Total RH service visits 2) New RH service visits 3) Youth

Youth-Friendly Health Services Characteristics Checklist

A Participatory method for designing a youth-friendly health service monitoring checklist

Using the checklist above as a reference, develop a checklist in collaboration with the health centers in the impact area with whom you are working. Ideally, after key staff from each center has been trained on youth-friendly health services or engaged in the Partnership Defined Quality for Youth approach, representatives for each health center and youth can be brought together to develop their own youthfriendly health services checklist. Have the group brainstorm the characteristics they feel are feasible in the local context that will constitute a youth-friendly health center. Use the characteristics to monitor each health center in achieving and sustaining key characteristics over time. An accreditation system can be developed within the program using the checklist, if one does not exist at the ministry of health. (From African Youth Alliance: Scaling up Youth Friendly Health Services; www.ayaonline.org)

Provider Characteristics
☐ Trained Providers in youth friendly services
☐ Respect for young people
☐ Privacy an confidentiality honored
☐ Adequate time for client and provider interaction
☐ Peer counselors available
Health Facility Characteristics
☐ Separate space and special time set aside
☐ Convenient hours
☐ Convenient location
☐ Adequate spaces and sufficient privacy
☐ Comfortable surrounding
Program Design Characteristics
☐ Youth involvement in the design and continuing feedback
☐ Drop-in clients welcomed and appointments arranged rapidly
☐ No overcrowding and short waiting times
☐ Affordable fees
☐ Publicity and recruitment that inform and reassure youth
☐ Boys and young men welcome and served
☐ Wide range of services available
☐ Necessary referrals available

Resources

1. Family Planning: A global handbook for providers, WHO http://www.infoforhealth.org/globalhandbook/
2. A Comprehensive Reproductive Health and Family Planning Training Curriculum: www.pathfinder.org
3. Contraceptive Options for Young Adults online training module, Family Health International, 2003 http://www.fhi.org/training/en/modules/ADOL/s3pg1.htm
4. Healthy Timing and Spacing of Pregnancies: A Pocket Guide for Health Practitioners, Program Managers, and Community Leaders, Extending Service Delivery Project; www.esdproj.org
5. The Lactational Amenorrhea Method (LAM): A Postpartum Contraceptive Choice for Women Who Breastfeed, ACCESS-FP, www.accesstohealth.org
6. Standard Days Method of Family Planning: Job Aids Packet for Counseling Clients; Georgetown Institute for Reproductive Health; www.irh.org
7. Provision of Injectable Contraception Services through Community-Based Distribution: Implementation Handbook. Family Health International http://www.fhi.org/en/RH/Pubs/booksReports/CBD_DMPA_imp.htm
8. How to Be Reasonably Sure a Client is Not Pregnant: A health provider tool, Family Health International; www.fhi.org
9. Using Male Motivators to Increase Family Planning Use Among Young Married Couples: training curriculum, Save the Children, http://www.infoforhealth.org/youthwg/pubs/SaveTheChildren.shtml
10. Handbook for Family Planning Operations Research Design; Population Council, www.popcouncil.org
11. A pocket guide to managing contraceptive supplies, CDC http://www.cdc.gov/reproductivehealth/Products&Pubs/PocketGuide.htm
12. A Reference Guide for FP Counseling of Individuals, Couples, and Special Groups by Trained VCT Counselors, a tool designed to help VCT counselors integrate family planning messages into their counseling sessions. http://www.pathfind.org/Pubs_Job_Aids

Annex 3: Measuring Developmental Assets

The Search Institute has developed a tool, the Developmental Assets Profile (DAP), to track changes in categories of assets for young people. The DAP is backed by several years of research related to positive youth development and resiliency. The Developmental Assets framework outlines a total of forty external and internal developmental assets which are divided into eight categories: Support, Empowerment, Boundaries and Expectations, Constructive Use of Time, Commitment to Learning, Positive Values, Social Competencies, and Positive Identity. Please see below for the DAP Framework.

The DAP tool is a 58 item survey instrument that was created in order to measure the presence-and change over time-of the eight categories of developmental assets found within Developmental Assets framework. The DAP is an individual measure that yields quantitative scores for each of these eight asset categories along with five broad context areas (personal, social, school, community, and family). The DAP is typically completed via self-administration (where the learner reads and scores each item on their own) or via oral administration (where a teacher/youth worker reads each item and the learner scores each item on their own). The DAP is designed to be sensitive to changes in reported assets over time, and it is suited to both research and program evaluation. Change over time is tracked through the administration of the DAP on at least two separate occasions (Time One and Time Two) using the same survey instrument with the same young people.[11]

Advantages of the DAP for Save the Children AD programs are in its length – the 58 items can typically be answered in 15-25 minutes – and the fact that it can be scored directly by the local AD field team (using either a category or a context view). The fact that the DAP can be administered to groups of 20-25 young people either orally or via self-administration also makes it relatively cost-efficient to apply – and the use of the data generated for profiling, tracking change over time, and supporting project level guidance counseling efforts, make it cost-effective in the multiplicity of its M&E uses.

Uses of the Developmental Asset Profile in AD Programs

Experience in three countries with sponsorship-funded AD programs (Bolivia, Nepal and the Philippines) have indicated that the DAP could be used for at least three purposes in AD programs:

a) **As part of the situational analysis:** The DAP was able to provide asset-based descriptions for young people who entered the AD programs and who came from a range of backgrounds. Data from Nepal indicated differences among young people who lived in different geographies and of different ethnicities. The data also provided information based on gender.

b) **To track change over time in monitoring and evaluation:** The DAP has proven to be a useful tool in tracking change over time in asset categories. Data from Bolivia indicates that significant changes in scores of asset categories can be tracked and can be used alongside other data to either monitor a program or do an evaluation. It is recommended that AD teams consider using the DAP as part of their monitoring and evaluation.

c) **As a reflection tool for adolescents:** Filling out the 58-item survey themselves provides young people with an opportunity to reflect on how they see themselves and the community around them. When young people are asked about filling out the DAP they often reply that it was an opportunity to think about questions they never gave themselves time for before. Others make plans to improve their scores and discuss with program staff.

