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From inception to large scale: The Geração Biz Programme in Mozambique

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ABBREVIATIONS

AMODEFA	To be added (page 2)
ART	Antiretroviral therapy
ASRH	Adolescent sexual and reproductive health
AVIMAS	To be added (page 2)
CDC	Centers for Disease Control and Prevention
CIADAJ	Intersectoral Committee for the Development of Youth and Adolescents
CTA	Chief technical adviser
DANIDA	Danish International Development Agency
DHS	Demography and Health Survey
DNAJ	National Directorate of Youth
GBP	Geraçao Biz Programme
GBV	Gender-based violence
ICPD	United Nations International Conference on Population and Development
KAPB	HIV/AIDS Knowledge, Attitude, Practices and Behaviour
MIS	Management information system
MOE	Ministry of Education
MOH	Ministry of Health
MOYS	Ministry of Youth and Sports
NORAD	Norwegian Agency for Development Cooperation
PLWHA	People living with HIV/AIDS
SIDA	Swedish International Development Cooperation Agency
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STIs	Sexually transmitted infections
TA	Technical adviser
TOT	Training of trainers
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFHS	Youth-friendly health services
YFS	Youth-friendly services
YPLWHA	Young people living with HIV/AIDS

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I. Purpose of the Document

This document describes a multisectoral adolescent sexual and reproductive health (ASRH) programme implemented by the Government of Mozambique with financial support from UNFPA and technical support from Pathfinder International. The programme has three main components: clinical youth-friendly services (YFS), in-school interventions, and community-based outreach. Although the document focuses on the establishment and scale-up of youth-friendly health services (YFHS), the service component cannot be examined in isolation, as the multisectoral approach has been critical to the success and use of YFHS within Mozambique. The sections on the development of Geraçao Biz, the implementation model and management structure include details on the overall multisectoral programme to help the reader understand how the components function together. After that the document focuses more specifically on the YFHS component that is implemented by the Ministry of Health (MOH).

This document has been written for programme and project managers at national, district, and local levels interested in the implementation and scale-up of multisectoral programmes that encompass YFHS. The document outlines the process used to design, implement, monitor and evaluate the Geraçao Biz Programme (GBP) in Mozambique. The steps taken during the pilot phase and subsequent scale-up of the programme are described, as well as key lessons learned. This case study is intended to provide an example of 'how to' design and implement a multisectoral programme that intends to be scaled up from the beginning.

The authors acknowledge that this document describes the process and steps undertaken in Mozambique and that other countries have different political, social and cultural contexts. However, the experience and lessons learned could be adapted and applied to help other countries that wish to establish or scale up YFS within multisectoral programmes.

II. Adolescent and Youth Sexual and Reproductive Health: The International Context

Young people between the ages of 10 and 24 are a significant and rapidly growing segment of the world's population, accounting for a quarter of the total population and comprising 30% of the population in the developing world. From a demographic standpoint, the importance of addressing the needs of this group is undeniable. The risks encountered by sexually active young people are myriad, and are intensified by the silence that surrounds them, thus demanding a dynamic and multi-pronged response.

The increasing gap between marriage and the age of sexual debut in developing countries means that there are a greater number of unmarried, sexually active adolescents and youth. Due to the powerful stigma surrounding the issue of premarital sexual activity by young people, many avoid seeking desperately

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needed sexual and reproductive health (SRH) information and services, out of fear or shame. If they do seek services, they often encounter barriers such as a lack of privacy, absence of services specific to their needs, and unfriendly staff who discourage them from pursuing future care.

The statistics are telling: less than 5% of the poorest young people worldwide use modern contraceptive methods, and 33% of women in less developed countries give birth before the age of 20[1,2]. WHO case studies in several

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[1] UNFPA. *State of world population 2003: Making 1 billion count: Investing in adolescents' health and rights.* New York: UNFPA.
[2] Meléndez Salgado, A. and N. Cheetham. 2003. *The sexual and reproductive health of youth: a global snapshot.* Washington, DC: Advocates for Youth. <http://www.advocatesforyouth.org/publications/factsheet/fsglobal.pdf> (15 June 2007).
[3] Brown, A. et al. 2001. "Consequences of unsafe sexual activity," *Sexual relations among young people in developing countries: Evidence from WHO case studies.* Geneva: World Health Organization, 21-28. <http://www.who.int/reproductive-health/publications/RHR_01_8/RHR_01_08_chapter5.en.html> (15 June 2007).
[4] Greene, M.E., et al. 2002. *In this generation: Sexual & reproductive health policies for a youthful world.* Washington, DC: Population Action International. <http://www.populationaction.org/Publications/Reports/In_This_Generation/English.pdf> (15 June 2007).
[5] Bogdanovich, L. and N. Cheetham. 2006. *Youth and the global HIV/AIDS pandemic.* Washington, DC: Advocates for Youth. <http://www.advocatesforyouth.org/publications/factsheet/fsglobalHIV.htm> (15 June 2007).
[6] National Institute of Statistics. 2007. *Projection for 2006.* Maputo: National Institute of Statistics.
[7] UNFPA. 2005. *Programme Document Agreement between the Government of Mozambique and The United Nations Population Fund.* Maputo: UNFPA.
[8] MINED, 2004 cited in UNFPA. 2005. *Programme Document Agreement between the Government of Mozambique and the United Nations Population Fund.*
[9] República de Moçambique. Ministério da Saúde. Direcção Nacional de Saúde Programa Nacional de Controle das DTS/HIV-SIDA. . 2005. *Relatório sobre a Revisão dos Dados de Vigilância Epidemiológica do HIV- Ronda 2004.* Maputo: Grupo Técnico Multisectorial de Apoio á Luta contra o HIV/SIDA em Moçambique.
[10] Senderowitz, J. et al. 2004. *Evaluation of the Geraçao Biz Program, Mozambique.* Maputo: UNFPA and Pathfinder International.
[11] Ministry of Health. 2003. *Strategic National Plan for HIV/AIDS 2004-2008.* Maputo: Ministry of Health
[12] Hawkins, K. et al. 2005. *Milking the Cow. Young Women's Constructions of Identity, Gender, Power and Risk in Transactional and Cross-Generational Sexual Relationships: Maputo, Mozambique.* Maputo: PSI.
[13] Instituto Nacional de Estatistica (INE). 2005. *Demography and Health Survey 2003 Mozambique.* Calverton, MD: Measure DHS/ORC Macro.
[14] Instituto Nacional de Estatistica. 2001. *Inqu'erito Nacional Jovens Adolescentes.* Maputo: INE.
[15] INE, 2005.
[16] Maputo Central Hospital. 1994. Service Statistics.
[17] UNFPA. 2005. *Programme document agreement between the government of Mozambique and the United Nations Population Fund.* Maputo: UNFPA.
[18] Ministerio de Saude, 2006 and INE 2005.
[19] UNFPA. 2005.
[20] United Nations International Conference on Population and Development. 1994. "Actions." *Programme of Action of the United Nations International Conference on Population & Development.* New York: International Institute for Sustainable Development Reporting Services. <http://www.iisd.ca/Cairo/program/p07016.html> (15 June 2007).

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developing countries have found that between 10% and 40% of young sexually active unmarried women report having experienced unwanted pregnancy.[3] Young people between the ages of 15 and 24 have the highest rates of sexually transmitted infections (STIs) worldwide, representing over two thirds of all cases in the developing countries.[4] Ninety-five percent of new HIV infections occur in the developing world[5], and youth between the ages of 15 and 24 account for over half of those – approximately 7000 each day.

III. Sexual and Reproductive Health of Young People: The Mozambican Context

Mozambique is characterized by a youthful population with 33% of the total population between the ages of 10 and 24.[6] While young people have the potential to bring positive change to the country and contribute to a vital workforce, they are also among the hardest hit by the economic, educational and health conditions in Mozambique. Almost 41% of the population is illiterate with 30.1% of young men and 51% of young women aged 15 to 19 unable to read.[7] Although the Government has increased the number of schools, 70.6% of the population over the age of 15 has not completed primary education, of which 63.3% are young people between the ages of 15-19.[8] Of greater concern is the fact that only 35% of those enrolled in secondary school are females, which has great implications for HIV prevention given that girls' education has been identified as a protective factor.

HIV prevalence in Mozambique is 16.2%, with young people under the age of 25 accounting for 60% of new HIV infections and young women aged 20-24 being infected at a rate that is triple that of men the same age.[9] The difference is even more acute in the age group 20-24 where HIV infection rates are three times higher among young women than among young men. Lack of education, combined with unequal distribution of power between men and women, intergenerational sex, urban and cross-border migration, and unemployment are contributing factors to the spread of HIV in Mozambique, especially to the high rate of infected young women.[10, 11, 12]

Sexual initiation begins during adolescence with young women becoming sexually active at an earlier age than their male counterparts; among those aged 20-24, sexual debut for females was 16 years and 16.9 years for males.[13] This is reflected both in higher rates of HIV infection among adolescent women and high rates of teenage pregnancy. Although 44% of married adolescents know of at least one modern contraceptive method, 83.3% of young women aged 15-24 who had sex in the last three months and 75.6% of young men reported not using any contraceptive method in the last sexual encounter.[14] Given such low contraceptive use, it is not surprising that the 2003 Demography and Health Survey (DHS) showed that 41% of women aged 15-19 had entered motherhood or were pregnant. There is a distinct correlation between education and teenage pregnancy: 62% of those aged 19 or under who have not received any education

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are pregnant or mothers while only 16% of those with a secondary or higher education have been pregnant or given birth.[15]

Unsafe abortion is one of the leading causes of maternal death among young women according the Maternal Death Review conducted by the MOH in 1998. Of those admitted to the Central Hospital for complications of abortion, 44% were women under the age of 20, while septic abortion is the second highest cause of death among patients under 20 years of age seen at the Gynecology and Obstetrics Department. [16,17]

While exact figures on STI prevalence are not available, the number of reported cases of STIs is increasing from 412,091 in 2002 to 526,045 in 2005 and syphilis prevalence is estimated to be 16% according to the 2003 DHS.[18] Service statistics from YFHS facilities indicate that 1/3 of all youth clients come for treatment of suspected STIs.[19]

IV. Milestones Preceding Geraçao Biz

The 1994 International Conference on Population and Development (ICPD) was a major milestone in the development of a comprehensive, multisectoral approach to address the SRH needs of young people. ICPD's Programme of Action acknowledged the previous lack of attention paid to adolescent reproductive health and urged governments that "information and services…be made available to adolescents [to] help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases (STDs) and subsequent risk of infertility".[20] In its proposed actions to address the issue of ASRH, the ICPD put forth two strategies: 1) making reproductive health services youth-friendly; and 2) involving multiple stakeholders, from different sectors from the community to the national level, in programmes addressing ASRH.

