

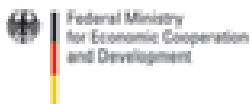


Addressing the Reproductive Health Needs
and Rights of Young People since ICPD -
The Contribution of UNFPA and IPPF



Nicaragua

Country Evaluation Report



Ministerium für
Zusammenarbeit und
Entwicklung



MINISTRY OF FOREIGN AFFAIRS
Danida



DFID Department for
International
Development

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

Nicaragua Country Evaluation Report

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ACRONYMS

AMUNIC	Asociación de Municipios de Nicaragua
CBD	Community-based distribution
CP	Country Programme
DHS	Demographic Health Survey (“Encuesta Nicaragüense de Demografía y Salud – ENDESA)
EC	Emergency contraception
FGD	Focus Group Discussions
FPA	Family Planning Association
GBV	Gender-based violence
GDP	Gross Domestic Product
HBC	Hospital Bertha Calderón
HIPC	Highly-indebted poor countries
ICPD	International Conference on Population and Development
IEC	Information education and communication
INEC	Instituto Nicaragüense de Estadísticas y Censo
INIM	Instituto Nicaragüense de la Mujer (Nicaraguan Women’s Institute)
IPPF/WHR	International Planned Parenthood Federation Western Hemisphere Region
JHU	Johns Hopkins University
LPIYD	Law for the Promotion of Integral Youth Development
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MECD	Ministry of Education Culture and Sport
MoH	Ministry of Health
MSN	Marie Stopes Nicaragua
NAR	Net attendance ratio
NDS	National Development Strategy
NGO	Non-government organisation
NPP	National Population Policy
NRHP	National RH Programme
POA	Programme of Action
PROFAMILIA	Asocioación PRO-Bienestar de la Familia Nicaragüense
PRS	Poverty Reduction Strategy (Estrategia Reforzada de Crecimiento Económico y Reducción de la Pobreza – ERCERP)
RH	Reproductive health
SEJUVE	Youth Secretariat (Secretaria de la Juventud)
SI MUJER	Servicios Integrales para Mujeres
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
SWOT	Strengths, weaknesses, opportunities and threats
TA	Technical assistance
TOR	Terms of Reference
UCA	University of Central America
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

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ANALYTICAL SUMMARY

Introduction

The German Ministry for Economic Cooperation and Development (BMZ), the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs have sponsored an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994. The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future; the purpose is to assess the performance of UNFPA country offices and Family Planning Associations (FPAs) in six selected countries in promoting the reproductive rights and health of adolescents and youth. Nicaragua is the Latin American country selected for the evaluation.

This analytical summary presents the main conclusions and lessons from the evaluation of the UNFPA Nicaragua Country Office and PROFAMILIA (the Nicaragua IPPF affiliate) against the five evaluation themes of strategic focus, institutional arrangements, policy and advocacy, service strengthening, and information and education. The summary highlights key findings against 10 key questions¹ set out in the original terms of reference (TORs) for the evaluation under the following headings:

Strategic Focus:

The extent to which UNFPA and PROFAMILIA:

- Recognise and articulate the country-specific socio-cultural factors that impact on the reproductive rights and health of young people;
- Recognise and articulate the diversity of needs of young people;
- Promote the concept and practice of reproductive rights; and
- Are gender-sensitive in addressing RH needs and rights of young people.

Institutional Arrangements:

The extent to which UNFPA and PROFAMILIA:

- Contribute to the response of government and civil society to the reproductive rights and health needs of young people;
- Provide quality technical support and promote lesson learning and best practice in young people's reproductive rights and health;
- Promote the participation and empowerment of young people;
- Demonstrate complementarities, coherence and cooperation with each other; and
- Demonstrate relevance, scope and effectiveness in coordination arrangements and partnerships with other actors in the field of reproductive rights and health.

Policy and Advocacy:

The extent to which UNFPA and PROFAMILIA are:

- Stimulating enabling environments for policy development in relation to young people's reproductive health and rights.

¹ See section 2.2 of *Addressing Reproductive Rights and Health Needs of Young People After ICPD: The Contribution of UNFPA and IPPF. Description of the Evaluation/Substantive Requirements of the Bid/Description of Measures* (issued by BMZ 2002). Of the eleven key questions one has not been addressed (with agreement of the Steering Group): "The extent to which both organisations are effective in promoting behavioural change... in particular safe and healthy sexual behaviour".

The issues on the previous page are explored in detail in the main report, and further elaborated in the discussions on service strengthening and IEC.

The Context: Priority Sexual and RH Issues Facing Young People

Significant progress has been made since ICPD in development of legal structures which establish young people's SRH rights in Nicaragua. Government and civil society have carried out IEC and many young people are now aware of their rights. However they often have great difficulty in exercising them.

The priority SRH issues facing young people are high rates of teenage pregnancy, increasing rates of STIs and HIV/AIDS, gender-based violence and substance abuse. These problems are generalised in all social groups, but are more acute in rural areas and amongst the very poor and those with low educational levels. Reasons include:

Inadequate access to education:

26% of Nicaraguans aged 15-24 years have no schooling, and 49% have less than 3 years' education (INEC, 2001), often due to poverty. Pregnancy rates (but not STI rates) are lower for adolescents with higher levels of education.

Inadequate access to IEC in SRH:

There has been no sex education in the Nicaraguan school curriculum for the last 25 years, and IEC programmes for out-of-school youth have had limited coverage

Lack of opportunities and expectations:

As a result of poverty and lack of education, many young women especially in marginal urban and rural areas, have low self-esteem, no future expectations and nothing else to do except have a baby (UNFPA 1999).

Intra-family violence:

Girls subject to domestic violence often see pregnancy as a way to escape from the family home (MECD & UNFPA, 2003).

Machismo:

Young men are still influenced by the cultural factors behind machismo, and young women have insufficient power in relationships and lack experience and skills to negotiate use of condoms.

"Cultural pregnancy":

In families where the mother, sisters and friends have had early pregnancies it is considered the norm.

Inadequate access to SRH services:

Even those who do have access to IEC still have a high pregnancy rate due to lack of access to services and family planning methods, especially services which are attractive and satisfy their particular needs. Obstacles to access are psychological (shyness, fear of being reprimanded, or that their parents will find out) and economical, particularly in the case of family planning methods. Service quality and attention is better for the higher income groups, even in the public sector

The following sections summarise how UNFPA and PROFAMILIA have tackled these issues in their programmes for young people.

Strategic Focus of the UNFPA and PROFAMILIA Country Programmes

UNFPA's strategic focus is on work with central government to support policy and legislation change which ensure the SRH rights of young people, and with local government and the MoH on demonstration projects to enable young people to exercise their rights by improving both demand and supply of IEC and services. Work has focussed on low income adolescents aged 10-19 years, who are a high priority group for UNFPA. In the current CP (2002-2006), work with young people has shifted from an emphasis on RH and family planning to a more integrated approach to youth development, in line with needs in Nicaragua. PROFAMILIA's organisational strategy is focussed on SRH service delivery with cost recovery, but within this organisational philosophy it has developed a programme for young people with social goals which approaches the question of SR rights in a practical way by increasing young people's access to IEC. The programme is urban-based and focuses on young people up to 19 years. Service delivery for young people is not differentiated from services for adults, and is generally used by young people 20-24 years who can pay.

UNFPA

UNFPA's work in Nicaragua is based firmly on the ICPD agreements and POA, and has a strong focus on SRH rights for adults and for young people. Work with young people has been a major part of the country programmes since 1994. UNFPA strategy has been to complement work on rights and SRH policies at national level with demonstration projects in IEC and service delivery at municipal level to put the policies into practice and increase young people's access to IEC and services. UNFPA has played a key role in supporting the development of legal structures to protect young people's rights, and the demonstration projects it supports have developed useful and appropriate methodologies to enable young people to understand their rights and start to exercise them. UNFPA has focussed on the adolescent group (10-19 years) on the premise that adolescents are the group with most acute SRH problems in Nicaragua. The 1998-2001 CP included a specific SRH sub-programme for adolescents. The current programme 2002-2006 does not have a specific sub-programme for this group but adolescents are a principal target group in its 3 sub-programmes of Population and Development Strategies, RH and Advocacy.