We recommend that the DAP be used as part of the baseline for AD programs. However, a country office may also wish to use the DAP for other purposes, as noted above. The following pages provide more detailed information on

[11] Description by David James-Wilson in "Creating Successful Transitions Report Card for Schools and Students", presented at the SEAMEO INNOTECH Regional Conference, November 2008.

the steps a country office will need to take to utilize the DAP.

Steps to be taken before utilizing the DAP

To ensure that the DAP tool is appropriate for a specific context, the following steps must be followed:

a) Language versioning

In order for AD teams to make informed choices about what steps to take in their country office, they need to first find out if the DAP tool has been translated and versioned to their context. The chart below provides information about which languages the DAP has been translated into and the country where it was versioned, as of 2009. Versioning refers to the contextualization of the language used. For example, it may be the case that versions from Bolivia are useful in the Andes region of South America but minor modification may be required for use in Central America.

b) Testing for relevance, reliability and validity

It is also important to find out to what extent the DAP has been tested in a given cultural setting. The chart below provides the information on the extent to which the reliability and validity steps have taken place in a region or country.

DAP Translation Available	Country Where Versioned	Steps Taken for Relevance, Reliability and Validity Testing
Arabic	Egypt and also used in Yemen	• passed qualitative assessment of applicability of asset-based framework • passed testing for reliability of scores including use at two different time intervals • integration of DAP into broader index – Youth Livelihood Development Index
Bengali	Bangladesh	• passed qualitative assessment of applicability of asset-based framework • some items show stronger demonstration of reliability than others • will be testing validity by comparing to end-line data on empowerment of girls
Nepali	Nepal	• passed qualitative assessment of applicability of asset-based framework • some items show stronger demonstration of reliability than others • across contexts, ethnicities and gender the context view of the DAP provides greatest reliability
Spanish	Bolivia	• passed qualitative assessment of applicability of asset-based framework • passed testing for reliability of scores including use at two different time intervals • integration of DAP into broader index – Youth Livelihood Development Index
Tagalog	Philippines	• passed qualitative assessment of applicability of asset-based framework

c) Strengthening capacity of field teams

The experience from many countries indicates that there is a minimum level of capacity building required for field teams to use the DAP with young people. The training can be delivered by international and regional technical assistance providers well versed in the use of the DAP. Country offices will need to consider the costs associated with this in their annual plans. TA level of effort and travel costs are detailed further under cost considerations. A description of these considerations is found in the DAP Coordinators' Handbook.

d) Data management considerations

The AD team should prepare their M&E colleagues for dedicated time to review data produced from the application of the DAP and come up to speed on data analysis using database software if available or excel spreadsheets. Please review the DAP data management handbook for more details.

Guidance available to country offices

Guidance documents have been developed to support AD teams in the incorporation of the DAP into their M&E toolset. There are four different documents that have been developed for country office teams, and which can be obtained from your STWG TA provider:

DAP Guidelines for AD Programs: This document provides an overview of the steps needed to get the highest level of quality from the DAP in a new country setting. The steps to testing for data reliability (ensuring that items measure the same result as other items are meant to and consistently do this over time) as well as validity (ensuring the tool measures items it is suppose to). Some of the subscales of the DAP could be tested alongside other measures such as those in education. The key testing outlined in this document is for relevance and reliability of the tool.

DAP Coordinator's Handbook: This document was developed with the program manager in mind. It provides an overview of a DAP implementation plan, the potential uses of the DAP and what kinds of support one needs to consider for using the DAP within a given program. It outlines special considerations for using the DAP in new settings.

DAP Administrator's Handbook: This document was developed for use by field level staff with support from M&E staff. It provides teams clear guidance on how to present the DAP to young people as well as options on how to administer it, especially with low-literacy groups. The document also outlines some of the common pitfalls in administering the DAP and provides tips on how to address common challenges field teams have encountered.