In response, governments and donors, including UNFPA, increased their focus on ASRH. With a burgeoning youth population and increasing HIV infection, the Mozambican Government, with support from UNFPA, established a multisectoral group to assess the current situation of young people and develop a national response. This group, which evolved into the Intersectoral Committee for the Development of Youth and Adolescents (CIADAJ), included various ministries, the National Youth Council, civil society (e.g. youth associations) and NGOs. The National Directorate of Youth (DNAJ) of the Ministry of Youth and Sports (MOYS) was the acting chair of CIADAJ.

In 1997, CIADAJ developed the Integrated Programme and Plan of Action to Support the Development of Adolescents and Youth, which included the following key areas: policies and legislation related to adolescents and youth; family life education (FLE); and YFHS. One major line of action in CIADAJ's Integrated Plan was to increase young people's access to SRH information and services. The first step taken in this arena was to conduct a national ASRH needs

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assessment. Findings from this assessment demonstrated that young people could not be treated as a homogenous group and concluded that the most effective response to their diverse needs was a multisectoral approach that included numerous interventions simultaneously conducted by government institutions in collaboration with existing NGOs and community-based organizations. With regard to health services, the assessment revealed that most of the health units selected to implement YFS needed renovation and equipment to serve the needs of youth clients.[21]

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[21] World Bank. 2003. "UNFPA and Pathfinder International: Geraçao Biz, Youth-friendly Health Clinics," *Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs.* Washington, DC: World Bank, 47-68.
[22] Hainsworth, G. 2002. *Providing Sexual and Reproductive Health and STI/HIV Information and Services to This Generation: Insights from Geraçao Biz* . Maputo: Pathfinder International and UNFPA.
[23] The MOYS does not currently have a district directorate. Most of the district level community outreach activities are coordinated by Provincial Directorate and implemented by local youth NGOs or youth associations.
[24] The MOYS does not currently have a district directorate. Therefore the provincial directorate assumes responsibility for project management of the outreach component at both the provincial and district levels.
[25] World Bank.
[26] UNFPA. 2001. *Final Evaluation: Adolescent RH in Maputo City and Zambezia.* Maputo: UNFPA.
[27] Hainsworth, 2002.
[28] Pacca, J. *Programma Geraçao Biz, Government of Mozambique, Pathfinder International, and UNFPA*. 2006. Powerpoint presentation at Pathfinder International Country Representatives Annual Meeting. Maputo: Pathfinder International.
[29] Mann, J. 1992. *AIDS in the World.* Cambridge: Harvard Press.
[30] This reduction in technical assistance is very new and began in 2007.
[31] Senderowitz, J. et al.
[32] Ibid.
[33] Ibid.
[34] The following limitations were taken into consideration in the comparative analysis: samples were calculated taking into account the adolescents involved in the programme and KAPB (Knowledge, Attitudes, Practices and Behaviours) studies were conducted among students of EP2 (junior secondary school) and secondary schools only, with the likelihood that some of those who took part in the first study did not participate in the second study.
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] UNFPA/Pathfinder. 2007. *Reproductive and Sexual Health of Adolescents and Youth. Programa Geraçao Biz. Summary Progress Report 2006.* Maputo: UNFPA/Pathfinder.
[39] Ibid.
[40] Hainsworth. 2002.
[41] Ibid.
[42] UNFPA/Pathfinder. 2007.
[43] Badiani, R. 2006. *WHO Informal Consultation on Community Interventions for Child and Adolescent Health.* Presentation. Geneva: WHO.
[44] UNFPA/Pathfinder. 2007.
[45] Hainsworth. 2002.
[46] Ibid.
[47] UNFPA. 2007.
[48] Ministerio de Saude, UNFPA, and Pathfinder International. 2005. *Estudo Satisfacao dos*

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This positive momentum to address ASRH, resulted in the following policies and actions that supported a multisectoral approach: the National Youth Policy, the National Strategic Plan on HIV/AIDS, the creation of the School and Adolescent Health Section within the MOH, the National Adolescent Health Policy, and the Education Sectoral Plan Against AIDS.

V. Overview of Geraçao Biz

From this foundation grew a multisectoral programme (later branded Geraçao Biz) which sought to address the SRH needs of in- and out-of-school youth. Encompassing three components: youth-friendly clinical services, school-based interventions, and community-based outreach, the project was designed from the outset for national scale-up. The Ministries of Health, Education, and Youth and Sports were the key implementers with support from UNFPA and DANIDA and technical assistance from Pathfinder International. The programme began in 1999 in two pilot sites, Maputo City and Zambezia Province, with the view to expand to other provinces while building on lessons learned from the pilot phase. As a result, the programme design included extensive monitoring and evaluation activities as well as a flexible management style that would allow for programme changes based on experience gained through implementation. To date, Geraçao Biz is being implemented in all provinces within Mozambique. The timeframe and map below describes the three phases of implementation.

Phase 1 (1999-2000): Pilot phase: Maputo City and Zambezia Province
Phase 2 (2000-2005): Expansion to four new provinces: Maputo Province, Gaza, Tete and Cabo Delgado, while increasing the number of YFS sites in Maputo and Zambezia.
Phase 3 (2005-2009): Expansion to five new provinces: Inhambane, Niassa, Nampula, Sofala and Manica while also increasing the number of YFS sites within each province.

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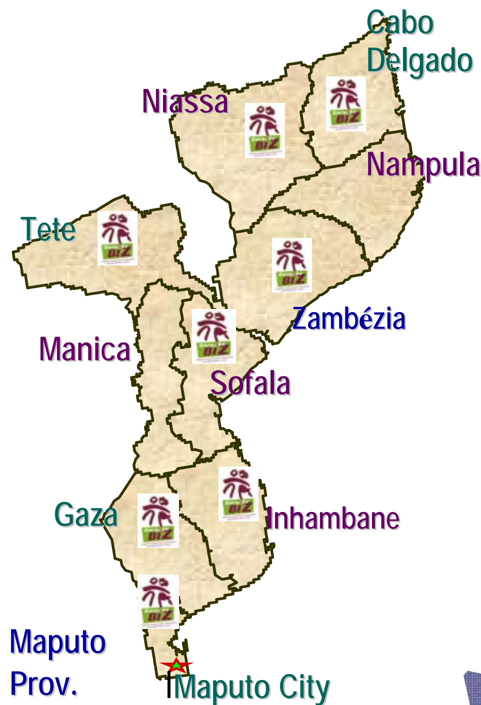

Phase 1 (1999-2000)
Phase 2 (2000-2005)
Phase 3 (2005-2009)

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Programme goals, objectives and guiding principles

At the project onset, Geraçao Biz had the following goals and objectives:
To improve ASRH, increase gender awareness, reduce the incidence of unplanned pregnancies, and decrease young people's vulnerability to STIs, HIV, and unsafe abortion through the following initiatives and supportive strategies:

- Establish a network of quality ASRH services and counselling within the public health system and at alternative sites.
- Develop a school-based programme for in-school youth that provides appropriate SRH information and counselling and is linked to youth-friendly, gender-sensitive health services.
- Develop an outreach component for out-of-school youth that provides appropriate SRH information and counselling and is linked to youth-friendly, gender-sensitive health services.
- Empower in- and out-of-school youth with life skills information that is related to the development of their SRH and oriented to behaviour change.

Supportive and cross-cutting strategies

- Create a supportive, cohesive social environment for behavioural development and change among in- and out-of-school youth and their social networks.

- Strengthen the capacities of institutional partners (government, NGOs and other facilitators/service providers) to plan, implement, monitor and evaluate multisectoral ASRH interventions.[22]

The guiding principles included:
- The right of young people to a positive and healthy sexual and reproductive life.
- Respect for cultural diversity.
- Commitment to gender equality.
- Recognition of all young people as citizens.

By 2004, there was recognition that the programme needed to support more fully young people's self determination and proactive participation to address their own needs. This led to an evolution of more encompassing and rights-based programme objectives and guiding principles. The new programme objective and expected results are as follows:

To improve ASRH, including a reduction in the incidence of early or unwanted pregnancy, STD and HIV, through activities that equip young people with the knowledge, skills, and services needed for positive behaviour change.

Expected results:
- Developed policies and strategies, embedded in a human rights and youth participation framework, which promote and support young people's access to SRH and HIV information, interventions, skills development and quality services.
- Improved capacity to plan, manage and provide SRH/HIV/AIDS programmes and services that mitigate the negative social impact of HIV/AIDS on adolescents and youth.
- To have contributed to the design, development and provision of essential tools and instruments for the management of the Generation Biz Programme and YFS service provision.
- Strengthened multisectoral coordination at central, provincial, district and local levels resulting in more effective resource allocation, integrated activities, and youth-friendly SRH services.

The following were also added to the programme's guiding principles:
- The right of young people to high quality SRH services.
- Community involvement and youth leadership to address ASRH issues.
- Ethical responsibility of young people.
- The promotion of unity and cooperation among youth to advocate for ASRH issues.

The new guiding principles emphasized young people's responsibility and capacity to evoke change and their right to high quality services and good health.