UNFPA considers that sexual and reproductive rights are the basic foundation of all the CP sub-programmes, projects and activities related to young people. Rights of access to services and information, and the right to participate are included in every activity. Other rights are included where appropriate and wherever there is an opportunity to introduce them.

Gender is a cross-cutting element in the whole country programme, and gender issues are taken into account in all youth-related activities. Historically this has manifested itself in an overriding concern to ensure the participation of young women, however UNFPA is aware of the importance of involving young men and the current CP includes a specific project on gender and masculinity.

Since 1998 the strategies at operational level have been built round a demand-supply paradigm, aiming at complementary improvements in service delivery and in demand for services. The principal partners have been the public sector at central and municipal level, concentrating activities in priority municipalities. UNFPA is now using an integral approach to youth development which includes SRH within a range of educational and development activities for low income adolescents in urban and rural areas. The approach takes account of the diversity of needs within the 10-19 age group, but there has been little work specifically aimed at young adults who are thought to be covered by the adult programmes.

SRH is a sensitive theme in Nicaragua's socio-political climate where the religious right has considerable influence within the government and traditional attitudes to young people's SRH are still common in the community. At national level the country office has steered a careful diplomatic course towards its programme objectives rather than taking a radical stance which could be counter-productive. It has been quick to take advantage of the opportunities which do arise for policy reform but has kept a low profile in its advocacy work, providing high quality technical support and funding for policy change rather than advocating it. At community level it has learnt from experience that participation by all local stakeholders is essential for successful youth development projects, and now looks for consensus and participation by parents, teachers, local government and community groups in the youth projects it supports.

PROFAMILIA

Since it was founded in 1970 PROFAMILIA's principal strategy has been service delivery, with a strong focus on family planning. The organisation played a key role in the 1970s when it was the only family planning provider in Nicaragua, and in the 1980s when family planning was first introduced into government programmes. It is still the second largest supplier of family planning after the MoH. PROFAMILIA's Mission and Vision are not specifically rights-based, however the principal strategy is to increase access to information and services, which is consistent with the ICPD consensus and in practice is a key factor in enabling young people and adults to exercise their rights. PROFAMILIA's four main lines of work are now RH service delivery, a CBD network, social marketing and the youth programme.

PROFAMILIA started its young people's programme in Managua in 1989, well before ICPD, in response to the growing need to provide spaces where adolescents could have opportunities for information, education, recreation and cultural activities and access to IEC and services in SRH in a context of high unemployment and lack of development prospects. The youth programme works through clubs linked to PROFAMILIA's clinics, and in 1997 expanded to national level. It is urban-based and most participants are students, male and female. Community outreach work by youth promoters (see below) is also focussed on schools with little work in marginal urban neighbourhoods. The youth programme is gender-sensitive and gender issues are included in training, IEC and outreach work. Although PROFAMILIA is aware of the diversity of young people's needs there is little participation by the very poor, rural youth or marginalized groups in the programme, with the exception of a current one-year project ("Dual Protection" project, discussed in detail in other sections of the report) which has had more success in reaching the poor, marginalized and some rural youth.

PROFAMILIA has received a large amount of funding from USAID since 1992 (over US\$24 million from USAID for all its programme activities including work with young people). This funding is now coming to an end, and the organisation has had to seek a balance between its social objectives and the need to charge for services to ensure financial sustainability. The youth programme is focussed on IEC rather than service provision, working on the premise that young people can use the normal PROFAMILIA services offered in the adult clinics. In practice this is not always the case as young people can rarely pay for services. This point is discussed further later in this report. PROFAMILIA's long-term strategy is to cross-subsidise the youth programme from clinic income, but this will be difficult until such time as the clinics themselves start to generate sufficient surplus to cover their own and Head Office costs. IPPF is a relatively small donor for PROFAMILIA at present, providing 8% of their total budget including contraceptive donations. When USAID funding stops in September this year IPPF will become a more significant donor.

Institutional Arrangements for Implementing Young People's Programmes

The current UNFPA CP allocates over one quarter of financial and staff resources to work with young people. UNFPA has developed strong working partnerships with the public sector at central and local government level, but its links with civil society have weakened during the last 5 years. Major areas of achievement have been the introduction of services for adolescents in MoH units, and work to introduce sex education to the formal school curriculum (see footnote 2 in main body of report). UNFPA has also worked in the non-formal education sector through SEJUVE and local government. UNFPA does a certain amount of internal analysis of lessons learnt to improve programme performance, but has not used its comparative advantages to promote lesson-learning at national level. In common with PROFAMILIA, youth participation is limited to implementation phases rather than programme design. PROFAMILIA's youth programme is at a more modest scale, taking up some 7% of the total organisational resources. Since 1992 PROFAMILIA has been heavily funded by USAID, resulting in a somewhat insular approach and limited contact with other organisations in the public or private sector or in the donor community. It is currently facing an uncertain financial future due to termination of its support from USAID and the lack of fund-raising from alternative sources to cover the gap between spending and cost recovery from its clinical programme.

UNFPA

UNFPA's work with young people takes up 28% of the current CP budget (US\$5m for work with young people during the 5-year period 2002-2006, out of a total budget of US\$18m approved by the UNFPA Executive Board for the whole CP) and an estimated 25% of the professional staff's time. There is a Programme Officer specifically assigned to adolescent work who participates in decision-making at institutional level. Funds for the adolescent work come from UNFPA regular and multi-bilateral sources.

Planning, implementation, monitoring and evaluation systems for the young people's programme are the same as those used for other work. Young people's participation in decision-making, planning and project design is limited, but they do participate fully in implementation and to a significant degree in monitoring and evaluation. In the absence of reliable quantitative indicators of progress UNFPA has developed an M&E system based on 6-monthly SWOT analyses using instruments designed to promote a high level of participation and foster reflection on rights issues.

UNFPA has formed strong working relationships with its principal partner organisations in the public sector. It participates in all the principal MoH and MECD Commissions on SRH and rights. It works with civil society as well as with municipal governments at local level through its community-based projects. However its work with NGOs has weakened in recent years, possibly as a result of the uneasy relationships between NGOs and the previous government and UNFPA's concern that close links with these groups might prejudice its public sector programme. SRH NGOs in Nicaragua were working from a gender and rights-based perspective prior to ICPD. They played an active part in the run-up to ICPD, in the conference itself and in the research and evaluation processes of Cairo+5.

UNFPA has taken a leading role in donor coordination for a sub-sector programme based on coordinating principles similar to those of a SWAp (known locally as the "Mini-SWAp") in SRH, to support the MoH in the development and implementation of a National SRH Programme. UNFPA sees its involvement as part of an on-going process in which the MoH is taking the leadership of a coordinated approach to sector development. The first stage has been coordinated by UNFPA in support of the MoH. As more donors have become interested and the MoH has become more involved in the SWAp concept, leadership of the process is being taken on by the Ministry. UNFPA also coordinates with other donors for

specific activities, but has not made full use of the opportunities which its comparative advantages provide for taking a more proactive role in experience exchange, lesson-learning and analysis of best practice.

UNFPA's focus on the public sector rather than civil society is a logical result of its emphasis on policy development and reform, described in the next section of this report. However this does make the programme more vulnerable to political change and to ministerial reshuffles, particularly when introducing new and relatively unknown concepts such as the sector-wide approach (SWAp). The 2002-2006 CP made little progress during its first year due to a change of government in January that year, and the Mini-SWAp also came to a halt as the new Minister and senior management were not familiar with the concept and had other priorities. The new team were briefed and progress was resumed briefly until the Minister of Health resigned at the beginning of 2003. The senior management team at the MoH also changed and effectively UNFPA had to start again with training and briefing on SWAp concepts and methods of implementation. Since the evaluation field work finished at the end of May 2003, the new Minister has made a clear public statement of his support for the SWAp process, and for the SRH "Mini-SWAp", which is seen as a pilot exercise to familiarise stakeholders with the process before moving to a full SWAp. International donors, among them DFID and other European donors, are however currently backing a full sector-wide approach in health and, although the debate between mini-SWAp or full SWAp continues, it seems likely that the Government will go direct to the full SWAp. At local government level elections were held during the last CP and the UNFPA demonstration youth projects had to make special efforts to ensure on-going support from the new mayors and councillors.