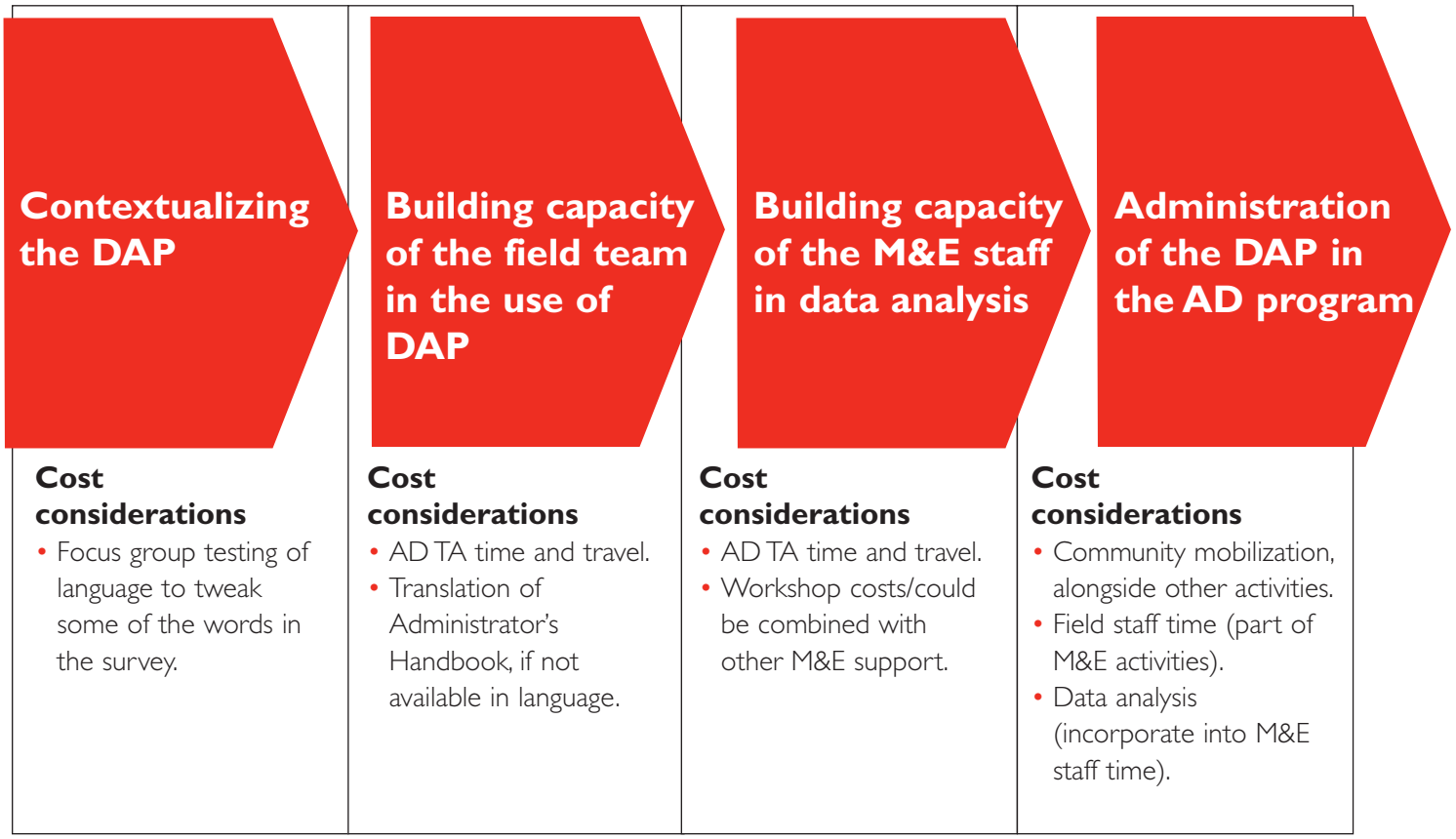
DAP Data Management Handbook: Within this document you will find in depth definitions of reliability and validity testing as well as how the DAP may be used with other M&E tools. The handbook provides guidance on ensuring data quality and details steps in data analysis. Guidance on data interpretation and reporting is also included.

Cost considerations

This section covers cost considerations for two possible scenarios for utilizing the DAP within an AD program. The first scenario is one where a language version exists for the country and much work has already being done to test the relevance, reliability and validity of this tool. The second scenario is for countries for which the DAP is new.

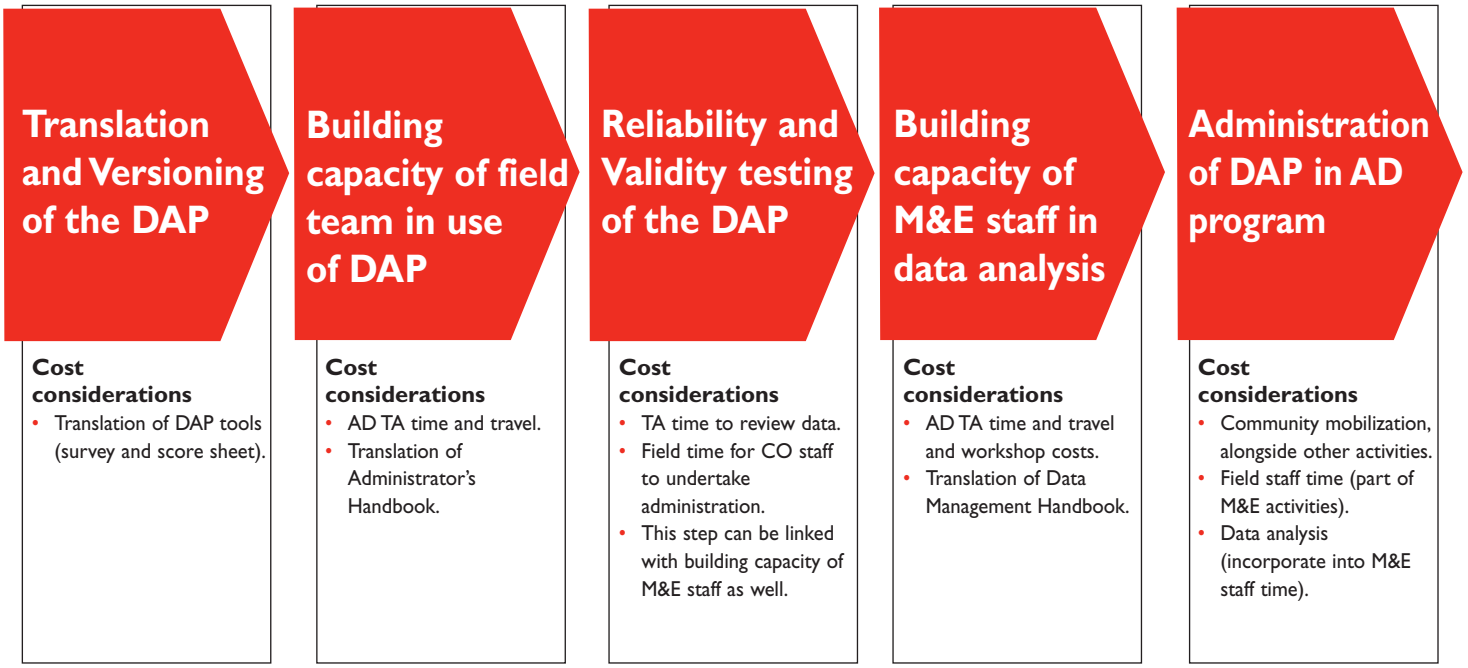
Scenario A: Language version already exists