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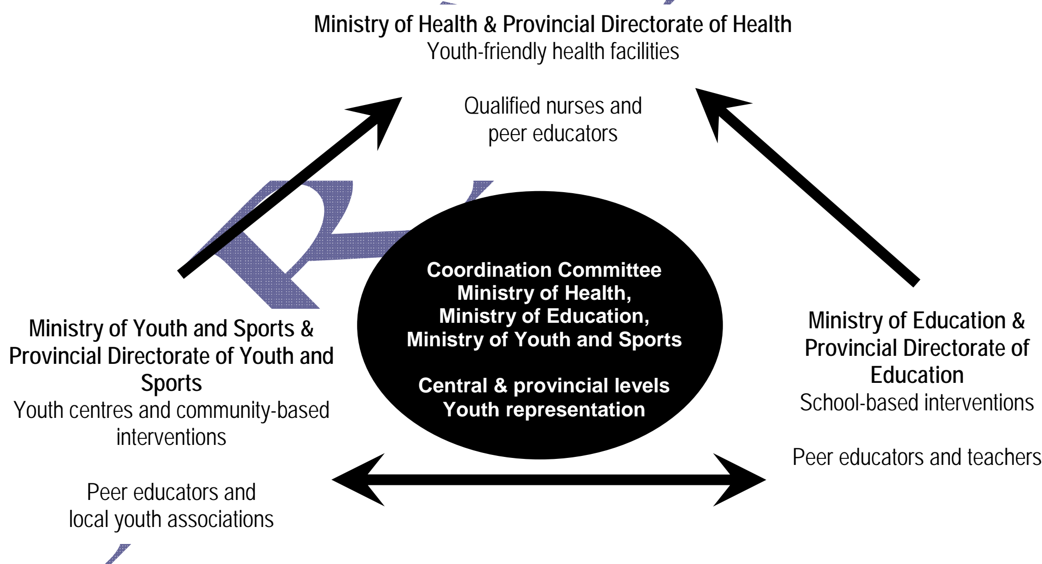
Multisectoral implementation model
The multisectoral design of Geraçao Biz relies on the coordination and collaboration of three implementing government partners and civil society (i.e. youth NGOs and youth associations). The MOH is responsible for establishing a network of youth-friendly health facilities where young people can receive a range of SRH services such as counselling, contraception, STI prevention and treatment, antenatal and postnatal care, postabortion care as well as VCT and ART in some instances. The MOE oversees the in-school interventions including peer education, adolescent counselling corners in primary and secondary schools, and intra- and extra-curricular SRH/HIV education. Referral linkages are established between the teachers, peer educators, adolescent corners and the YFS facilities to increase service utilization and maximize impact. The MOYS manages the community outreach component which includes out-of-school peer educators and community-based youth centres where young people can receive counselling, condoms and referrals for clinical YFS. Youth associations/NGOs also provide support to networks of in- and out-of-school peer educators. Figure 1 illustrates the interconnectedness of the three components and the implementing partners.

Figure 1: Multisectoral implementation model



As with the school-based component, considerable effort has been made to strengthen referral linkages with the nearby YFS facilities. In some cases, peer educators conduct information sessions in the waiting room of the YFS facilities and help with other duties, while providers from the YFS facility visit schools or youth centres involved with the programme on a rotational basis. In addition, peers and providers hold joint quarterly meetings to share experiences and strengthen interaction between the two entities. These cross-linkages have helped peers feel more comfortable referring young people to the YFS sites and

have reinforced the need for providers continually to reach youth with SRH information and services.

Implementing partners and management structure

It is important to note that Geraçao Biz is not viewed as an external project but is rather part and parcel of the Government's overall mandate. Programme activities are integrated within each sector's work plan. For example, clinical YFS is situated within the context of the national health services and is supported by MOH policy.

Within each sector (health, education, and youth and sports) there are implementing partners at the central, provincial and district levels. While management and coordination happens at all three levels (central, provincial, and district), direct implementation of programme activities primarily occurs at the district level. Figure 2 outlines the various partners' responsibilities.

Figure 2: Implementing partners

Central Level

MOH-The School and Adolescent Health Section of the MOH is responsible for overall coordination and implementation of clinical YFS.

MOE-The National Institute of Educational Development at the MOE is responsible for overall coordination and implementation of school-based interventions.

MOYS-The National Directorate of Youth, operating under the MOYS, is responsible for overall coordination and implementation of community-based outreach.

Provincial Level

DPJD-Provincial Directorate of Youth and Sports is responsible for provincial management of the community-based outreach.

DPE-Provincial Directorate of Education is responsible for provincial management of school-based interventions.

DPS-Provincial Directorate of Health responsible for provincial management of clinical YFS.

District/Community Level

DDS/DSCM- District Directorate of Health/City Directorate of Health is responsible for direct implementation of clinical YFS.

DDE/DEC: District Directorate of Education/City Directorate of Education is responsible for direct implementation of school-based interventions.

Youth Associations-Various youth associations are responsible for direct implementation of school-based and community-based peer education programmes and outreach activities.

As with other aspects of the programme there has been some evolution in the management and coordination structure over time to respond better to programme expansion and maturity. In the pilot phase, DNAJ (MOYS) was given responsibility for the multisectoral programme coordination. This decision was based on the fact that DNAJ (MOYS) was the chair of CIADAJ and the multisectoral programme emanated from the CIADAJ plan of action, and also because as a new ministry, DNAJ (MOYS)'s role in programme implementation was less clear. However, there was lack of clarity regarding CIADAJ's role versus DNAJ (MOYS) and this resulted in some unmet expectations. In addition, DNAJ (MOYS) was a young entity and required further capacity building. The recognition of the coordination challenges during the pilot phase coupled with the expansion of the programme and more clarity in each sector's roles and responsibilities led to the decision that such an extensive multisectoral project could not be done by one agency alone.

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Therefore a new multisectoral coordination and management structure was established in 2002 at the central, provincial and district levels. This new coordination and management structure was supported by the preceding development of sectoral policies that included provisions for implementation of ASRH and HIV prevention activities (e.g. MOYS' Outreach Strategy for Out-of-School Youth, the MOE's National Strategy for HIV/AIDS) and the culmination of the First National Youth Meeting and the resulting Chokwe Declaration. The Chokwe Declaration's Monitoring and Evaluation Plan underlined the need for interventions to reduce high risk behaviour among 10-24 year olds and highlights priority actions such as expanding YFS, increasing young people's ability to negotiate safer sex, promotion of dual protection and VCT, and expanding the training of service providers.

The management and coordination structure is as follows at the various levels:

Central level:

Project Directors: Senior staff from each respective ministry serve as project directors at the central level. They are responsible for the overall coordination, management, monitoring and evaluation of programme activities.[23]

Technical Advisers (TAs): Each sector has a technical adviser, supported by UNFPA and technical assistance from Pathfinder International, who resides within the respective ministry and provides on-site daily technical assistance related to programme planning, implementation, and monitoring and evaluation. A chief technical adviser (CTA) oversees all programme aspects and supervises the central level technical advisers, who in turn supervise the provincial technical advisers.

Central Management Committee: Due to the complex nature of the project, there is a central management committee which is made up of the different sectoral project directors, the central level technical advisers, the Pathfinder International chief technical officer, the UNFPA ASRH team director and other UNFPA officials. In 2007, the National AIDS Council was asked to join the committee as well. The management committee holds quarterly meetings where decisions are made, work plans and budgets are harmonized, and expansion to new locations and joint activities are approved. The management committee also ensures that the multisectoral approach is present throughout all stages of the programme. The technical advisers provide technical support during the committee meetings but do not vote or make decisions. The committee chair rotates on an annual basis. Currently, the MOE is the central level chair.

Provincial level:

Project Directors: Like the central level, each province has provincial project directors comprised of senior staff from the three provincial directorates (health, education, and youth and sports). They are responsible for provincial level coordination, management, monitoring and evaluation of programme activities.

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Technical Advisers: Each province has its own technical advisers for each of the three components. They are based in the provincial directorates of health, education, and youth and sports. These provincial level technical advisers provide direct support to local NGOs and youth associations and report to the central level technical advisers.

Provincial Management Committee: A management committee also exists within each province although there is additional representation from other provincial level collaborators (e.g. youth associations, NGOs, bilateral and multilateral agencies, other ministries, and the Provincial AIDS Commission) as well as youth representation. Their responsibilities are similar to that of the central level management committee although focused on programme implementation within each province.

Technical Meetings: Quarterly technical meetings for YFS service providers are held in each province to ensure that service providers' skills and knowledge are up to date.

Funding: Currently financial support flows from UNFPA to the respective provincial directorates for programme implementation, although there is a move to decentralize funding so that districts can also directly access funds needed for implementation. In addition to these external funds, the Government also allocates its own resources at the central and provincial levels to support Geraçao Biz activities.

District level:

Project Directors: The project directors at the district level are comprised of senior staff from the district directorates of health and education and the provincial directorate of youth and sports.[24] Unlike the clinical and school-based components, direct implementation of the community outreach activities is conducted through local youth NGOs or youth associations rather than the public sector.

Coordination and Technical Meetings: Quarterly coordination and management meetings, similar to the management committee meetings, are held at district level and comprise representatives of three sectors as well as other district level partners (e.g. youth associations). These coordination meetings are to plan, coordinate, and monitor programme activities. To strengthen linkages between the in-school, the out-of-school and the clinical YFS component, quarterly district level technical meetings are held between peer educators and service providers. District directors facilitate the meeting with involvement of the provincial level staff. In districts where there are multiple YFS sites, health providers and district directors also meet quarterly.

Collaboration with other donors (NORAD, DANIDA, SIDA, Trocaire)

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Geraçao Biz has enjoyed the support of a multitude of donors allowing for nation-wide scale-up. The first phase of the programme was supported by UNFPA and DANIDA. However, given the mandate to expand the programme to cover all the provinces in the country, support was solicited from other European donors. UNFPA/Pathfinder International in conjunction with the three implementing ministries organized a study tour for donors. Geraçao Biz was an attractive programme for donors to invest in given that it is a government-implemented multisectoral programme that addresses two key donor programme areas: adolescents and HIV. Because it was designed to be a national programme, it allowed donors to achieve more impact for their investment while funding expansion of Geraçao Biz within their respective priority provinces. NORAD and SIDA joined forces with UNFPA and DANIDA making national level scale-up possible. In addition, Geraçao Biz has also partnered with Trocaire to implement the three programme components in the district of Buzi in Sofala Province. This was in addition to the other districts already implementing Geraçao Biz within Sofala.

While the Government of Mozambique's financial contributions were not formally documented within the programme, the Government has supported the programme through the allocation of 90 staff members who work at least part-time on the project, infrastructure such as health facilities and schools that are used for programme activities, financial support for renovations (e.g. they supported the construction of the YFS centres in Inhambane Province), and provision of clinical equipment and other materials.