UNFPA has made a major contribution to the response of government to the reproductive rights and health needs of young people through its work at policy level in the MoH and the Ministry of Education and through its support for development of differentiated SRH services for adolescents in MoH health units. It has provided high quality technical support in key areas such as the introduction of sex education in the formal school system, and in development of norms for attention to adolescents². UNFPA will fully monitor and evaluate the implementation of the process from its current initial stage of teacher training through the later stages of adoption of a school curriculum and its overall impact on adolescent SRH. These activities are discussed in detail in sections 5 and 6 of the report. UNFPA has focussed on adolescents up to 19 years of age in these initiatives, however young people aged 20-24 are covered by its support for SRH for adults. The current programme includes work with young adults through SEJUVE, with the army and police, and in the "Maquila" industrial zones. UNFPA has focussed on the public sector and its support for civil society has been far more limited, as discussed elsewhere in this report and summary.

UNFPA has done a certain amount of analysis of the projects it supports with a view to lesson-learning (see discussion on the lessons learnt from service delivery in the penultimate section of this summary). However such analysis has not included examination of other alternatives in either service delivery or IEC, and has not been carried out in cooperation with other agencies with a view to dissemination of lessons or identification of best practice. UNFPA as a multi-lateral organisation with high quality technical resources and access to decision-makers in government and civil society could play a more effective role in this respect.

² Since this report was written the sex education curriculum has been withdrawn by the government and significantly watered down from its original form. As of September 2003, negotiations are on-going regarding its final form.

PROFAMILIA

The youth programme is managed by PROFAMILIA's Medical Services Division at Head Office. The Coordinator has a middle management position and participates in decision-making which affects the programme.

There is very little participation by young people in PROFAMILIA's institutional structure or decision-making, even though IPPF encourages youth membership of the decision-making bodies of its affiliates. Young people do participate fully in programme implementation, validation of IEC materials and local level planning, and to some extent in M&E.

In addition to the Coordinator at Head Office and support from the Head Office training team and Social Marketing division, the young people's programme has a local Coordinator ("orientadora") in each of the 11 youth clubs. Programme staff are skilled, competent and committed. Medical staff in the clinics are also committed to the programme, but administrative and financial staff are less concerned to give it high priority as it represents a cost without generating any income, an important consideration in the current financial crisis.

Direct programme costs for work with young people in 2002 (including salary of the youth programme manager and direct operating costs of the youth clubs but excluding indirect subsidies from other parts of the programme) were US\$113,000, about 4% of PROFAMILIA's total budget. Indirect subsidies such as Head Office staff time, monitoring costs, IEC, space in the clinics for clubs, utilities etc are estimated at roughly the same figure. This budget covers the cost of training and outreach activities of 600 promoters, and is comparable to the direct cost of similar activities in UNFPA-sponsored youth clubs of the same order of magnitude in terms of promoters and outreach contacts.

The young people's programme is funded from PROFAMILIA's regular resources which come from clinic income (49%), USAID (43%) and IPPF (8%). There is one externally financed "Dual Protection" project, funded by the Dutch Trust Fund through IPPF. This is a one-year project which covers the operating costs and outreach activities of 2 clubs in the border towns of Chinandega and Rivas.

M&E for the young people's programme is carried out under the same system as normal clinic M&E, with periodic visits from Head Office and regular numerical and written reports. The M&E system is time-consuming and does not always produce the information necessary for good management control. Financial control is highly centralised and clinic directors have little autonomy.

PROFAMILIA has had limited working relationships with other organisations at central level, although it maintains contacts with the MoH. It has chosen to keep a low profile and not get involved in advocacy or policy change. At local level coordination is better and PROFAMILIA is more proactive. Coordination with donors has been very limited as PROFAMILIA's financial needs were covered by its USAID grant. Now that is coming to an end PROFAMILIA will have to make a concerted effort to establish relations with other donors. In the short to medium term sustainability of the young people's programme will depend on PROFAMILIA's ability to raise funds externally, a skill it has lost during the recent years of abundant funding from USAID.

PROFAMILIA is itself a civil society organisation, and as such has contributed to the response of civil society to young people's reproductive rights and health needs. However it has not made significant efforts to disseminate its experiences or promote lesson-learning in the public sector or among other civil society groups. Its technical support has been limited to very occasional training for MoH staff on specific SRH topics.

Complementarity, coherence and cooperation between UNFPA and PROFAMILIA

The strategic approaches of UNFPA and PROFAMILIA to young people's SRH and rights are complementary to some extent, with UNFPA focussing on strengthening policy and practice in the public sector, whilst PROFAMILIA concentrates on IEC from within civil society, referring young people to public sector service delivery units if they need services and cannot pay. However this degree of complementarity has resulted from internal evolution of strategies and practice within each organisation rather than from a conscious effort to coordinate their activities or take into account their comparative advantages.

Their approaches are coherent in terms of recognition of young people's rights to SRH information and services, and the content and methodology of their IEC activities through youth clubs and peer promoters are very similar. However there are fundamental differences in their approaches to service delivery, UNFPA promoting separate free services for adolescents whilst PROFAMILIA offers young people the same services as adults, on a fee-paying basis.

Both organisations participate in multi-sectoral forums on young people's SRH, but apart from this there has been little contact and no practical cooperation between them. Clearly there are opportunities for cooperation, particularly in the areas of IEC methods and materials where the two organisations have worked independently resulting in some duplication of efforts, and in comparison of the two models of service delivery which would be a fruitful area for analysis and lesson-learning.

Discussion in the de-briefing meeting at the end of the in-country evaluation showed that both organisations are aware of the complementary nature of their work, and that there are areas where cooperation would be fruitful. Both organisations considered that the evaluation had provided an opportunity to start dialogue in specific areas where experiences can be shared and lessons can be learnt. For example, UNFPA were interested to learn about PROFAMILIA's experience and the methods it has used to facilitate work in the formal education system. In common with many other organisations in Nicaragua, both UNFPA and PROFAMILIA have a heavy workload and many immediate managerial and operational problems to solve, leaving insufficient time or opportunity to coordinate and share experiences with others.

Whilst it may be thought that the government could play a role in bringing the two organisations together to improve the potential synergy of their approaches to young people's SRH, it is important to take into account the political context of SRH in Nicaragua. Conservative and traditional groups still have a profound influence on public policy, and public sector management and staff have to tread a careful path in introducing reforms without antagonising their traditional supporters or the church. It is often more productive for leaders in government ministries to distance themselves from public discussion of sensitive SRH issues to prevent confrontations which could close rather than open doors for young people in exercising their sexual and reproductive rights. Frequent changes in senior staff in the ministries and the pressing need to tackle immediate crises in public sector service provision also affects the Ministries' capacity to develop long-term agendas for fostering interaction between other organisations such as UNFPA and PROFAMILIA.

Policy and Advocacy

UNFPA has played an active role in support for development of legal structures and policies which protect young people's SRH and rights, and has had an important impact in these areas. Its advocacy work has maintained a lower profile, supporting change through provision of technical and financial support to public sector partners. PROFAMILIA has not taken an active role in policy development or advocacy, and in order to safeguard its USAID

funding has signed the Mexico City Accord which prevents any discussion or counselling on abortion-related topics.

UNFPA

Support for policy development has been a key area of UNFPA's work and it has made an important contribution since ICPD. The Vice-Ministers of Health and Education both agreed that it had been instrumental in helping Nicaragua implement the ICPD agreements ("We wouldn't have been able to implement Cairo without UNFPA", according to the Vice-Minister of Education).

UNFPA has worked with MoH and MECD, and supported the formation of the Youth Secretariat, now one of its key partner organisations in government. The Youth Ombudsman is another important partner for fostering young people's SRH rights. It has also formed close links with local government in the municipalities where it works, and has obtained their support for youth development activities.

UNFPA has played an important role in the development of legal structures to protect young people's rights, which are now in place in Nicaragua. The present and future challenge is development of mechanisms to help them exercise those rights and ensure that the achievements to date are sustained.