Whether a country office decides to use the DAP for just a situational analysis or for both the situational analysis and M&E, the following steps apply:



Scenario B: A country in which the DAP is new

These steps would be taken in a country or region where a language version does not exist and testing of the use of the DAP has not yet taken place. It is likely that the country office wishes to pursue use of the DAP for much more than just sponsorship adolescent development programming and sees the applicability of this tool for broader use with other programs that benefit adolescents such as HIV/AIDS and Protection.



The 40 Developmental Assets for Adolescents Twelve to Eighteen (see www.search-institute.org)

External Assets

Asset Category	Asset Name	Asset Definition
Support	1. Family support	Family life provides high levels of love and support.
	2. Positive family communication	Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).
	3. Other adult relationships	Young person receives support from three or more non-parent adults.
	4. Caring neighborhood	Young person experiences caring neighbors.
	5. Caring school climate	School provides a caring, encouraging environment.
	6. Parent involvement in schooling	Parent(s) are actively involved in helping young person succeed in school.
Empowerment	7. Community values youth	Young person perceives that adults in the community value youth.
	8. Youth as resources	Young people are given useful roles in the community.
	9. Service to others	Young person serves in the community one hour or more per week.
	10. Safety	Young person feels safe at home, at school and in the neighborhood.
Boundaries and Expectations	11. Family boundaries	Family has clear rules and consequences, and monitors the young person's whereabouts.
	12. School boundaries	School provides clear rules and consequences.
	13. Neighborhood boundaries	Neighbors take responsibility for monitoring young people's behavior.
	14. Adult role models	Parent(s) and other adults model positive, responsible behavior.
	15. Positive peer influence	Young person's best friends model responsible behavior.
	16. High expectations	Parent(s) are actively involved in helping young person succeed in school.
		Both parent(s) and teachers encourage the young person to do well.
Constructive Use of Time	17. Creative activities	Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
	18. Youth programs	Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
	19. Religious community	Young person spends one hour or more per week in activities in a religious institution.
	20. Time at home	Young person is out with friends "with nothing special to do" two or fewer nights per week.

Internal Assets

Asset Category	Asset Name	Asset Definition
Commitment to Learning	21. Achievement motivation	Young person is motivated to do well in school.
	22. School engagement	Young person is actively engaged in learning.
	23. Homework	Young person reports doing at least one hour of homework every school day.
	24. Bonding to school	Young person cares about her or his school.
	25. Reading for pleasure	Young person reads for pleasure three or more hours per week.
Positive Values	26. Caring	Young person places high value on helping other people.
	27. Equality and social justice	Young person places high value on promoting equality and reducing hunger and poverty.
	28. Integrity	Young person acts on convictions and stands up for her or his beliefs.
	29. Honesty	Young person "tells the truth even when it is not easy."
	30. Responsibility	Young person accepts and takes personal responsibility.
	31. Restraint	Young person believes it is important not to be sexually active or to use alcohol or other drugs.
Social Competencies	32. Planning and decision making	Young person knows how to plan ahead and make choices.
	33. Interpersonal competence	Young person has empathy, sensitivity, and friendship skills.
	34. Cultural competence	Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
	35. Resistance skills	Young person can resist negative peer pressure and dangerous situations.
	36. Peaceful conflict resolution	Young person seeks to resolve conflict nonviolently.
Positive Identity	37. Personal power	Young person feels he or she has control over "things that happen to me."
	38. Self-esteem	Young person reports having a high self-esteem.
	39. Sense of purpose	Young person reports that "my life has a purpose."
	40. Positive view of personal future	Young person is optimistic about her or his personal future.

Asset-Based Strategy Matrix for Multi-Sector and Individual Adolescent Development Strategies

This matrix identifies examples of multi-sector and sector-specific AD strategies that support the different asset categories outlined above.

External Assets

Asset Category	Multi-Sector	Sector Specific
Support	• Support families to discuss difficult issues with their children regarding such topics as reproductive health, money management, and school attendance. • Engage adults to develop relationships with adolescents within families and in the communities (in schools, youth structures, businesses) to provide access to education opportunities focused on asset-building and healthy development.	• Engage parents to understand livelihood contributions of young people (livelihoods development). • Engage families and communities around health needs of girls at age of puberty (ARSH).
Empowerment	• Train service providers in youth-friendly approaches (education, health and livelihoods development) • Incorporate training of adolescents as peer educators as part of delivery of services.	• Strengthen youth, family and community capacity to assess and use educational assets (in particular literacy and numeracy and other life skills) for lifelong learning and development. • Position education for adolescents within the larger development context of poverty reduction. • Promote acknowledgement by community and parents of new livelihood skills taken up by young people.
Boundaries and Expectations	• Parents are supported to establish gender appropriate expectations in areas of marriage, work and education.	• Promote development of clear vision, objectives and a framework for shared accountability in respect of educational programs (e.g. in schools missions and school improvement plans; in youth club charters; in codes of conduct; in non-formal education guidelines; government youth education policies etc.). • Use peer-based strategies to develop financial problem solving skills. • Use simulation-based activities that help articulate consequences to financial/earning decision-making. • Schools are enabled to establish policies that lay out consequences for young people and teachers who harm students.