V. PILOTING GERAÇAO BIZ

In the initial phase of the programme, technical advisers worked with the central level to develop strategic plans and supportive policies, programme materials and tools, and mechanisms for coordination and oversight. One of the first steps that the MOH took to establish YFS was to define the characteristics of a youth-friendly clinic and identify a minimum package of SRH services (see Figure 3 for details).

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Figure 3: Characteristics of YFS

<u>Provider's characteristics:</u>
- Specially trained provider
- Respectful to youth
- Ensures confidentiality
- Allocates enough time for interaction with youth

<u>Facility characteristics:</u>
- Stand-alone space or special hours for delivering the services
- Accessible location
- Adequate site/privacy
- Comfortable surroundings

<u>Programme characteristics:</u>
- Youth involved in the design, giving continuous feedback
- Short waiting time
- Free of charge or subsidized fees for services
- Publicity for mobilizing youth for YFS
- Young men welcomed
- Referral when needed
- Availability of Behaviour Change Communication material at the YFS facility and to take home
- Group discussion on ASRH and HIV prevention in the waiting room
- Alternative ways to access information and counselling services

Minimum service package
- Information and counselling on SRH
- Contraceptive information, counselling and provision of methods
- STD prevention and treatment
- HIV information and referral for Voluntary Counselling and Testing is not available on site
- Pregnancy testing, prenatal and postnatal care
- Post-abortion care and referral
- Referral for more specialized services as needed
- Psychological support or referral if not offered on site

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Maputo City and Zambezia Province were selected as the first two sites by the Government in consultation with UNFPA, based on the following factors: high

population density, poor health infrastructure, and poor health indicators such as high maternal mortality, low Contraceptive Prevalence Rate and high prevalence of early childbearing. The city/provincial directorates of the two pilot sites developed work plans, budgets and mechanisms for technical support and monitoring of programme activities. Maputo City chose to pilot three different approaches to YFS:

- An adolescent-only clinic affiliated with the Central Hospital of Maputo.
- An adolescent clinic attached to a vocational training programme (i.e. Mozarte Centre).
- Integration of YFS within existing public sector facilities. Initially six public sector facilities were chosen within Maputo City based on the results of the facility assessments conducted by the MOH and UNFPA.

In Zambezia four public sector facilities within Quelimane City were chosen based on the facility assessment results, followed by the selection of one facility in each of the seven other districts in the province for a total of 11 YFS facilities. After the facilities had been identified, discussions were held with the facilities' senior management in order to solicit commitment. Advocacy with the community was also undertaken to ensure that there was support for YFS and to counter any opposition to offering SRH services to young people.

As part of it capacity building and technical assistance role, Pathfinder International worked with the MOH to adapt and translate Pathfinder International's training curriculum on YFS. This training curriculum was adopted by the MOH and used to conduct two trainings of trainers (TOTs). Planning for future expansion, the TOTs not only included trainers from the two pilot sites but also from other provinces. These trainers then conducted step-down training for service providers from Maputo City and Zambezia. Participants were selected by their supervisors based on the following criteria: willing to work with adolescents, willing to learn, friendly, open, able to communicate, and treating people with respect. The training included both theory and a practicum covering topics such as adolescent development, communication with adolescent clients, STI prevention and treatment, HIV/AIDS, counselling, contraceptive options for adolescent clients, pregnancy, gender-based violence and gender, and making services more youth-friendly.

Selected facilities were rehabilitated and refurbished based on the assessment results. Young people were involved in decisions on how to arrange the space for YFS and how services should be set up. Particular attention was placed on improving visual and auditory privacy and ensuring that essential equipment was available.

Capitalizing on the efficacy of social marketing techniques to reach young people, the programme worked with young people to develop a brand name "Geraçaõ Biz" or "Busy Generation". The brand name and logo were used at all YFS services delivery points, schools and youth centres as well as in the

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promotion of any programme activities. Once YFS was established, meetings were conducted with the community and participating schools to make them aware of the services and how to access them.

Figure 4 outlines the steps taken to implement YFS within the pilot sites. Given the dearth of monitoring tools and Management Information System (MIS) formats that captured youth data, a great deal of effort went into the development of a monitoring system and accompanying tools. This was seen as an essential task given the need to use data and lessons learned from the pilot phase to inform the design and implementation of subsequent scale-up to other provinces.

Figure 4: Steps taken to implement YFS

Central level:

- Developed characteristics of YFS and a minimum service package.
- Selected project sites in consultation with Government and UNFPA based on selection criteria.
- Developed ASRH training curriculum.
- Conducted TOT.
- Developed mechanism for youth involvement so that young people could be involved in the design, monitoring, and implementation of YFS.
- Worked with young people to develop BCC materials for use in YFS facilities. Developed MIS that allowed for clients to be disaggregated by age and developed monitoring forms.
- Monitored activities and progress.

Provincial/district levels:

- Conducted facility needs assessment that examined issues of provider training, the facility environment, confidentiality and privacy, range and quality of SRH services provided, needed equipment and materials, hours of operation and cost of services.
- Selected YFS sites based on assessment results.
- Trained service providers.
- Rehabilitated and equipped clinics so they were youth-friendly and offered privacy during counselling and consultation.
- Oriented other facility staff on ASRH and communicating with young people.
- Conducted sensitization meetings with the surrounding YFS community in order to mobilize community support for addressing ASRH.
- Monitored activities and progress.
- Conducted quarterly technical meetings for service providers to exchange information and reinforce key issues like privacy and confidentiality.

The minimum package of services described above was offered to youth clients during set hours. While the adolescent clinic at the Central Hospital is open 7:00-15:00, other YFS facilities had more limited hours for YFS (e.g. one facility offers YFS 14:00-17:00 three days a week). Although adolescents were served whenever they came, they were served with the adult clients if they came outside the designated hours. A typical visit is described in the box below.

Typical youth visit to YFS facility
(adapted from the World Bank, Education and HIV/AIDS: A Sourcebook)

When a youth client comes to the YFS facility for the first time, s/he is greeted and asked to fill out a registration card. While waiting to be served, youth clients either watch videos on ASRH or HIV prevention or talk to peer educators who work at the facility. The provider counsels and attends to the youth based on the nature of the visit. If the client is sexually active, the provider discusses a range of contraceptive methods, the advantages and disadvantages of each method, the fact that only condoms prevent STI/HIV, and then demonstrates how to use a condom. Dual protection is the main message that is promoted during these visits. The provider also may discuss self-esteem, life skills such as negotiation skills, or other issues like relationships with parents or family. If there is a problem that the provider cannot address, the patient is referred. In the case of Maputo City, complex cases are referred to the adolescent clinic at the Maputo Central Hospital.

During the pilot phase, technical assistance at both the central and provincial levels was continuous and provided on-site to ensure that government staff were fully integrated in the programme. Technical advisers worked hand-in-hand with government programme staff, developing work plans and tools, implementing activities and monitoring progress. Besides, skills building in management, planning, monitoring and evaluation, technical advisers transferred technical knowledge on ASRH and HIV prevention.

Results

In July 2001, UNFPA commissioned two consultants to conduct an external evaluation of the pilot phase. Unstructured interviews were conducted with providers, students, and youth clients to assess perceptions of the project and identify areas for improvement. The evaluation found that the YFS facilities were functioning well and that young people felt the services were relevant and able to meet their SRH needs. Facility staff were found to be well informed, willing to work with young clients, and treated youth clients with respect. Counselling and clinical services were found to be of quality, resulting in a significant increase in youth service utilization in the three years that the project had been operating (1,173 youth visits in 1999 to 18,809 visits in 2001 in Maputo City and only a few youth visits in 1999 to 11,673 youth visits in 2001 in Zambezia Province). Condom distribution also increased significantly from 2,472 to 146,894 in Maputo and from 26,800 to 230,661 in Zambezia.

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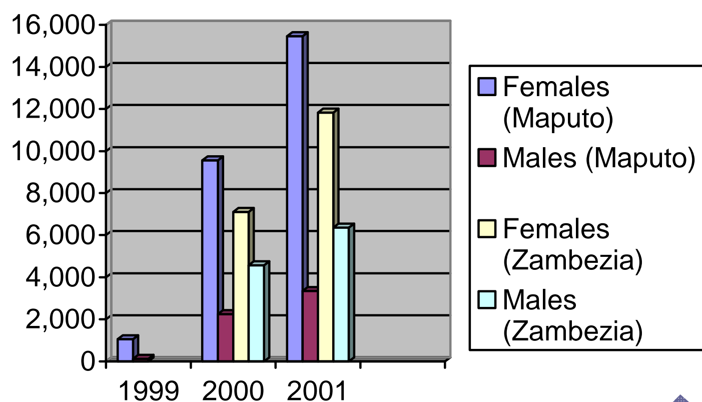
Figure 5: Youth visits disaggregated by sex in pilot sites 1999-2001



While noting the success in attracting young clients for SRH services, the evaluation does note that the youth client profile was disproportionately female and in-school. The high proportion of female clients as shown in Figure 5 is in keeping with many other countries. This is due in part to young women coming for antenatal care and contraception, the fact that SRH services were traditionally set up for women contributing to the perception that SRH services are only for women, and gender norms that make young women feel more comfortable discussing their problems with people they don't know than their male counterparts. The evaluation report recommended that different approaches be tested to increase male utilization of services and that the outreach component of the project should be strengthened to increase range to out-of-school youth.[25,26,27]

Evaluation results were then shared with all programme stakeholders at both central and provincial levels and recommendations were discussed and incorporated into the second phase work plans (e.g. extra focus was placed on strengthening the outreach component and building the capacity of the MOYS and DPJS to coordinate effectively and monitor programme activities).

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VI. Scaling Up Geraçao Biz

The following timeframe illustrates the progression of the development of the programme and scaled up coverage.