UNFPA has kept a low profile in advocacy work, preferring to promote policy change through financial and technical support to government when opportunities arise (for example, introduction of sex education in schools) and through promoting policy dialogue (for example, in the introduction of population dynamics and population and development issues in the PRSP). It has not used its comparative advantages of technical and financial resources and access to decision-makers to strengthen civil society groups (in particular NGOs) who are very active in support of young people's rights in Nicaragua and are prepared to take the lead in advocacy work. These organisations could have greater impact with UNFPA's support.

PROFAMILIA

Although IPPF's Vision 2000 proposes that its affiliates should be active advocates of SRH rights PROFAMILIA has not been prepared to take on this role in the sensitive socio-political context of Nicaragua. Parts of IPPF's Vision 2000 are incompatible with the policies of USAID, and in order to safeguard its USAID funding PROFAMILIA signed the Mexico City Accord. However PROFAMILIA staff are well-versed in SRH rights and staff of the young people's programme are effective local advocates at community level.

PROFAMILIA has developed norms for its services which are generally higher standard than those of the MoH. It has shared these norms with the MoH and professional bodies, but has not taken the lead in raising service quality standards at national level.

Strengthening RH Services

UNFPA has promoted the establishment of separate services for adolescents in MoH health units, and has done important work in development of norms for attention to adolescents. Its principal demonstration projects have linked adolescent clinics which improve the supply of services to youth club (or "Adolescent House" – see below) activities which are aimed at increasing the demand for services. Other demonstration projects in the CP are piloting innovative alternative methodologies for reaching young people with IEC/BCC and service provision. PROFAMILIA does not consider that young people prefer separate services, and

service delivery for this group is carried out in the normal adult clinics. A comparative analysis of the UNFPA and PROFAMILIA models would be fruitful.

UNFPA

UNFPA has promoted a “differentiated services” model to strengthen RH services for young people, and has supported the MoH in implementation of a pilot scheme in the Bertha Calderón Women’s Hospital (HBC) in Managua. Lessons learnt from the HBC project have been applied in extension of the differentiated services concept to several health centres in the municipalities where UNFPA works. Service statistics from the sites visited during the evaluation field work are given in Section 5 of the report, and show increasing numbers of users during the last 12-month period. The original model was designed to set up separate service facilities for young people, but this is not feasible in all MoH units where staff, infrastructure and equipment are in short supply. There are many ways services can be differentiated (opening hours, separate waiting-rooms, staff trained in adolescent service delivery, etc.). Given the lack of resources in the MoH it is now important for UNFPA to analyse the lessons more carefully and support the MoH in development of a range of differentiated service models for adolescents. This would be a fruitful area of cooperation with PROFAMILIA, which uses an integrated service model for adults and adolescents (see below).

UNFPA has also supported the MoH in development of norms for adolescent services. The norms manual has now been published and UNFPA is supporting MoH staff training. The manual has a rights-based gender-sensitive approach and will have an important impact on service quality for adolescents once it is widely disseminated throughout the MoH.

PROFAMILIA

PROFAMILIA provides services for young people in its normal adult clinics, maintaining that high service quality is sufficient to attract young people. Although data on use of services by young people is not collated at central level, individual clinic statistics show that about 10% of PROFAMILIA clinic users are below the age of 24, most of them being in the 19-24 age group. Young people have to pay for services, although there are discounts for youth promoters and their family members. A limited amount of contraceptives is distributed free to young people.

Given its current resource constraints it would be difficult for PROFAMILIA to offer differentiated services in separate facilities or free services. The issue of whether the cost of services is an obstacle to access for young people has been widely debated, and in some cases it may be true that young people are willing to pay. However, although they may be willing, they are not always able to pay in Nicaragua, where few young people have an independent income. It is clear from discussions in the evaluation and the FGD that the price of services is a major obstacle for young people, and low income groups do not use the clinics. PROFAMILIA’s service user group is relatively middle-income, and there is little outreach to marginalized groups or the extremely poor. PROFAMILIA promoters and “orientadoras” refer young people to the MoH facilities for medical and SRH services. Some PROFAMILIA doctors provide free services for young people, but as the doctors are paid on the basis of the number of fee-paying clients they attend this is effectively a personal donation from the staff.

PROFAMILIA’s Dual Protection project has external funding and is the exception to the rule. It has done outreach work with marginalized groups and in rural areas. Data on the first 6 months of this one-year project (see section 5 of the report) show that it has provided services to a significant number of young people in the 2 clinics participating in the project, but it is not possible to ascertain whether this number represents a trend to increased use as

historical data on use by young people is not available (the MIS which does not consolidate information on the age of users in the normal clinics). Observations and discussions during the evaluation suggest that the Dual Protection model does have potential to increase access for young people, but unfortunately funding will end in September this year and to date no additional funding has been secured. The project could provide value opportunities for lesson-learning which could be applied to PROFAMILIA's work in other clinics if more resources were available.

In view of the importance of the youth programme in terms of PROFAMILIA's social objectives, it is surprising that more resources were not channelled to development of a service delivery programme for young people when generous USAID funding was still available. PROFAMILIA could have taken advantage of the opportunity to set up a viable youth programme which could have attracted funding from a wider range of donors.

RH Information and Education

UNFPA is working in the formal education sector supporting the introduction of sex education into the school curriculum, and in the non-formal education sector through a community-based model of youth clubs with promoter networks. These activities are not mutually exclusive but are likely to have very different levels of impact and cost-effectiveness. UNFPA has funded production of IEC materials in a number of partner organisations but has not taken the lead in sharing resources and experiences, resulting in duplication of efforts. PROFAMILIA's youth IEC work has been developed as part of the organisation's overall IEC strategy, but with materials and methodologies specifically designed for young people. Practical work is focussed on youth clubs with promoter networks. Although the UNFPA and PROFAMILIA models are very similar neither organisation has taken the initiative to coordinate and share experiences, resources or lesson-learning.

UNFPA

UNFPA is working in promotion of RH information and education in the formal education system and in community-based projects.

Its work in the formal education is potentially one of its major contributions to SRH IEC for young people in Nicaragua and will have a far-reaching impact if carried to a successful conclusion. Socio-political forces in Nicaragua have kept education in sexuality and SRH out of the school curriculum for the last 25 years, although this is a pressing need and one of the major factors behind the high rate of adolescent pregnancy and STI transmission. UNFPA has supported the development of a National Population Policy Action Plan, which includes provision of sex education in and out of schools, and has used the opportunity created by this Plan to provide high quality technical support and financial support to the MECD in the preparatory stages of development of a school curriculum in sex education and sexuality. However, since the fieldwork for this evaluation was carried out in May 2003, the introduction of the new curriculum has resulted in a highly visible national debate with conservative political powers campaigning for its withdrawal. Unfortunately, the final curriculum is likely to be a much weaker version of that originally proposed and supported by UNFPA. A teachers' manual is now in print, to be followed by teacher training and development of the school curriculum thereafter. UNFPA has known how to use its comparative advantages to the best effect to support this initiative. Since the field work for this evaluation was completed there has been a heated debate in the news media about the teachers' manual. UNFPA and the MECD have come under fierce attack from the religious right and PRO-life groups who assert that the manual will undermine moral values, promote promiscuity and encourage adolescents to experiment with different sexual preferences. Apart from the issue of responsible journalism (the content of articles in the papers suggests that the authors may not have read the manual with care), the debate clearly illustrates the difficulties for UNFPA's

work in the socio-political context of Nicaragua, and the country office's skills in promoting change in this sensitive field of work.

At community level UNFPA has supported development of a model of motivation and education in SRH and rights through municipal youth clubs ("Casas del Adolescente"). These "Adolescent Houses" are based on the same principals as those of PROFAMILIA, providing a space where young people can obtain education, recreation and SRH IEC, and giving them opportunities to develop life skills. The clubs train adolescent promoters for outreach work in the community using adolescent-to-adolescent methodology. UNFPA has promoted establishment of clubs in municipalities where the MoH has developed an adolescent clinic, and encourages the development of links between the clubs and clinics. Adolescent promoters refer young people to the MoH clinics, where staff are trained in service provision for this group. The clubs reach low income groups, marginal urban neighbourhoods and rural areas. They are supported by a range of public sector and civil society organisations in each zone.

The youth club model has a positive impact on its members and their families, and young people contacted through the community outreach work also benefit, but the model requires time, effort, resources and commitment from all stakeholders and its coverage is relatively low compared with the potential coverage of UNFPA work in the formal education sector.