	Asset Category	Multi-Sector	Sector Specific
External Assets	**Constructive Use of Time**	• Promotion of after-school programs, weekend sports, cultural and other programs that also include ARSH, livelihoods and education activities. • Strategies promote application of learning to young person's context, teaching others and sharing learning with family and friends.	• Promote peer-based homework support.
Internal Assets	**Commitment to Learning**	• Use interactive activities that can be run by young people themselves and that promote participation. • Use of peer-based support for learning related to health, livelihoods development and school subjects.	• Provide opportunities for adolescents to participate in school governance and management (e.g. school management committee training).
	Positive Values	• Promotion of service learning activities for young people. • Promotion of planning out expenditures and budgeting . • Use of real life scenarios for young people to realize consequences (health, livelihoods and education).	• HIV/AIDS and gender-focused education.
	Social Competencies	• Provide opportunities for young people to apply life skills (planning and decision making, resistance skills) in health, education and livelihood scenarios.	• Engage young people to relate budgeting to goal setting. • Support young people to peacefully resolve money based conflict situations. • Foster team-based livelihood activities to develop financial negotiation skills. • Peace education. • Pre-vocational and orientation skills development (in basic education, and non-formal education).
	Positive Identity		• Recognize adolescents' educational efforts and accomplishments. • Adolescent transition programs. • Comprehensive sex education, family planning education for married and non-married adolescents (personal power).

Annex 4: The Common Approach Adolescent Development Indicator Reference Sheets

Adolescent Development: ARSH Indicators

STRATEGIC OBJECTIVE

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Total RH service Visits	Number of total visits at SDPs by adolescents during set time period	Sum of visits by adolescents during time period	Health service staff tracks number of youth clients (or by Youth Community Based Distribution Agent- YCBDA)	Health Service records or YCBDA records, LQAS	Monthly or quarterly	YCBDA and health service contact	RH services include FP visits, STI testing and treatment, RH counseling, antenatal and postnatal care at health facilities or at community based delivery points (mobil clinics, YCBDA, etc.)
New RH Service Visits	Number of new adolescent clients visiting health SDP's (service Delivery Point)	Total # of new adolescent clients visiting health SDP	Health service staff tracks number of new clients	Health Service records or YCBDA records, LQAS	Monthly or quarterly	YCBDA and health service contact	This will give you a sense of how many adolescents visited SDPs
Youth Couple Years of Protection	The estimated protection provided by family planning service delivery during a 12-month period, based on the total volume of all contraceptives sold or distributed free of charge to clients during that 12-month period	(seek TA if unclear) • SDM: 2 years pertrained, confirmed adopter • Condoms: 120 distributed = 1C Y P • Depo Provera (injectable): 4 doses (ml) = 1 C Y P • LAM: 4 active users = 1CYP • Oral contraceptives: 15 cycles = 1 CYP Total CYP = Sum of the CYPs across all methods	Health service records, YCBDA records, TBA forms (any service providers distributing contraceptive methods to youth)	Consolidation forms/ monthly reporting forms	Monthly or quarterly	Calculated by ARSH program manager	Please seek TA assistance to in using this indicator. It is a good results level indicator to show impact of all methods distributed including condoms for family planning use.
VCT utilization	Number of adolescents who have gone for VCT (voluntary testing and counseling) during time	Sum of VCT visits	VCT registry	Utilization records , disaggregated by sex, age at VCT sites	Monthly or quarterly	VCT or health service contact	

Adolescent Development: ARSH Indicators, continued

STRATEGIC OBJECTIVE

IR #1

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Rate of behavior change/ adoption of positive practice	Percent of adolescents who report adopting at least one positive practice(abstinence, monogamy, partner reduction, condom use, contraceptive use)	# of adolescents reporting adoption of positive practice X100/ Total # of adolescents	Survey (only to be completed when the program calls for a special survey)	Survey (self reported by youth)	Baseline/ endline	ARSH program manager	
RH service Utilization rate	Percent of adolescents who received RSH services (type of service to be specified by COs)	# of adolescents receiving RH services x 100/ Tot a l # of adolescents			Baseline/ endline	ARSH program manager	
Availability of YFHS (Youth Friendly Health Services)	Percent of service delivery points (SDPs) in target areas where adolescents can obtain reproductive health services (SDP included facility based and community based RH services)	# of SDPs where young people can obtain (youth Friendly) services x 100/ Total # of SDPs in target area	Project reports of trained YCBDA's and health clinics meeting YFHS standard	YFHS checklist & youth friendly health assessment tool	Annually	ARSH program manager	Definitions and compenents of YFHS can be provided by the ARSH TA provider as well as sample checklist to monitor YFHS
Contraceptive Supplies	Percent of SDPs with a regular supply of FP commodities during the last three months(eg. condoms, modern contraceptives)	# of SDPs with a regular supply of FP commodities in last 3 months x 100/Total # of SDPs in target area	YCBDA a n d Clinic records	Health service staff and YCBDA records of s toc k -ou t s monthly	Annually	YCBDA and Health service contact	Alternatively, one can also use Contraceptive stockouts: % of SDPs expereincing a stock-out in the last three months of FP commodities
Youth Friendly Hours at SDP	Percent of SDP which have flexible hours for youth	# of SDP with flexible hours X 100 / Total number of SDP in target area	Clinical Assessments/ project reports/ health service records	YFHS checklist & youth friendly health facility as ses sment tool	Annually	ARSH program manager	