Pre-1999	• Advocacy with Government and community on ASRH
1999	• Multisectoral programme designed to be scaled up • Needs assessment carried out by MOH • YFS integrated into six existing health facilities, adolescent-only clinic established in Maputo Central Hospital, and YFS offered at Mozarte Vocational Centre in Maputo City • YFS integrated into four facilities in Zambezia Province • Technical assistance provided within the Government
2000	• Branding of Geraçao Biz and advertisement of YFS facilities • Initiate development of IEC/BCC materials with high level of youth participation • Phase 2 scale-up begins - YFS integrated into four facilities in Gaza
2001	• KAP and client satisfaction surveys conducted • IEC/BCC materials disseminated • INJAD (National survey on adolescents and youth) conducted • External evaluation of pilot phase • Scale-up to Maputo Province - YFS integrated into four facilities
2001/2	• Consolidation as a national programme • Formally recognized as a multisectoral programme (MOH, MOE, MOYS) and NGOs • Full integration of HIV/AIDS content, which enhanced community involvement • Scale-up to Tete Province - YFS integrated into four facilities
2003/4	• Electronic M&E system developed • Scale-up to Cabo Delgado - YFS integrated into two facilities
2004/2005	• External evaluation conducted • Scale-up to Inhambane - YFS integrated into eight facilities • Scale-up to Niassa - YFS integrated into three facilities
2005/6	• Phase 3 scale-up begins - YFS integrated into 15 facilities in Sofala • Conceptual framework on vulnerability added • New capacity-building approach • Stronger emphasis on sexual and reproductive rights • HIV/AIDS full package including ART integrated into select sites • Results oriented, evidence based practices documented and disseminated
2007/2008	• Scale-up to Nampula and Manica

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From the outset Geraçao Biz was designed by the Government of Mozambique with guidance from UNFPA to be scaled up to a national programme. Scale-up consisted not only of expansion to new provinces but also increasing coverage by expanding the number of YFS sites within each province. In the pilot phase, the Government, in consultation with donors, selected the sites based on HIV prevalence, need and donor funding interests. As the number of donors supporting Geraçao Biz grew (see Collaboration with Other Donors), more provinces were selected for scale-up. In 2005, there was consensus to support the overall development of the programme with an understanding that a portion of the funding would be specifically allocated to the respective donor's priority provinces. This allowed for increased government ownership and decision-making regarding which provinces to select for expansion.

Key interventions to scale up programme activities to new provinces included:

- Needs assessment to determine where to expand.
- Coordination between the three sectors to determine which districts to select and how many schools, facilities and communities in which to work.
- Technical assistance provided to the respective sectors of the new provinces. Approaches, tools and steps to YFS developed under the pilot phase were then applied (see Figure 4) in each expansion site.
- Establishment of provincial management committees, project directors, technical advisers, and coordination mechanisms (see Implementing Partners and Management Structure).
- Experience exchange between the new provinces and existing provinces, programme meetings held in Maputo so that the new provinces could learn from the Maputo experience, and application of lessons learned from earlier stages of implementation.

Specific to the youth-friendly clinical component, the three models piloted in Maputo City were reviewed for scale-up. While the adolescent-only clinic in Maputo Central Hospital received a large number of youth clients, a stand-alone facility is usually only cost-effective in very large cities. Given overall resource constraints, youth population in the expansion sites, and the sustainability of the public-sector service delivery, integration of YFS within existing health facilities was chosen as the model to scale up.

Scale-up of Geraçao Biz was greatly facilitated by the programme's dynamic response to challenges, a culture of curiosity and willingness to learn, and a flexible design and management style that allowed for change. As discussed earlier, Geraçao Biz prides itself on being a programme that embraces learning and strives to improve its efficacy and cost-effectiveness by using monitoring and evaluation data to revise and adapt programme approaches and interventions. The programme's technical approach has expanded over time to include the following essential elements: framework of vulnerability (individual, programmatic, and societal), multisectoral approach, capacity-building of local

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ministries, institutions, and personnel, emphasis on human rights, and sexual and reproductive rights, full package of HIV/AIDS services including ART, and results-oriented using well defined targets based on Mozambican national and sectoral policies.[28] Examples of how this expanded technical approach has been applied include:

- The use of Jonathan Mann's vulnerability framework[29] to address the different levels of vulnerability that young people face with regard to HIV and ASRH issues. Vulnerability is incorporated into programme discussions, different types of training (e.g. TOT, provider training and teacher training). Specific interventions have been developed to mitigate vulnerability such as addressing gender-based violence, intergenerational sex, and substance abuse within programme activities.
- Human rights are used as a platform to discuss and address various programme issues. For example, issues of gender from a human rights perspective are explored within peer education training and school and community-based interventions. Acknowledging the rights of HIV-positive youth led to the establishment of support services, treatment and support groups within Geraçao Biz.
- Capacity building is focused on management and technical skills development of local counterparts and systems development (i.e. financial, monitoring and management systems). In some cases, local counterparts are given scholarships to help them complete a related university degree. As a result, some of the early project sites (e.g. Maputo, Tete, Zambezia, Gaza, and Cabo Delgado) now only have one technical adviser as opposed to three as the provincial directorates are now able to take on much more by themselves.[30]

Community involvement

During programme scale-up, community involvement played a more prominent role in creating a supportive environment for the provision of YFS and addressing ASRH issues. In Inhamabane Province, before even establishing YFS, sensitization sessions were conducted at the provincial level to discuss the programme and the need to address ASRH issues through a multisectoral approach that included YFS. This was followed by district level sensitization sessions where traditional and community leaders, parents, and youth were invited from each implementing community as a way to encourage community participation, facilitate programme ownership, and create a supportive environment for programme interventions, especially YFS.

Once YFS were up and running, provincial and district staff conducted a community launch of the new services. The opening ceremonies of the YFS sites brought together community stakeholders, the media and parents. Additional meetings were held with community and traditional leaders to discuss HIV/AIDS, ASRH, and to introduce the newly established YFS.

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Multisectoral coordination ensured that the education sector sensitized students and their parents on the need for services while the community outreach component targeted out-of-school youth and community members. District-level project coordinators conducted periodic meetings with parents to discuss teenage pregnancy, the use of YFS to prevent unwanted pregnancies and ways to help pregnant adolescents stay in school.

Certification of YFS

While in the early stages of implementation, the emphasis was on key interventions to establish YFS, the focus has shifted to improving service quality. Facility assessments using the Pathfinder International YFS facility assessment tool provided guidance on which areas of service delivery needed improvement. These assessment results were used to determine quality improvement activities. To establish a benchmark for "youth-friendly services", Geraçao Biz adapted Pathfinder International's YFS certification tool developed under the African Youth Alliance. The certification tool looks at key elements of YFS (e.g. privacy, confidentiality, range of services and methods provided, competent staff, short waiting times, convenient hours, affordable fees and a comfortable environment) and uses a scoring system to rate each element. Geraçao Biz is currently collaborating with the MOH to assess and certify YFS facilities in Maputo. The certification process provides a clearly articulated and objective standard that all facilities must meet in order to be certified by the MOH.

Results

External evaluation 2004

At the request of the donor, a group of consultants conducted an external evaluation in October 2004, focusing on Maputo City, and Maputo, Tete, Zambezia and Cabo Delgado Provinces. The scope of work was to conduct a broad, systematic evaluation, including analysis of collected data, to understand better programme successes and weaknesses in light of possible expansion (i.e. Phase 3). Information and data were collected through: a review of programme documents, a review of monitoring data and research findings, interviews (including focus groups) with stakeholders and beneficiaries, and observation of services and programmatic interventions.

General findings

The evaluation concluded that Geração Biz was a well-known and respected programme with good potential for sustainability and expansion and that there was evidence of significant impact of the programme on young people's knowledge, attitudes and behaviour (see KAPB results below). The evaluation report called for greater emphasis on the issue of intergenerational sex as it is a driving force in the HIV epidemic. It also recognized the progress in establishing an enabling policy environment but concluded that more work was needed to make ASRH a top policy issue if programme goals were to be achieved.

Youth-friendly services and linkages

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The evaluation showed that most designated YFS facilities have trained providers that "appear to be comfortable in their work, able to relate well with their young clients, who, in return find them respectful, caring, and able to deal with their needs", confirming the results of the client satisfaction studies that were conducted (see below).[31] As a result youth visits have steadily increased (see Figures 9 and 10). For example, youth visits in Maputo City increased from about 11,800 in 2000 to over 24,000 in 2003.

Although YFS received generally favourable reviews, some weaknesses were identified: a) concern about confidentiality, and whether referral providers (e.g. VCT providers) have been oriented in youth-friendly communications; and b) project design issues such as the need to extend YFS to a broader area for adequate coverage and the problem of service providers reporting directly to the programme technical advisers versus the facility manager as is normally the case.

In-school and out-of-school peer educators were found to be referring youth clients to the YFS facilities, which accounted for some of the increased demand for services. However, out-of-school peers were hampered by limited resources needed for support and implementation. Youth involvement was seen to be strong with regard to implementation activities and some aspects of programme design and monitoring, but weaker in governance, ongoing input to programme design and management.

The report recommended that:

- More training, including refresher courses, was needed to address weaknesses or gaps, such as the issue of confidentiality.
- Providers of referral services be trained or oriented in youth-friendly communication.
- Plans be developed to expand YFS to health centres in districts where Geraçao Biz is operating.
- YFS providers are mainstreamed in the clinic management structure.
- A study should be conducted to determine ways (channels, organizations, and other means) to reach effectively the out-of-school population, including the most vulnerable and illiterate.
- Peer educators receive a continuous and sufficient supply of materials and condoms to do their work, and are able to obtain a re-supply when needed.
- The programme should identify incentives that are valuable and motivate peer educators; suggestions such as reserving space in secondary schools and opening slots for paid training positions. The programme should also try linking with projects that provide livelihood and income-generating activities to help meet the needs of their peer educators (and not try to provide these directly).

Multisectoral approach and programme sustainability

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Geraco Biz's multisectoral approach was credited with contributing to improved communications and interactions among government institutions and sectors. In addition, the capacity-building and technical assistance related to ASRH (including HIV/AIDS) competencies, management skills, internal policies, strategic planning, and public policy development was viewed by the three sectors as useful and relevant to the achievement of programme goals. While considerable efforts had gone into developing a contingency of qualified public sector staff that can carry the programme forward, additional human resources would still be needed for successful scale-up.