UNFPA points out that work in the formal education sector and non-formal community-based education are not mutually exclusive and community-based work has potential to reach the neediest out-of-school groups. Whilst this is true UNFPA does not have the comparative advantages for this work which it has in the formal education sector. PROFAMILIA and UNFPA are two of several organisations which are supporting youth clubs of this type, and there is clearly an opportunity for collaboration, experience exchange, lesson-learning and analysis of cost-effectiveness. UNFPA could take the lead in this.

UNFPA has funded the production of IEC materials in this and other projects, but has not developed a coherent IEC strategy. Most of the organisations working in adolescent SRH in Nicaragua have produced their own IEC materials, often working from the same rights and gender perspective. Some of the most effective materials are those produced by the adolescents themselves. They are clearly opportunities for collaboration, coordination and lesson-learning in this area, and again UNFPA could use its comparative advantages to take the lead.

PROFAMILIA

PROFAMILIA has received TA in IEC and communications from Johns Hopkins University for the last 5 years, and as result has an IEC strategy linked with its social marketing and institutional promotion activities, and has in-house capacity for design of good quality materials.

The young people's programme has benefited from this capability. IEC materials and methods are high standard, clear, easy to understand and effective for community outreach work. Young people participate in the development and validation of materials and in evaluation, but as respondents to questionnaires rather than protagonists in the process. However the availability of IEC in the field is limited, perhaps due to current resource constraints. PROFAMILIA has not used potential links with other IPPF-affiliated young people's programmes in the Region, some of which have excellent materials which could be adapted to the Nicaraguan context.

One of the principal successes of the PROFAMILIA IEC programme has been its ability to provide adolescent-to-adolescent IEC in the school system through the youth promoters.

PROFAMILIA is one of the few organisations to achieve this in Nicaragua. The more experienced promoters are well-informed and good communicators, and have worked successfully in the schools. PROFAMILIA is currently changing its promoter model, recruiting a higher number of promoters and reducing training time to achieve higher coverage. This may affect the quality of the outreach work.

In common with UNFPA's youth club work, this model provides IEC and opportunities for personal development to young people, but its coverage is relatively low.

KEY FINDINGS AND RECOMMENDATIONS

The evaluation notes that both UNFPA and PROFAMILIA have worked on the SRH and rights of young people since ICPD, and are now implementing SRH activities within an integrated approach to development of life skills. Both organisations are aware of the complex socio-cultural, political and economic environment in which they are working, and the key SRH issues facing young people in Nicaragua. Whilst UNFPA has focussed on supporting change in legal structures and policies to protect young people's rights and has mounted demonstration projects to help them exercise those rights, PROFAMILIA with more limited resources has focussed on a smaller scale community-based IEC approach linked to its adult clinical services activities. Although both organisations are working in the same field there has been little contact between them and opportunities for sharing experiences, resources and lessons learnt have not been taken up. Whilst the potential future impact of UNFPA's work is likely to be high, the future potential of PROFAMILIA's youth work is less predictable due to financial constraints which may affect the sustainability this work.

UNFPA

- UNFPA's work in Nicaragua is based firmly on the ICPD agreements and has a strong focus on SRH rights for young people and adults. Work with young people is a high priority and takes up over one quarter of the country office financial and staff resources. The current CP has moved towards including SRH within a more integrated approach to development of life skills.
- The country office has played a key role in supporting the development of legal structures and policies to protect young people's SRH and rights. The legal structures are now in place, but more work needs to be done in assisting young people to exercise their rights.
- Since 1998 the strategy for work with young people has been built around a demand-supply paradigm, linking improvements in the quality of IEC and service provision with increases in demand through community-based activities. Where the two activities have been carried out in the same locations this model shows encouraging signs of success.
- UNFPA has concentrated its efforts on the adolescent age group 10-19 which it considers the highest priority in Nicaragua, but has done little work with young adults (20-24 years).
- Principal partners are the public sector at central and local government level. Links with civil society still exist and are being developed at local level through community-based projects, but work with NGOs has weakened during the last 5 years. This may have reduced the impact of UNFPA's work on public opinion change. The focus on the public sector makes the CP more vulnerable to political change, which has caused delays in programme implementation.
- The approach to advocacy has been cautious, taking advantage of the opportunities which occur at government level for supporting policy change and providing technical support to implement change rather than advocating it.

- UNFPA has made major contributions to public sector practice to enable young people to exercise their SRH rights through its work with MoH on provision of differentiated services for adolescents and its work with MECD in development of a teachers' manual for sex education in schools. If implemented successfully at national level both these initiatives are likely to have a far-reaching impact on Nicaraguan youth now and in the future
- UNFPA has been adept at using its technical and financial resources and access to decision-makers to promote change in the public sector. However it has not used these and its other comparative advantages to promote experience sharing and lesson-learning in and between the public sector and civil society.
- There has been little analysis of the cost and impact of different activities to identify where UNFPA could most effectively concentrate its efforts.

PROFAMILIA

- PROFAMILIA's principal strategic focus is service delivery on a fee-paying basis. Since 1994 it has moved away from its previous strong focus on family planning towards a more integrated approach to SRH.
- Its youth programme is urban-based and concentrates on IEC delivered through youth clubs and a community promoter network. It caters for a slightly higher income group than UNFPA-supported activities. No special provisions have been made for service delivery to young people who are offered services in the adult clinics and normally have to pay.
- The work with young people is a low-cost programme which absorbs only a small percentage of PROFAMILIA's total budget but contributes towards the organisation's social goals.
- PROFAMILIA is one of the few organisations in Nicaragua which has been successful in introducing IEC activities into schools in the public sector.
- PROFAMILIA has been primarily funded by USAID since 1992, which has had an effect on its approach to SRH rights. Specifically, it has signed the Mexico City Accord although this is contrary to IPPF policy and restricts access to information on abortion-related issues.
- Despite generous funding from USAID during the last 11 years PROFAMILIA has been unable to reach a point of financial equilibrium to cover its costs from clinic and social marketing income. The financial future of the organisation is therefore uncertain at present. PROFAMILIA management are focussing on the issue of financial sustainability. This may affect continued implementation of the youth programme, which generates costs but no income.

- PROFAMILIA has not been involved in advocacy or promotion of policy change. It has worked independently and to some extent in isolation from other organisations concerned with young people's SRH and rights. As a result it has not had an identifiable impact on lesson-learning or identification of best practice in the field of young people's SRH and rights.

Complementarity of UNFPA and PROFAMILIA

- There is some complementarity between the approaches of UNFPA which concentrates on policy change, IEC and service provision in the public sector and PROFAMILIA which concentrates on community-based IEC for young people, but this complementarity is more by accident than design. The two organisations work independently and have had little contact.
- There are fundamental differences in their approach to service provision, UNFPA promoting a model of differentiated services for adolescents free of charge and PROFAMILIA offering the same services which it provides for adults on a fee-paying basis.
- There is scope for experience and resource-sharing and joint analysis of lessons learnt. Dissemination of lessons learnt could support the work of other organisations in the public sector and civil society in Nicaragua.

Recommendations:

The following strategic recommendations were discussed with UNFPA and PROFAMILIA in the evaluation de-briefing:

UNFPA:

- Promote comparative analysis of the youth club models developed by different organisations to improve experience-sharing and the use of an evidence base in project design.
- Support the MoH or an alternative coordinating institution in the analysis and sharing of IEC materials, to avoid duplication of efforts.
- Develop closer relationships with civil society organisations, particularly in the field of advocacy, and strengthen civil society work through provision of TA and resources.
- Support the development of mechanisms to implement laws and policies.
- Analyse the costs and benefits of UNFPA support for community-based education in comparison with its support for the formal education system.

PROFAMILIA:

- Analyse the possible impact of the proposed change in the current youth promoters model on the quality of IEC provided by the promoter network. PROFAMILIA's planned evaluation of the new model (programmed for the end of this year) should address and analyse the comparative impact in relation to the previous model.