Adolescent Development: ARSH Indicators, continued

IR # 2

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Client satisfaction	Percent of adolescent clients satisfied with care received from RSH service providers	# of adolescent clients satisfied with care received from RSH service providers x 100/ Tot a l # of adolescent clients using RSH services	Clients at health services or survey respondents	Client exit interviews as periodic study or self -reported in a survey	When Clinical assessments aredone or in a survey	ARSH program manager	
Trained Youth Friendly Providers	Percent of providers specially trained to work with youth	# of providers who were trained in youth friendly services and communication with youth X 100/ Total # of providers	Tracked by SC project staff	Project records	Annually	ARSH program manager	
Client Confidentiality	Percent of SDP's with sufficient privacy for counseling	# of SDPs with sufficient privacy for counseling x100/ Total # of SDPs	Health assessments	YFHS checklist and youth friendly health assessment tool, confidentiality checklist	Annually or as needed for project monitoring	ARSH program manager	Client confidentiality may be one item on a YFHS checklist
Quality Improvement Process	Number of SDP which have been engaged in in a Quality Improvement Process (PDQ, COPE, PI, etc.)	Sum of SDPs using PDQ for Youth (or anotherquality improvement process)	project records	project records	Annually	ARSH program manager	PDQ for youth is the Save the Children developed Quality Improvement process most widely used in the our Cos.
Quality Improv emen t Teams: Youth Involvement	Number of QI teams where youth are present at each meeting	Sum of QIT with youth involvement at each meeting	QIT records	QIT attendance	Annually	ARSH program manager	QIT are formed after the PDQ for Youth process to ensure collective action and quality improvements. Yet, youth should be present at every QIT meeting to truly say there is youth involvement.
Youth Friendly Health Information Systems	Percent of SDPs in target area that have modified/ established recordkeeping tools to track adolescent visits	# of SDPs that have modified/established recordkeeping tools to track adolescent visits x 100/ Total # of SDPs in target area	Program staff tracks changes in SDP protocols for record-keeping, Clinical assessments	Program documentation	Annually	Health service contact	

Adolescent Development: ARSH Indicators, continued

IR # 3

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Delay Sexual Debut	Percent of adolescents not yet sexually active who wish to delay sexual debut for 6 months	# of adolescents not SA who intend to delay sex for 6 months x 100/ Total # of adolescents not SA surveyed	Self Reported in a survey	ARSH IR#3 indicators to be tracked through a special survey when needed and agreed upon with Home office TA. Specific technical assistance for development is recommended for these indicators	Baseline & end line	ARSH program manager	
HIV Knowledge	Percent of adolescents who can name three ways of preventing STI/HIV/AIDS	# of adolescents who can name 3 ways of preventing HIV X 100/ Total # of adolescents surveyed	Self Reported in a survey		Baseline & end line	ARSH program manager	
Parental or Partner RH communication	Percent of adolescents who talked with their parents (or partners) regarding contraception in the past 3 months	# of adolescents who talked with parents regarding Reproductive Health issues in the past 3 months X 100/ Total # of adolescents surveyed	Self Reported in a survey		Baseline & end line	ARSH program manager	RH issues include puberty, abstinence , condom use, contraception use, marriage plans, fertility plans, etc.
Knowledge on Available ARSH services	Percent of adolescents who know where to get contraception/ condoms / HIV testing	Number of adolescents who know where to get a method (or condoms or HIV testing) X 100/ Total#of adolescents surveyed	Self Reported in a survey		Baseline & end line	ARSH program manager	
Condom negotiation	Percent of adolescents who believe they could successfully negotiate condom use with their partner	# of adolescents who believe they could successfully negotiate condom use with their partner x 100/ Total # of adolescents surveyed	Self Reported in a survey	ARSH IR#3 indicators to be tracked through a special survey when needed and agreed upon with Home office TA. Specific technical assistance for development is recommended for these indicators	Baseline & end line	ARSH program manager	
perceived Refusal skills	Percent of adolescents who feel confident they could refuse unwanted/coerced sex, drugs or alcohol	# of adolescents who feel confident they could refuse unwanted/coerced sex, drugs or alcohol x 100/ Total # of adolescents surveyed			Baseline & end line	ARSH program manager	

Adolescent Development: ARSH Indicators, continued

IR # 4

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Cross cutting: Safe Spaces	Number of communities with safe spaces for youth gathering	Sum of communities with safe spaces	Project records	Program staff tracks safe spaces	Annually	ARSH program manager	Safe and supportive environments are regarde as a prerequisite for the program to have a real effect on its beneficiaries . This is especially true for girls, who historically have been excluded, whether intentionally or unintentionally, from public spaces.
Government Policies	Notable changes in ARSH policy in the last 12 months	Yes or No	Environmental scan	Program staff tracks policy changes	Annually	ARSH program manager	

Adolescent Development: Education Indicators

STRATEGIC OBJECTIVE

IR # 1

Completion of youth education activity/ program	Percent of youth completing a youth education program	# of youth completing youth education program x 100/ Total # of youth enrolled in program	School records; certificates of completion	Review school records or other indicators of program completion, such as certificates of completion	Beginning & End of Program Cycle (Annually reported)	Youth / Education program manager	Activity/program will be defined by CO
Literacy skills development	Percent increase of youth who pass a literacy assessment	Number passing Literacy assessment x 100/ Number taking the assessment	Pretest and post test	Literacy assessment	Beginning & End of Program Cycle (Annually reported)	Youth / Education program manager	Compared from pre and post test scores.
Enrollment	Number of youth enrolled in formal or non-formal education program	Count the total number of youth enrolled by cohort	Program enrollment records	Summary enrollment form	Annually	Youth/ Education program manager	