The evaluation team identified programme sustainability as a key challenge that would need to be addressed in the following phase of the programme. However "in spite of the challenge, Geraçao Biz has made significant gains in institutionalizing its activities as regular functions within government agencies" which is critical to long-term sustainability. The evaluation also stated that "in view of considerable need for, and interest in, expanding the [programme to a national level], information about project costs and cost-effectiveness of various activities would be most valuable."[32]

The following key recommendations were offered in the evaluation report:

- Key players involved in the programme (TAs, Project Directors, Project Coordinators) at all levels should receive training to help advocate for Geraçao Biz as a sustainable, government programme.
- There is a need for clarification of roles; especially in multisectoral opportunities, efforts should be made to increase synergy and reduce duplication. Lines of authority should be clarified to ensure more effective implementation of the project.
- Criteria for selection of trainers should be developed, certification standards established, and performance evaluations conducted.[33]

Client satisfaction studies

In 2004, GBP conducted a youth client satisfaction study in 14 YFS facilities in Maputo City and Gaza and Maputo Provinces. The study measured clients' satisfaction with the facility environment, administrative and operational procedures, and the quality and range of available services. The study was designed to yield useful results to improve the quality of programme interventions and YFS. The study sought to determine the extent to which services at the YFS sites were youth-friendly and the overall quality of services. 1,400 structured interviews were conducted using a structured questionnaire of 35 close-ended and 5 open-ended questions. Due to the sensitivity of the information that was being asked and the fact that youth reported being more comfortable discussing such SRH issues with other youth, trained peer educators conducted the interviews. Data was then disaggregated and analyzed by province to capture provincial differences in the quality of services offered and clients' satisfaction with existing services. The study revealed overall satisfaction with the services

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offered (e.g. 98.1% of clients in Gaza reported that services were excellent or good). Study results are highlighted in Figure 5 below.

Figure 5: Satisfaction with facility environment and operations by characteristic

CHARACTERISTIC	GAZA	MAPUTO	MAPUTO CITY
Able to access the facility during current schedule of operation	84.6	91.4	89.3
Would prefer a more convenient schedule of operation from 8:00-15:00	54.3	70.4	58.1
Clean environment	93.3	96.2	94.6
Friendly environment	81.7	94.1	93.4
Privacy ensured	76.9	91.1	82.9

Figure 6: Indicators of quality youth-friendly services

QUALITY INDICATOR	GAZA	MAPUTO	MAPUTO CITY
Spoke with a peer educator	47.1	9.2	14.6
Availability of reading material	34.1	5.9	16.3
Discussed the importance of contraception	67.8	47.9	71.2
Provided information on available FP methods	68.8	42	53.5
Discussed the importance of the using a condom	79.3	67.2	84.0
Discussed what to do in the case of STI	78.4	54.1	70.6
Discussed how to involve the partner in the prevention of STI/HIV	79.8	45.0	64.1
Provider showed how to use a condom	79.3	58.0	64.0
Discussed importance of VCT and where to get tested	81.3	68.6	59.5
Discussed condom negotiation with sexual partner	55.8	35.5	47.4
Discussed gender-based violence	44.7	13.9	30.3

Figure 7: Overall rating of YFS

	GAZA	MAPUTO	CID. MAPUTO
Excellent	37.5	14.8	33.9
Good	60.6	76.9	61.5
Bad	1.9	8.3	4.6

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Key recommendations from the study included:

- Extend the hours of YFS operation. It was suggested that services be offered any time during regular facility operating hours (i.e. 7:30-15:30) as well as during the weekends.
- Increase the number of health professionals dedicated to serving youth.
- Considering the number of facility staff dedicated to YFS is increasing, and the quality of existing YFS providers' skills may vary, there is a need for regular refresher training.
- Incorporate more discussion about abortion, STIs, gender-based violence and sexual abuse within the context of service visits even if clients do not request it. Subjects such as the use of condoms for dual protection, sexual pleasure within relationships, and negotiation skills also need to be explored more during youth client visits.
- Increase routine screening or discussion of Gender-Based Violence (GBV) within any service visit to ensure that youth who have experienced GBV are able to receive the necessary support. Specialized training in GBV can help bolster provider's comfort with discussing such sensitive and difficult issues.
- Involve community leaders in efforts to mobilize young people to seek services when needed.
- Conduct an analysis of materials available in the waiting rooms to verify the types of messages as well as the number and attractiveness of materials.
- Deploy more in- and out-of-school peer educators to work in the waiting areas of the YFS sites as a way to promote linkages between the three components of the programme.
- Offer free STI treatment, including drugs at YFS facilities and offer VCT and antiretroviral therapy to HIV+ youth clients at YFS facilities.

KAPB studies
Changes in SRH and HIV knowledge have been tracked through ASRH and HIV/AIDS Knowledge, Attitude, Practices and Behaviour (KAPB) studies conducted in 2003 and 2005 in Maputo City, Zambezia, Gaza, Tete, and Maputo Provinces. The charts below highlight some key indicators. [34]

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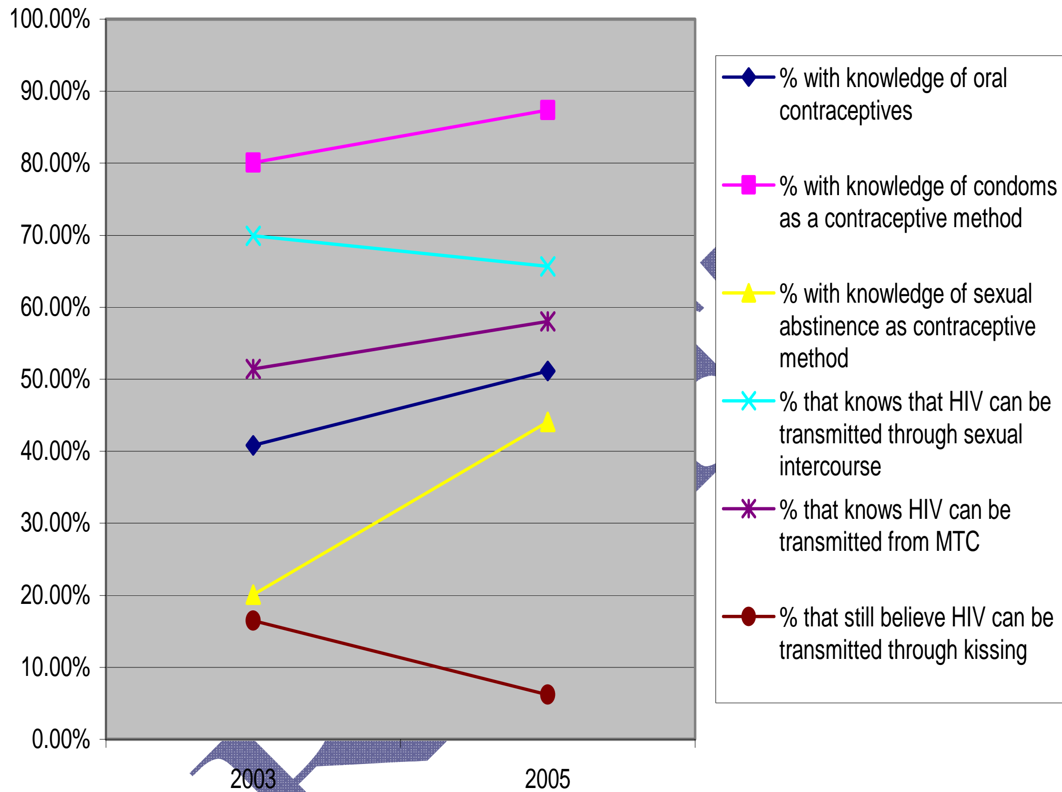
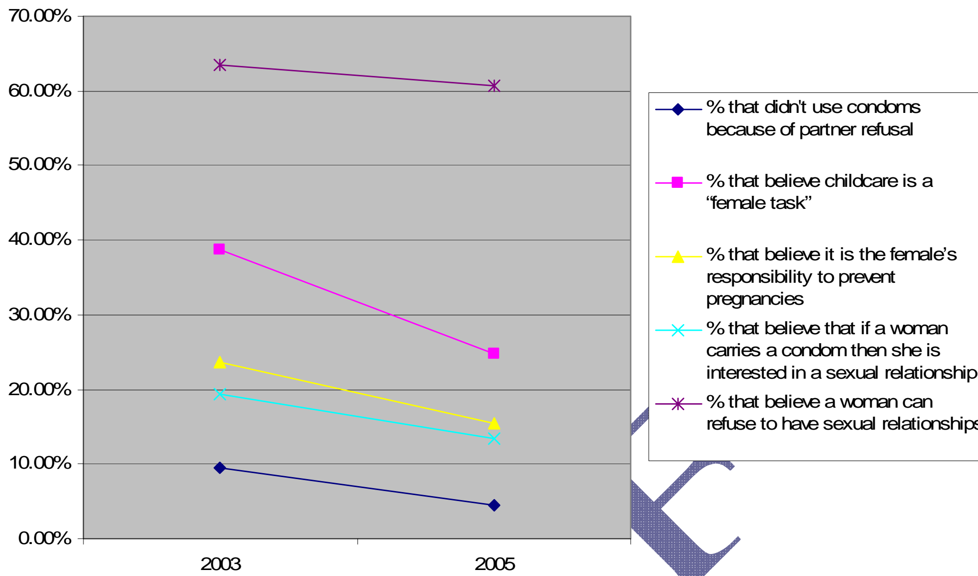
Chart 1. Knowledge about Sexual and Reproductive Health and HIV issues. GBP 2003-2005



Knowledge of contraceptive methods increased while knowledge of abstinence as a protective method showed a significant increase from 20% in 2003 to 44% in 2005. Respondents' access to information through peer educators increased from 43.8% in 2003 to 65.6% in 2005.

Chart 2. Attitudes abouth gender and SRH. PGB 2003-2005



The belief that HIV can be transmitted through kissing dropped to 6.2% in 2005 from 15.6% in 2003. While certain attitudes related to gender such as belief that childcare is only a female task dropped to 24.8% in 2005 from 38.8% in 2003, and belief that it is the female's responsibility to prevent pregnancy dropped to 15.5% from 23.7%.