- Develop closer relationships with other civil society organisations at central level, and with donors who work in the area of young people's SRH and rights, in order to obtain funding and ensure scarce resources are used well. PROFAMILIA will have to strengthen its current activities in this field if it is to achieve the financial sustainability proposed for next year.
- Seek methods of strengthening service provision for young people, through further research on the feasibility of alternative models in Nicaragua and investigation of the methods used by other FPAs in the Region.
- Strengthen internal capacity for development of project proposals within the youth programme staff team to enable successful fund-raising.
- Propose that IPPF facilitate in-depth sharing of experiences and lessons learnt between the FPAs in Latin America.

Both organisations:

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

INTRODUCTION

The Ministry for Economic Cooperation and Development (BMZ) of Germany, the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs are jointly sponsoring an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people³ - and especially adolescents - in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994.

The evaluation focuses on six country case studies: Tanzania, Burkina Faso, Bangladesh, Egypt, Nicaragua and Vietnam undertaken between March and May 2003. The findings from these six country studies will be synthesised into a final report to be presented at an international workshop in December 2003.

Objectives of the Evaluation

The overall aim of the evaluation is to clarify how UNFPA and IPPF contribute to the implementation of key aspects of the ICPD Programme of Action, relating to the reproductive rights and health of young people. UNFPA and IPPF have affirmed their commitment to the ICPD framework; central to which are the notions of gender empowerment, equity and a rights based approach. IPPF's commitment to a rights based approach is outlined in the IPPF Charter on Sexual and Reproductive Rights (1995), and in the objectives and strategies of Vision 2000.

The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future.

The purpose is to assess the performance of UNFPA country offices and Family Planning Associations (FPAs) in selected countries in promoting reproductive rights and health (with the aim of achieving behavioural change), with a particular emphasis on adolescents and youth.

Composition, Timing and Schedule of the Country Evaluation

The country evaluation covered the Nicaraguan UNFPA Country Office and the Nicaraguan affiliate of IPPF, the Asociación Pro-Bienestar de la Familia Nicaragüense (PROFAMILIA).

The local partner for the country evaluation was Marie Stopes Nicaragua (MSN), the Nicaraguan partner of Marie Stopes International. MSN contracted preliminary studies ahead of the international team's visit. Three studies were carried out: a review of the legal framework of young people's sexual and RH and rights; a review of information, education and communication (IEC) materials produced by UNFPA and PROFAMILIA; and a youth opinion study, using a focus group methodology. These studies were carried out by Guadalupe Canales and a team of 4 young focus group moderators.

The international team for the country evaluation was: Meg Braddock (team leader, resident in Nicaragua), Corinne Grainger (international team member) and Fidel Moreira (young national team member). Corinne Grainger arrived on 4th May 2003, and departed 23rd May 2003.

³ The evaluation adopts UN definitions: adolescents are aged 10-19 years, youths are aged 15-24 years; young people include both categories (10-24 years).

The team worked in the capital city, Managua, during the first week of the consultancy. A stakeholders' workshop was held on 6th May, and the remainder of the week was used for detailed discussions with UNFPA and PROFAMILIA, and visits to other stakeholders including government, donors and multi-lateral organisations.

During the second week the team travelled to Estelí, Ocotal, Somoto, Matagalpa, Jinotega and La Dalia in the north of the country to visit UNFPA and PROFAMILIA projects. The international team member and the young national consultant reviewed the PROFAMILIA projects, and the team leader reviewed UNFPA-supported projects. Mrs. Stegeman from the evaluation Steering Group accompanied the team on this trip. Later that week additional meetings with PROFAMILIA project staff and UNFPA partner organisations were held in Chinandega and Managua.

The third week was spent on analysis of the data, follow-up with UNFPA and PROFAMILIA, additional visits to stakeholders and preparation of the Aide Memoire for presentation of the preliminary results to UNFPA and PROFAMILIA.

A detailed itinerary and people met are shown in Annex 1, together with a list of documents consulted. Annex 2 gives a brief summary of the stakeholders' workshop, and Annex 3 describes the evaluation methodology. Annex 4 lists current UNFPA youth projects, and the Aide Memoire is shown in Annex 5. The Aide Memoire includes a series of recommendations which were discussed with UNFPA and PROFAMILIA in the in-country debriefing session.

Report Format

The report is in six sections, relating respectively to the country context, the strategic focus of the two agencies' national programmes, institutional arrangements, and the contribution of each agency to policy reform, strengthening services and provision of information and education. Each section is structured around the criteria of the evaluation, which include relevance, integration of rights, capacity, efficiency, effectiveness, and sustainability. With the exception of section 1, the remaining sections are divided into two separate sub-sections on UNFPA and PROFAMILIA respectively, each sub-section concluding with a short summary of the main conclusions.

SECTION 1: THE COUNTRY-SPECIFIC CONTEXT

1.1 Demographic and Socio-Economic Context

Poverty

Nicaragua is the poorest country in the Americas with the exception of Haiti, with GDP per head of US\$507 in 2000 (PRS, 2001). 46% of its 5.48 million people live below the poverty line, and 15% live in extreme poverty (UNFPA, 2001). Poverty is worse in rural areas where 42% of the population live. Two out of every three people in rural areas are poor compared with one in every three people in urban areas (PRS, 2001). Income distribution is highly skewed with 51% of national consumption spent by the richest population quintile and only 5% by the poorest quintile.

Social and economic dislocation resulting from civil war, political instability, frequent natural disasters and mistaken macroeconomic policies are among the key causes of poverty. Nicaragua made significant advances in the social sectors during the post-revolutionary period of the 1980s including a very successful literacy campaign, provision of free health and education services, and expanded employment opportunities in the public sector. Government spending on the war and social reforms was high, leading to sustained hyperinflation and accumulation of an extremely high external debt burden. Economic growth dropped drastically, and Nicaragua became dependent on external aid to maintain basic services. Structural adjustment programmes introduced in the 1990s improved macroeconomic indicators but caused great hardship for the poor and further reduced their living standards as basic social services and public sector employment were cut. In 1998 Hurricane Mitch caused widespread loss of life and destruction of infrastructure. Nicaragua has been badly affected by the recent collapse of the world coffee market, and private and foreign investment and donor funding have been reduced due to economic instability and widespread corruption. The government is now taking steps to reduce corruption and is seeking debt relief under the World Bank's highly indebted poor country (HIPC) scheme. Currently 14% of national income is remittances from family members living overseas (UNFPA, 2001).

Lack of economic and social opportunities together with fragmentation of society and collapse of the post-revolutionary social structures of the 1980s has led to reduced expectations and growing despondency among young people. Drug abuse, gang warfare and domestic violence are common problems for adolescents (UNFPA 2001). Surveys reported in the national press show that the large majority of young people see little future in Nicaragua and would emigrate if they had the opportunity (La Prensa, various articles during 2002).

Demographic and health indicators

Nicaragua is currently in a "delayed demographic transition" period as defined by the World Bank, with high to medium fertility rates which have been declining recently (6.9 births per woman in 1970 to 3.2 in 2001), population growth still high at 2.6%, and RH poor. 66% of married women use modern contraceptive methods, a significant increase of 17% in the last 3 years (DHS, 1998 and 2001).

Currently 63% of the population are under 25 years of age. Adolescents aged 10-19 comprise 26% of the total population, and the group 10-24 years 35% (INEC, 2003). The dependency ratio has been declining over the last 10 years, and was estimated at 78 in 2001. The ratio is higher in rural areas where it reaches 92 compared with 69 in urban areas. Government institutions have recently started to interpret this age structure as a "demographic bonus", bringing opportunities for economic growth as more young people

enter the workforce. Whether the bonus can be realised will depend on the success of efforts to revive the economy and provide employment for young people.

Despite acute poverty levels and low public sector spending in the social sector, health indicators have maintained the advances achieved in the 1980s, although there are great differences between social groups and between urban and rural areas. Life expectancy has increased from 59 in 1980 to 69 in 2001. Infant mortality has declined from 90 per 1000 in 1980 to 35 per 1000 in 2001. Maternal mortality has been declining and is currently estimated at 133 per 100,000 live births. The country is undergoing an epidemiological transition, with decreases in death rates from infectious and respiratory diseases and diarrhoea and rising rates from chronic and degenerative disease.