Adolescent Development: Education Indicators, continued

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
IR # 1 Education services	Number of formal and/or non-formal education services offered to youth	Count number of services	Program documents	Summary form for education services	Annually	Youth/ Education program manager	A service is a single activity, such as how to create a CV and conduct an interview, computer skills training, literacy instruction, civic education, life skills, etc. List all education services that are provided by the program. This will allow us t gain a sense of what services are being provided directly by SC or its partners.
IR # 2 Learner attendance rate	Percent of adolescents attending the education program on a given day	Tot a l # of adolescents present in the program on a given day x 100/ Tot a l # of adolescents that enrolled	Program attendance and enrollment records; spot check attendance log	Summary attendance and enrollment form	Quarterly (Annually reported)	Youth/ Education program manager	It is recommended that programs use this indicator.
IR # 2 Learning environment	Percent of adolescents that report improvements in the quality of their learning environment	Number of adolescents that report improvements in the quality of their learning environment x 100 /Total number of adolescents in the education program	Survey data	Survey	Baseline & endline	Youth/ Education program manager	Quality improvements may include relevant content and activities as well as a safe and conducive environment for active youth participation.
IR # 3 Participation in community service	Number of adolescents participating in community service activities	Count number of adolescents participating in community service activities as documented through records	Community and school records	Summary form of participants in community service	Annually	Youth/ Education program manager	This indicator is intended to measure adolescent participation in a range of community service activities defined locally that may include: facilitation of voter registration, caring for elderly members, environmental awareness and clean up projects and teaching in ECD centers, etc.

Adolescent Development: Education Indicators, continued

IR # 4

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Parent/ community commitment to adolescent learning	Percent of parents/ community members demonstrating commitment to support learning for adolescents in their communities	Number of parents or community members demonstrating commitment to support learning for adolescents in their communities/ Total number of parents orcommunity members in the impact area	Survey data	Survey summary form	Baseline & endline	Youth/ Education program manager	Demonstration of commitment is a financial or material contribution to support adolescents in their community to continue learning. This is also a cross – cutting indicator.
Government Policies	Notable changes in education policy for adolescents in the last 12 months	Yes or No	Environmental scan	Program staff tracks policy changes	Annually	Youth/ Education program manager	

Adolescent Development: Livelihoods Indicators

STRATEGIC OBJECTIVE IR # 1

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Use of financial services	# of adolescents participating in savings and loans or generating resources.	Total number of adolescents in record sheets at the end of the year	MFI records or adolescent savings group records	Record sheets	Annually	Livelihoods program officer	
Increased livelihood options	Number of adolescents who are able to list increased number of livelihood options	Total number of adolescents in the course with increased lists of livelihood options	Pre/post test	Course assessment forms	Annually	Course facilitator	
Livelihood program completion	Number of adolescents completing livelihood preparation programs	Number of adolescents who complete the program (full number of sessions)	Data collection records	Program record forms	Annually	Livelihoods program officer	
Use of financial management practices	Percent of adolescents who improve their financial management	Number of those whose skills improved (based on baseline and endline comparisons) divided by the total numbered of participants	Course records, MFI records on savings	Course assessment forms	Annual (as per course)	Course facilitator	
Access to non financial readiness services	Number of adolescents enrolled in livelihood readiness programs	Number from records	Data collection records	Records	Annually	Program facilitator	
Report of income	% of adolescents reporting ability to complement household income with income from non exploitive employment	adolescents self reporting non exploitative sources of income to complement household income/all adolescents participating	adolescents self reporting	survey	Baseline & endline	Livelihoods program officer	

Adolescent Development: Livelihoods Indicators, continued

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Access to financial services	Percentage of SC microfinance partners that provide access to financial services for adolescents and their families	Number of providers with adolescent inclusive services/ total number of providers	Save and partners' records	Client records	Annually	Financial Service Manager	
Availability of skills building services	Number of sites that include adolescent skills building (vocational, apprenticeship , business, money management, entrepreneurship)	Total number of sites providing adolescent skills building services	Save and partners' records	Site records	Annually	Site Manager	
Improved environment at MFIs	Percent of adolescents reporting improved environment at MFIs	# of adolescents reporting improved environment at MFIs x 100/ # of adolescents accessing MFI services	MFI records	Site records	Annually	MFI Officer	
Quality of financial and non financial services	Number of MFI and livelihood services providers trained in adolescent client services	Total number of sites providing adolescent skills building services	SC training records	Training Participants' lists	Annually	Service provision Manager	
Improved money management skills	Number of adolescents who can demonstrate improved money management skills	Total number of adolescents who can demonstrate improved money management skills	Pre-post test	Pre-post test	Before and after course	Course facilitator	
Improved problem solving skills	Percent of adolescents who improve their problem solving skills	#of adolescents who demonstrate improved problem solving skills /total number of adolescents who participated in the program	Scenarios on prepost test (request TA assistance in developing scenarios for a pre/post test)	Pre-post test	Before and after course	Course facilitator	

IR # 1

IR # 2

IR # 3

Adolescent Development: Livelihoods Indicators, continued

IR # 4

	Definition			Means of verification			
Indicator name	Description	Calculation	Source	Tool	Frequency	Person	Notes
Youth inclusive policies	Existance of policies that promote internships in the private sector or inclusive of youth	Number and types of policy changes	Save records	Documentation of policy changes in the private sector including financial services	Annually	SC Youth Program Manager	
Government investment	Number of adolescent economic opportunities programming or MFI services that are expanded with government funds	Accounting for number of programs expanded with government funds	Save records	Documentation on expanded programs	Annually	SC Youth Program Manager	
Government policies	Notable changes in policy concerning ecomomic opportunities for adolescents in the last 12 months	Yes or No	Environmental scan	Program staff tracks policy changes	Annually	SC Youth Program Manager	

Annex 5: Glossary

Adolescent livelihood development
This refers to the acquisition and application of knowledge and skills that help a young person improve an existing or future income opportunity. As a result, the outcome of interventions of this kind cannot be measured simply by income but rather in consideration of age, life stage and role in the family – by outcomes related to family application of knowledge, investments in ongoing education or associated costs and savings to address risks, especially related to health. Examples include the combined use of financial literacy and savings or market literacy and improved family business.