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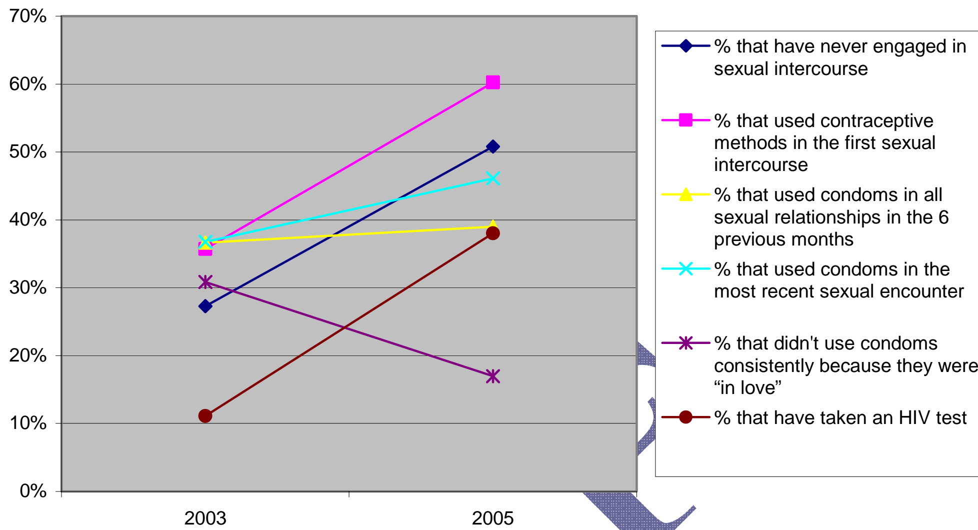
Chart 3. Behaviour changes about HIV prevention among adolescents and young people PGB 2003-2005



Use of contraceptive methods during the first sexual experience increased from 35.7% to 60.2%. Comparatively condom use in the first sexual relationship is higher (43.4%) than the use of oral contraceptives (15%). Consistent condom use even when "in love" increased from 70% to 83%. Among respondents, 38% had undergone VCT in 2005, compared to 11% in 2003. It is important to highlight that of those who were tested, a significant decrease in those who reported a positive test was noted: 18.6% in 2005 compared 57% in 2003.

Overall achievements of YFS clinical component

While the overall improvements in knowledge, attitude and behaviour are a result of a multisectoral effort and cannot be attributed solely to the information and counselling received at the YFS facilities, these results would not have been possible without the YFS component. The figures below illustrate how the number of YFS facilities, trained providers, and trainers as well as programme coverage has grown over time. Figures 9 and 10 also show that the availability of YFS can greatly increase SRH service use by young people. While some of this increase is due to increased numbers of YFS sites over time, much of it is due to increased number of youth clients per facility.

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Figure 8: Key achievements related to YFS as of December 2006

PROVINCE (START DATE)	MAPUTO CITY (1999)	ZAMBEZIA (1999)	GAZA (2000)	MAPUTO PROV. (2001)	TETE (2002)	CABO DELGADO (2003)	INHAMBANE (2004/2005)	NIASSA (2005)	SOFALA (2006)
Number of YFS sites	17	23	18	19	14	29	11	3	15
Number of YFS with/nearby VCT	2	7	11	10	12	9	9	1	5
Number of providers trained	128	59	126	99	68	47	41	59	N/A
Number of trainers trained in YFS	14	15	8	12	13		12	none	8
Number of young people reached through peer educators at YFS facility	24,109	28,997	21,719	46,326	9,196		13,748	9,123	

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Figure 9: Visits by young people at YFS facilities by gender and site 2000 to 2006								
		2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Maputo City	Females	9,561	15,466	20,928	19,549	20,832	22,285	25,505
	Males	2,255	3,343	4,133	4,478	5,739	4,108	4,892
Gaza	Females			809	8,461	15,073	17,125	17,726
	Males			405	3,687	3,895	4,719	3,993
Zambezia	Females	7,110	11,826	8,544	12,033	19,532	18,455	17,174
	Males	4,563	6,353	4,874	4,148	6,871	9,384	9,737
Maputo Province	Females			169	2,939	12,922	20,854	21,231
	Males			60	437	4,928	2,506	2,595
Tete	Females			293	995	2,300	3,221	6,362
	Males			12	443	914	1,282	2,834
Inhambane	Females					1,335	6,856	10,035
	Males					161	1,463	3,713
Cabo Delgado	Females				173	1,864	4,029	9,830
	Males				128	1,882	3,166	6,460
Niassa	Females						6,566	5,566
	Males						1,217	3,557
Sofala	Females						14,154	7,842
	Males						8,520	5,772
Total PGB		23,489	36,988	40,227	57,471	98,248	149,910	164,824

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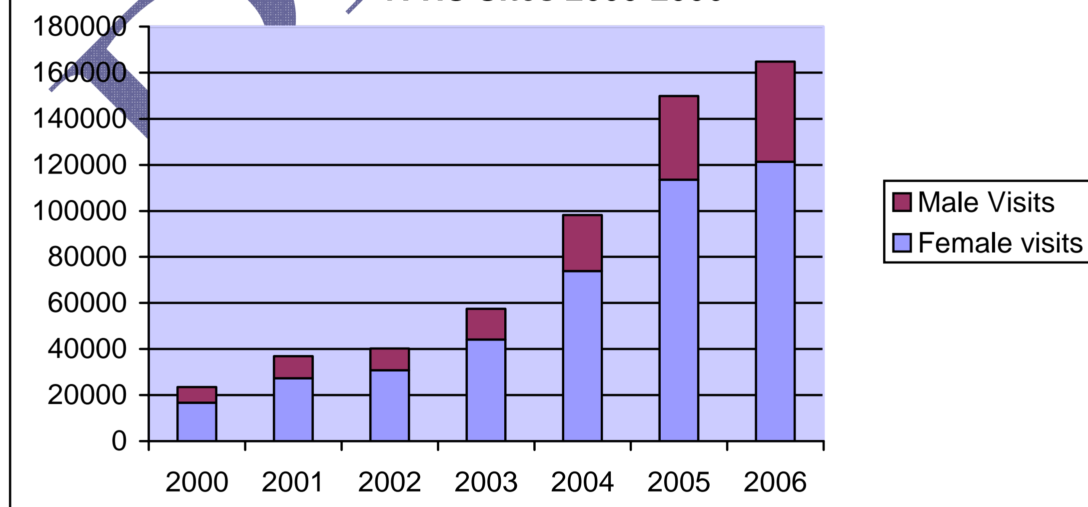

Figure 10: Total Number of visits by young people to YFHS Sites 2000-2006

VII. Enlarging Geraçao Biz Scope Through Other Partnerships and Initiatives

As Geraçao Biz evolves, the programme is branching into additional areas, such as young people living with HIV/AIDS (YPLWHA), gender-based violence, safe abortion services and treatment/support for alcohol and drug abuse.

Currently over 500,000 young people are infected with HIV in Mozambique. Most of them will develop AIDS in the next six years. This grave statistic demands more mobilization to ensure that YPLWHA have access to the care and treatment they require. Pathfinder International has begun to address this issue to some extent within Geraçao Biz. Pathfinder International received funding from the World Bank TAP Programme to support the integration of VCT, treatment of opportunistic infections, CD4 monitoring, ART and adherence support, and Preventing Mother To Child Transmission '+' (PMTCT + care and support including ART for the mother) within YFS facilities in Maputo City and Gaza. The initiative began in 2001 and to date 20 YFS facilities provide a range of HIV/AIDS care, treatment and support services. Home-based care and YPLWHA support groups are also being rolled out to complement facility-based services. Recently Pathfinder International, in partnership with the Centers for Disease Control and Prevention, USA and the MOH, developed a protocol and training materials to be used in the integration of VCT within 40 YFS facilities. Sixty service providers were trained and the new services are just beginning.

Recommendations from the client satisfaction surveys as well as results from the KAPB study pointed to the need to focus more heavily on gender issues including gender-based violence. Funding from the Flanders Government and the USAID Interagency Working Group on Gender allowed the programme to develop tailored approaches to improve the recruitment, retention, and performance of female peer educators. With further support from the Flanders Government, Geraçao Biz is piloting an integrated response to gender-based violence in Tete Province. Within the multisectoral integrated response, the Provincial Directorate of Health will oversee the development and application of a protocol to address gender-based violence within the health facilities, the training/orientation of providers and staff on gender-based violence, the provision of HIV post-exposure prophylaxis and Emergency Contraceptive Pills to facilities, and the development of measures to ensure increased privacy and confidentiality for clients who have experienced gender-based violence.

These various initiatives and partnerships allow for greater impact and increase the responsiveness of the programme to the various needs of young people. The involvement of an international NGO facilitates these collaborations as NGOs often have more dynamic and responsive systems and financial agility than government institutions, which allows them to respond to funding mechanisms with short turn-around times. The challenge will be building the capacity of the Government to seek out these complementary endeavours on its own.

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VIII. Challenges and Lessons Learned

Capacity building and sustainability

Lessons learned:

- By designing a programme that fits within government mandates and is situated within different government sectors, programme sustainability is increased.[35]
- By working with the Government to develop and adopt programme tools and policies, their use will continue beyond the project period. The MOH has adopted the Geraçao Biz training manual while content from the in-service training has been institutionalized into pre-service training for nurses. YFS indicators are being integrated into the MOH-wide system and the certification tool is currently being tested by the MOH and considered for future adoption.[36]
- Continuous investment in capacity-building has enabled a sizeable group of qualified staff to take on key positions within government, national and international organizations.[37]
- Investing in capacity building of good trainers is essential to sustainability and helps ensure that the providers and peer educators are competent to perform their tasks. In the future, trainers' roles could be expanded to include advocacy and supervision.