Nicaragua has the lowest prevalence and incidence of HIV/AIDS in Central America. The epidemic started late, the first case being reported in 1987. By 2002 803 HIV seropositive cases had been reported, of which 368 were AIDS and 199 had died (UNAIDS, 2002). UNAIDS estimates a low annual incidence of 3.27 per 100,000 with a total of 5,800 people living with HIV/AIDS. Prevalence of HIV in vulnerable groups has increased over the last few years but is still low (2% amongst sex workers in Managua, for example). Reasons include isolation during the war of the 1980s, almost no intravenous drug use, no commercial blood banks, limited tourism industry and relatively high awareness amongst vulnerable groups at the start of the epidemic. However during the last few years HIV incidence has started to increase and an epidemic can be expected to develop unless strong measures are taken. Because of the currently low rates of infection it has been difficult to convince decision-makers or the population in general that HIV/AIDS is a real danger. There is little experience in Nicaragua of working with people living with HIV and AIDS.

Services for diagnosis and treatment of STIs are inadequate in the public and the private sectors and statistics are unreliable as most people self-medicate and only seek medical services if this does not work. In the public sector the Ministry of Health (MoH) and the Ministry of Education, Culture and Sport (MECD) have been weak in educational work, and the specific area of education on STIs/HIV/AIDS has been almost exclusively the work of non-government organisations (NGOs) and community groups.

Net attendance ratios (NAR) in primary school are 86 for girls and 83 for boys in urban areas, and 73 for girls and 66 for boys in rural areas. NAR in secondary education is 61 for girls and 51 for boys in urban areas, but much lower in rural areas where the figures drop to 23 for girls and 15 for boys (DHS, 2001). Adult literacy rates are 79%, with higher rates in urban areas (93% compared with 71% in rural areas) and female literacy slightly higher than male rates. However functional literacy is often lower than these figures in rural areas where people have little opportunity to use reading and writing skills.

Sex education in schools has been limited by political factors including conservative leadership and strong influence of fundamentalist religious groups in the MECD. There has been practically no sex education in the school system during the last 25 years. This key point is discussed in detail later in the report. Sex education for out-of-school youth is a major area of concern as only the NGO sector has programmes in place to reach this group. NGO programmes have limited coverage.

Gender relations and status of young women

In Nicaragua 39% of households are headed by single women, and only 61% of children live with both parents. The low % of nuclear families is due to a number of factors including seasonal labour migration and the aftermath of the civil war when families were separated and women had to manage on their own. Although poverty is not necessarily more severe in female headed households, women are usually poorer than men due to reduced employment

opportunities, lower wages and lack of assets such as land. In male headed households women often lack access to household income and control over household budgets.

Gender equality has been achieved in primary and secondary education, where female enrolments are now higher than male enrolments in both urban and rural areas.

Legislation and institution-building to strengthen women's rights have set a framework for gender equality (see section 1.2). However in the community practice lags behind the structural changes and women are still disadvantaged, particularly the poor and the young. Gender relations in Nicaragua as elsewhere in Latin America are affected by "machismo" which relates manliness to the number of children fathered, generally with multiple partners. Within this culture men are caught up in a system where they are not expected to take responsibility for their children.

"It's much more difficult for girls, because they're far more criticised by society. Boys can do what they like and no-one says anything, its machista; we don't have equality"
(FGD, La Dalia)

Gender relations are also affected by the discrepancy between the expected and real roles of men. Men's role as providers has been declining as economic depression reduces opportunities for work in the formal sector of the economy, and cultural globalisation has alienated men and made it hard for them to identify with their children. As women gain more independence and demand more reproductive rights men find it increasingly difficult to maintain their authority in the family and to act as traditional role models for their children. The response of many men to this crisis of authority is violence, generally directed at women and children because they have unequal power in relationships with men. Studies in Nicaragua have shown that 50% of women have experienced gender-based violence, and 33% of girls and 20% of boys have experienced sexual abuse before the age of 12 (UNDP, 1999).

1.2 National Policies, Strategies, Programmes and Laws

National population, health, HIV/AIDS and youth policies and programmes as they affect or relate to young people's RH and rights

Key policies and programmes related to or affecting young people's SRH and rights have been formulated within the framework of the Poverty Reduction Strategy (PRS, 2000), now superseded by the National Development Strategy (NDS) of 2002. The PRS integrated concepts of population growth and distribution with economic development, and this is continued in the NDS. Young people's RH rights and unmet needs are recognised in the PRS indicators, which include targets for coverage of sex education in and out of school, for reduction in maternal mortality and for increased contraceptive use in age groups 15-19 and 20-24.

Key policy and programme documents related to adolescents' SRH and rights are:

- Action Plan of the National Population Policy (NPP) 2001-2005
- Declaration of Policies: Towards a National Sexual and RH programme within the Health Sector Reform 2001
- National Plan for Prevention of Intra-Family and Sexual Violence 2001
- Strategic National Plan to counter STIs, HIV/AIDS 2000-2004
- Policy for Integral Youth Development, the precursor of the Law for Promotion of Integral Youth Development (LPIYD) discussed in the next section

The NPP has 3 principal elements: Education in Population and Sexuality in both the formal and non-formal education sectors; sexual and reproductive health; and spatial distribution of the population. All elements give high priority to the most vulnerable groups in rural areas and those living in extreme poverty, and young people are a principal target group particularly for educational work.

The SRH policy statement aimed to increase the equity and quality of services in a sustainable way, through an integrated approach for adults and adolescents and coordination of the public, private and NGO sectors. Gender-based violence (GBV) was included specifically as an element of SRH. Progress in transforming the policy statement into a plan of action was held up due to political factors including a change of Minister in the MoH. The policy has now re-emerged as a draft “National RH Programme (NRHP)” which will be tabled for public discussion in the next few months. Although sexual health has been removed from the name of the document, it is still included in the content. Adolescent sexual and RH was formerly managed by a special unit within the MoH, but is now included in the overall sexual and RH policy and management area for all population groups.

The national plans for prevention of violence and HIV/AIDS are rights-based and both refer specifically to young people. Mechanisms to implement the plan for prevention of violence involving joint action by the public sector, civil society and the community are in place in a number of local government areas and have made a promising start. Implementation of the HIV/AIDS plan may be more difficult due to the scarcity of resources in all sectors for STI diagnosis and treatment.

The youth policy emphasises gender equity and the need to respect sexual and reproductive rights in provision of health services for young people. The policy was the basis for development of the LPIYD discussed below.

Laws regarding and/or affecting the reproductive rights of young people

The legal structure described below only provided special protection for young people under 19 years of age until 2002. Young people aged 19 to 24 were considered to be adults and no special provisions were made to protect their rights. This has now changed with the LPIYD of 2002 which covers young people up to the age of 24 years, as well as young adults up to 30 years of age.

Significant progress has been made in the legal framework for young people’s SRH rights since ICPD. The principal laws relating to young people’s reproductive rights are the Children and Adolescents’ Code (1998) and the LPIYD (2002).

The Children and Adolescents’ Code establishes civil rights and liberties, and rights to family life, health and education, social security, culture and recreation for young people up to the age of 19 years. All the provisions are based on Universal Human Rights declarations and incorporate the ICPD agreements, and the law describes the role of the State in guaranteeing rights. The right of access to family planning is not stated explicitly but the law can be interpreted to include it. Mechanisms for implementation of the Code have been set up, including a National Council for Integral Attention to Children and Adolescents, and a special Ombudsman for these groups.

The LPIYD has a gender focus and explicitly refers to SRH and rights, defining these as human rights and clearly identifying the right of young people to have access to the RH information and services they need. Rights to participation and non-discrimination are also stated. A National Youth Commission including public and civil society representatives has been set up to oversee implementation of the law.

A new law of Equal Opportunities for Men and Women is currently awaiting approval by the National Parliament. This law will also apply to adolescents and young people.

Other laws pertinent to young people's SRH include the marriage and divorce laws, the Penal Code which defines abortion as a crime with the exception of therapeutic abortion when the woman's life is endangered. The penal code also has provisions relating to GBV, including physical and psychological violence. There are no legal restrictions on access to SRH services for young people. The Labour Code has special provisions to protect young people from exploitation, abuse and exposure to risky conditions.