Affected by HIV/AIDS
This module uses the phrase "children affected by HIV/AIDS" to mean: 1) Children living with parents who are infected by HIV/AIDS; 2) Children who are orphaned by HIV/AIDS; 3) Children who are infected by HIV/AIDS; 4) Children who live away from home because of HIV/AIDS. These children are often further isolated from others and may find themselves living on the street and devoid of family support.

Asset
This refers to a useful or valuable quality, person, or thing. Building upon current assets will empower adolescents and increase success and sustainability of holistic and integrated programming. Knowing young people's assets is also key to understanding which economic activities young people are engaged in, have to the potential to engage in, or can be adequately supported to engage successfully in.

Community-based distribution agent
This is a community member who is trained to provide some health services within the community, such as counseling, conveying disease prevention information, etc.

Continuous assessment
This refers to evaluation of students' work throughout the year; not just at the end of the year.

Curriculum
The set of skills, attitudes, and performance objectives that students are expected to learn from an education program.

Service delivery points
These are sites where community members can receive health services, such as hospitals, clinics, and resource centers.

Vulnerable groups
In this module, the term "vulnerable groups" is used to refer to populations including, among others:

- **Children in poverty:** Children who live in the poorest 20 percent of households in the country.
- **Children of disadvantaged ethnic/language/caste groups:** Children/families who self-identify as being of an ethnic, linguistic, or caste group that is disadvantaged.
- **Orphans and children affected by HIV/AIDS:** Children who have lost one or both parents for any reason; children living in communities with high HIV/AIDS prevalence; children infected by HIV/AIDS or in households where caregivers are seriously ill.

- **Working children, especially those in the worst forms of child labor:** Children who do work that harms or exploits them physically, mentally, morally, or by blocking access to education. The International Labor Organization has identified four categories of the worst forms of child labor. These are: 1) all forms of slavery or practices similar to slavery, such as the sale and trafficking of children and the use of children for use in armed conflict; 2) the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances; 3) the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties; 4) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.
- **Street children or children living on their own:** Such children could be street children, children who have been orphaned, or underage mothers choosing to live away from their families.
- **Children affected by crisis:** Conflict or natural disaster disturbs children's protective networks within their family and community. This can affect children in two ways: 1) risks prior to the crisis such as disease or trafficking can increase; 2) new threats such as trauma, landmines, or separation from their families. Not all children are affected equally by these events. Experience has shown that children are naturally resilient and will resume normal developmental pathways with support.
- **Children with special needs:** Children who have impairments, medical conditions, or illnesses that lead to a loss of opportunities, or children who are developmentally delayed.
- **Women and girls:** Program data should be disaggregated by gender to ensure parity, or equal numbers of males and females.

Partnership Defined Quality (PDQ) for Youth

Partnership Defined Quality for Youth is a Save the Children approach that engages young people and health providers in a process of exploring and sharing perceptions of quality health services, and it emphasizes mutual responsibility for problem identification and problem solving. A "bridging the gap" workshop brings together youth and providers during which they create a shared vision of "youth-friendly services," agree upon definitions of quality, and create a work plan for implementing and monitoring the desired changes. A core team of providers and youth are then tasked with carrying forward the plan.

Annex 6: Resources

1. Save the Children (2007). *Advocacy Matters: Helping children change their world: and International Save the Children Alliance guide to advocacy.* Both Participant's and Facilitator's manuals are available on the Save the Children International extranet at: https://www.savethechildren.net/xtranet/resources_to_use/prog_areas/advocacy_initiatives/Alliance Advocacy Guide.html?location=/xtranet/index.php
2. The United Nations Fund for Population Activities has several seminal publications on youth, including the State of the World's Population. Available at: www.unfpa.org
3. Population Reference Bureau also develops population-based reference materials. Available at: www.prb.org
4. The Population Council is an international, non-profit, non-governmental organization that conducts biomedical, social science, and public health research. Available at: www.popcouncil.org
5. The Search Institute has developed an approach and tool for measuring developmental assets. Their tools are being adapted for use in adolescent programming at Save the Children. Available at: www.search-institute.org
6. The USAID PVO/NGO Flexible Fund promotes the development of, interest in, and quality of community-based family planning and reproductive health services worldwide. At this site, you may find information on the current community-based family planning projects funded by the Flexible Fund including maps of the project areas and summary reports of activities and accomplishments. Available at: www.flexfund.org
7. Advocates for Youth is an international NGO that creates programs and advocates for policies to help young people make responsible decisions about their reproductive and sexual health. Available at: www.advocatesforyouth.org
8. The 2007 World Development Report by the World Bank focuses on youth. Available by searching for Report Number 35999 at: www-wds.worldbank.org
9. Family Health International is an international non-profit organization that has expertise with youth, HIV/AIDS and contraceptive technology. To learn more about their youth-friendly and healthy services program in Latvia, their national youth consultation in Ethiopia or other tools and resources see: www.fhi.org
10. Promundo is an international NGO based in Brazil with a strong focus on "social technologies that contribute to advance the potentialities of children and youth in the global South." They have a strong history in gender work, especially with boys and men. Project H is one such program that has been highly successful in its approach. To learn more about Promundo's programs and tools. Available at: www.promundo.org
11. Pro Mujer is a women's development organization whose mission is to provide Latin America's poorest women with the means to build livelihoods for themselves and futures for their families through micro-lending, business training, and healthcare support. Available at: www.promujer.org