Challenges:

- Decentralization simplifies management processes but also requires capacity building at different levels (i.e. district level).[38]
- Financial sustainability is still a challenge due to the large dependency on donor support.
- Low capacity in equipment maintenance at the provincial level requires external (i.e. programme) resources to be allocated for equipment repair.[39]

Multisectoral programmes

Lessons learned:

- Well functioning multisectoral programmes increase service utilization more than programmes that only concentrate on improving health services. Referrals from the adolescent corners, teachers and peer educators in schools as well as from peer educators operating in the community have significantly contributed to increases in service utilization. In addition, using peer educators in the waiting areas of the clinics helps ensure that young people receive sufficient SRH information and feel comfortable accessing the facility.
- Bringing together a range of stakeholders elevates the influence of an issue (e.g. ASRH) but demands clarity in the definition of roles and responsibilities and a strong ability to coordinate the various stakeholders involved.[40]
- Differences among agencies' work styles, approaches and mandates must be respected and valued.[41]
- Increased involvement of top-level decision-makers is needed at the central, provincial and districts levels so that they are convinced of the importance of the programme and make decisions that facilitate and sustain programme implementation.

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- Improved monitoring systems benefited the programme as a whole and improved information sharing within and between sectors.[42]
- Peer educators are critical to programme efforts as they help attend to youth clients in the clinic, create a good environment and help attract new clients. Provider and peers with good relationships form an effective team that better serve the needs of youth clients than providers alone.
- Effective coordination between the health coordinators and peer coordinators working in schools and the community has led to increased motivation of peers and makes them feel welcome and clear on their role.

Challenges:

- Inclusion of youth representatives at all levels of multisectoral management still remains a challenge.
- Consistent quarterly management meetings in all provinces are needed in order to guarantee a continuous multisectoral approach.

Scaling up

Lessons learned:

- Designing a programme for scale-up right from the beginning accelerates the speed of implementation.
- Developing tools, curricula, approaches and guidelines that can be used as the programme expands to new sites facilitates rapid implementation and ensures more consistent results.
- Monitoring, evaluation and operations research are crucial in capturing the implementation process, results, recommendations and lessons learned that can be applied to new programme sites (allows for more cost-effective and rapid implementation).
- Capacity building through on-the-job technical assistance in management and technical content is key to ensuring qualified human resources as the programme expanded to new provinces.[43]
- Selected programme sites can serve as models for developing new protocols and systems that can then be applied throughout the programme.
- International (e.g. LoveLife/National Adolescent Friendly Clinic Initiative, South Africa) and provincial experience-exchange can lead to greater learning and application of best practices.
- A dynamic programme response to challenges, a culture of curiosity and willingness to learn, and a flexible design and approach that allows for change greatly facilitate scale-up.
- As the number of YFS sites is scaled up in a given province, the number of referral sites must also be augmented to reduce the burden on the existing referral sites as the number of youth referrals increases.

Challenges:

- Scaling up the three components simultaneously can be a challenge as the three sectors move at different paces. However, when only one component exists, it undermines the multisectoral nature of the programme and does not generate the same results as when all three components are functioning together.

Youth involvement

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Lessons learned:

- Youth involvement from the beginning is essential to ensure that services are designed in a way that resonates with them and that services continue to meet their various needs.
- The programme has influenced how people perceive HIV and accelerated the acceptance of PLWHA in general and YPLWHA in particular.
- Young people when equipped with the appropriate skills are capable of influencing policy, providing different types of services and support (e.g. as peer educators or home-based care providers) and mobilizing the community[44]. Partnerships with adults that provide mentoring and direction enhance youth participation.

Challenges:

- Youth associations, especially in the provinces, are limited in number or weak. A new approach was taken whereby the programme reduced the overall number of youth associations it supported in order to build more successfully the capacity of a limited number of organizations. However, few of these organizations were able to reach youth outside their community. This poses a challenge, as there are not adequate funds or time to strengthen/develop youth associations in all the different communities where the programme works.
- Peer educators are committed and politically engaged; however, they are eventually forced to address other realities such as earning an income or pursuing professional opportunities.

Service delivery

Lessons learned:

- Ongoing training in ASRH is needed to address staff transfer and turnover within the health facilities.
- To maintain high quality YFS, an effective supervision system should be in place to support providers as they implement this new endeavour. Provider training is essential in the implementation of YFS, although training by itself is not sufficient to maintain the introduction of special services for young people. Ongoing supervision is needed to support provider attitudinal change and address challenges as they arise.[45]
- YFS services must be provided in a comprehensive and integrated manner. Young people often come to a facility with more than one SRH need; it is therefore important that providers are able to meet a range of needs in one visit.[46]
- Integrating Voluntary Counselling and Testing for HIV and other HIV/AIDS care and support services can serve as an entry point for young men to come to the YFS facilities. It also improves the overall quality and uptake of services that will help young people live longer and more positive lives.

Challenges:

- Shortages of condoms and youth-specific educational materials are a constraint faced by many health facilities.[47]
- The overall response to gender-based violence within the YFS facilities is insufficient, highlighting the need for protocols, specialized training, and support.

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- Intergenerational sex is an important factor that influences young women's ability to negotiate and use protection. While YFS can provide counselling, information and condoms, normative change is also needed to address this issue.
- Substance abuse is directly linked to gender-based violence, vulnerability, and often HIV infection or unwanted pregnancy. While efforts have been made to integrate this into various aspects of the programme, including YFS, additional human resources (e.g. psychologists) are often required to address adequately this issue. Given the human resource constraints of public-sector health services, it is difficult to provide these additional support services without external funding.

IX. Conclusion

Geraçao Biz is one of the few multisectoral programmes to be national in scale. While there is still room for increased coverage within the provinces, all eleven provinces of the country are now part of the programme. Utilization of YFS is quite high compared with many other programmes operating in sub-Saharan Africa — in large part because it is supported by complementary components that seek to change behaviours, including care-seeking behaviours.

Evaluations and research studies (KAPB and client satisfaction studies) reveal the progress that has been made in the past seven years to develop a network of YFS facilities that offer high-quality SRH services. The vast majority of youth clients report that the services meet their needs, they are treated with respect, and privacy and confidentiality is ensured.[48,49,50]

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[49] Ministerio de Saude, UNFPA, Pathfinder International. 2006. *Estudo Satisfacao dos Clientes dos SAAJs no Ambito do Programa Geraçao Biz. Provincia de Gaza 2004.* Maputo: Pathfinder International.
[50] Ministerio de Saude, UNFPA, and Pathfinder International. 2005. *Estudo Satisfacao dos Clientes dos SAAJs no Ambito do Programa Geraçao Biz. Provincia de Maputo 2004.* Maputo: Pathfinder International.

The vitality of the youth movement that has been nurtured under Geraçao Biz is an integral part of the programme. Young people not only participate in the programme design, implementation and evaluation but also identify new areas that are of importance and advocate for the programme to respond to these needs. The recent forum held between youth activists and United Nations General Assembly Special Session (UNGASS) to address issues of HIV/AIDS treatment and care is a striking example. Young people planned and conducted the forum on their own, demonstrating that they can be leaders in solving their own issues. They discussed the Government Report to UNGASS, producing a parallel report showing the youth point of view, and addressed challenges in achieving UNGASS targets and objectives in relation to youth needs. Two young people also joined the Mozambican mission to attend the UNGASS 2006 Meeting.

The active participation of young people and the active involvement of the Government at different levels are two key features that external technical assistance has encouraged and supported. It is important that capacity building continues and is focused at helping to ensure that the Government can take over and maintain this programme independent of external technical assistance. As the programme widens to encompass different issues affecting young people, such as gender-based violence, intergenerational sex, substance abuse, and services and support for HIV positive youth, it will need to strike a balance between ensuring the quality of the basic package of services and interventions while also continuing to be responsive to youth needs. Overall Geraçao Biz serves as a model for other governments and organizations in terms of scale-up, its multisectoral approach, and the use of public-sector SRH services.

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ANNEX: TOOLS/DOCUMENTS PRODUCED UNDER GERAÇAO BIZ OR WITH GERAÇAO BIZ PARTICIPATION

GERAÇAO BIZ TOOLS
CDC/Pathfinder International/UNFPA. 2006. *Training of Trainers' Manual on Voluntary Counselling and Testing within Youth-friendly Services*. Maputo: CDC/Pathfinder International/UNFPA.
CDC/Pathfinder International/UNFPA. 2006. *Manual for providers' training on Voluntary Counselling and Testing within YFS*. Maputo: CDC/Pathfinder International/UNFPA.
Pathfinder International/UNFPA. 2005. *"Fala Menina Fala Rapaz": Handbook for peer educators*. Maputo: Pathfinder International/UNFPA.
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Geração Biz. 2004. *Manual de teatro interactivo em cena HIV/SIDA*. Maputo: Geração Biz, 2004. (Manual on using interactive theatre to deliver HIV prevention Behaviour Change Communication messages).
Senderowitz, J., G. Hainsworth, and S. Ladha. *Certification tool for youth-friendly services*. Watertown: Pathfinder International. (Portuguese version)
Senderowitz, J. G. Hainsworth, and C. Solter. 2003. *Clinic assessment of youth-friendly services: A tool for assisting and improving reproductive health services for youth.* Watertown: Pathfinder International. (Portuguese version).
Senderowitz, J., C. Solter, and G. Hainsworth. 2002. *Reproductive health services for adolescents - A comprehensive training course*. Maputo: Pathfinder International. (translated and adapted for use in Mozambique)
Technical guidelines and updates on Adolescent Sexual and Reproductive Health/YFS (in Portuguese)
Behaviour Change Communication Videos: *Risco Zero, TPC – Nosso Trabalho Sobre o SIDA,* and *Conviver e Vivier*
Video on using theatre to deliver Adolescent Sexual and Reproductive Health/HIV prevention Behaviour Change Communication messages (under development)
Radio Broadcasts: *Mama Biz* (under development)
Music CD that incorporates HIV and Adolescent Sexual and Reproductive Health issues
Management Information System formats
Survey instruments for client exit interviews and Knowledge Attitude Practice studies
REPORTS
Treatment Acceleration Project: World Bank, Pathfinder International, and UNFPA. 2005 and 2006. *Increasing access to youth-friendly HIV/AIDS care and treatment in Mozambique*. (Quarterly and Annual Project Reports). Watertown: Pathfinder International.
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STUDIES
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Raposo, C. 2006. *Estudo CAP–Jovens fora da escola. Províncias de Zambézia, Tete, Gaza, Maputo e Cidade de Maputo*. Maputo: Pathfinder International.
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