Constitutional rights of young people

The Nicaraguan Constitution includes a bill of rights which guarantees the right to equality and to life. Nicaragua has ratified international and regional rights conventions including CEFDW (ratified by Nicaragua in 1981, but ratification of the 1999 Protocol is still pending), CRC (1989), Human Rights (UN Vienna 1993), ICPD (1994), Beijing Platform for Action (1995) and the Belem do Pará Interamerican Convention to prevent, sanction and eradicate violence against women (1994).

Legal age of adulthood is 21 years, but the Constitution also specifies for the exercise of other rights and responsibilities. Men and women have the right to vote at 16 years of age. They can work legally at 14. At 18 they can be tried under the Penal Code rather than the Children and Adolescents Code. Women can marry at 14 and men at 15, however they have to pass through a process of judicial approval of the marriage if they are under 21. Age of consent for sexual relationships is not established in the Constitution or in any law.

Young people's participation in policies and programmes

Young people are one of the key groups in Nicaraguan society and have played a major role in the country during the war and post-war years, as well as in reconstruction efforts after natural disasters. Since the legal voting age was lowered to 16 in 1984 politicians interested in capturing the youth vote have paid more attention (or at least lip-service) to young people's needs. Government has recently revised its policies to take into account young people's and children's rights to participate in decisions affecting their lives, and these are included in the Children and Adolescents Code and the LPIYD. The LPIYD defines the State's role in promoting participation by young people in "the design, implementation and evaluation of national policies". However these laws are relatively new. In practice children and young people are still frequently denied the right to participation at household level, in school settings, and in public policy decision-making forums.

The PRS provides a supportive framework to promote young people's participation, however opportunities for young people are very limited in the context of acute poverty and lack of economic opportunities. The education system is still traditional and does not encourage participation. Out-of-school youth have few opportunities for participation due to lack of participatory structures and limitations on their own time which is often completely taken up in contributing to the family income.

1.3 Sexual and Reproductive Behaviour

Social and cultural attitudes towards young people's sexual activity, marriage, fertility

Attitudes towards young people's sexual activity are still influenced by the Catholic church, machismo and the generalised disapproval of recreational sex for women and young people. Despite the social changes after the revolution of 1979, attitudes in Nicaragua are still dominated by the Catholic paradigm of sexual relationships as a means of procreation rather

than a source of pleasure, and the importance of the nuclear family. Women are considered to be primarily responsible for domestic work and child-care despite the changes in women's legal status.

Results from an in-depth study by Sofia Montenegro (2000) show that adults' attitudes to their own sexuality are fraught with problems, and these are reflected in their attitudes to young people's sexual activity, particularly among low-income groups. In the survey sample (which included adults and young people) 89% of respondents considered that abortion is a sin, 85% that homosexual relations are a sin, 78% that marriage is for life, 72% that masturbation is a health hazard, 65% that a woman's role is to be wife and mother, 60% that the purpose of marriage is to have children, and 58% that girls should be virgins when they marry. Similar results were obtained from Sofia's focus group discussions. Her conclusion is "If the principal reason for sex is pleasure and communication, the data shows that [in Nicaragua] we have a situation of heterosexual activity which brings very little gratification, particularly for women, either in a physical or emotional sense".

Young people do not have reliable information on SRH due to adults' reluctance to talk about it, often due to their own lack of sex education. The emphasis on "innocence" in sexual matters prevents young people from seeking information and services and reduces the use of family planning methods by young couples. Once girls (married or single) have a baby their access to information and services increases.

"No-one talked about sexuality when we were young. We just got swamped with children" (Mother of youth club participant, Somoto)

"In my community some parents don't like to give us information about SRH because they think it's vulgar" (FGD participant, Somoto)

"A girl won't go to the health centre, it taints her reputation. It's much easier for boys" (FGD, La Dalia)

Attitudes towards young people's sexuality are more traditional in rural areas, precisely where the major problems of adolescent pregnancy exist. Because sex is still regarded as a taboo subject young people cannot get reliable information from their families, and do not have opportunities for frank and open discussion with their parents or other adults who they can trust.

In urban areas problems of communication between adults and young people still exist, but attitudes are more influenced by the globalisation of culture. Young people have more sources of information, including the mass media, and more opportunities to find spaces for discussion with other young people and with adults to help them make their own decisions.

Growing awareness of HIV/AIDS and the danger of unprotected sex for transmission of STIs has been more effective in opening up spaces for information and discussion with young people. To some extent this has given the MoH and NGOs a legitimate basis for more open IEC on young people's sexuality and condom use, however there is still a strong and influential current of thinking in Nicaragua which has used the HIV/AIDS epidemic to reinforce traditional value systems, abstinence and fidelity.

Despite the advances in the legal framework discussed earlier, many key government ministries (MECD, MoH, Ministry of the Family) are still strongly influenced by fundamentalist religious groups, notably Opus Dei. At policy level these ministries do not recognise the reality of young people's sexuality and continue to promote abstinence and postponement of the start of sexual activity. At operational level Ministry staff are more pragmatic and recognise the need to provide information and services to sexually active adolescents and

young people, married or single. However many teachers and service providers still have traditional attitudes and lack knowledge and skills to provide the information and services which young people need.

Marriage is not universal, with more women living in *de facto* relationships than in formal marriages. In the 15-19 age group 5% of women are currently married and 17% are in a cohabiting union. Studies show that 50% of this age group are sexually active (ALMA, 2001). Multiple partners are accepted as the norm for men, but not for women.

Attitudes to fertility have been tempered by the economic depression and lack of employment. Adults as well as young people want fewer children, and it is becoming more socially acceptable for young people to postpone child-bearing until their education is completed. However, in rural areas traditional attitudes still persist, and young women who do not conceive early in a stable relationship are made to feel inadequate.

The influence of religious groups is now structural rather than cultural. The church has pressured government to keep sex education out of schools, but very few adolescents or adults in Nicaragua feel family planning or pre-marital sex is a sin in the religious sense.

Sexual and reproductive risk-taking among young people

The principal sexual and reproductive risk taken by young people is unprotected sex which leads to early pregnancy and transmission of STIs, including HIV/AIDS. Although 98% of 15-19 year olds can name family planning methods, only 46% of sexually active girls in this age group use them, according to the DHS of 2001. Other in-depth studies give a much lower % of users (ALMA, 2001). Nicaragua has the highest adolescent pregnancy rate in the Americas. 46% of women have been pregnant at least once before they are 19, and 21% of all adolescent women aged 15-19 have at least one child (DHS, 2001). Birth intervals are short, with 29% having another pregnancy within 18 months of the previous birth. STI/HIV/AIDS rates are increasing in this age group, who are particularly vulnerable.

Reasons behind this situation include inadequate access to education in general, and lack of sex education in the school curriculum; lack of opportunities and expectations; intra-family violence; machismo; “cultural pregnancy; and inadequate access to SRH services. These points are discussed in the following section. Important differences exist between socio-economic groups: girls from poor families who have few expectations or life plans often want to get pregnant as they expect pregnancy to confer a new status (that of mother) and enable them to escape from the family home. In the better-off and better-educated groups adolescent pregnancy is more likely to be by accident rather than by design, and both the adolescent and the child have more prospects for support from the nuclear family (parents or other relatives of the adolescent often bring up her child as if it were their own).

1.4 Priority sexual and RH issues facing young people

SRH rights are now protected by law in Nicaragua, and many young people are aware of them, as shown in the in-country FGD study, stakeholders’ workshop and interviews with young people during the evaluation. However, young people have great difficulty exercising their rights and face major SRH issues, including:

- High rates of teenage pregnancy
- Increasing rates of STIs and HIV/AIDS
- Gender-based violence
- Substance abuse

These problems are generalised in all social groups, but are more acute in rural areas and amongst the very poor and those with low educational levels. Reasons include:

Inadequate access to education:

26% of Nicaraguans aged 15-24 years have no schooling, and 49% have less than 3 years' education (INEC, 2001), often due to poverty. Pregnancy rates (but not STI rates) are lower for adolescents with higher levels of education.

Inadequate access to IEC in SRH:

There has been no sex education in the Nicaraguan school curriculum for the last 25 years, and IEC programmes for out-of-school youth have had limited coverage

Lack of opportunities and expectations:

As a result of poverty and lack of education many young women especially in marginal urban and rural areas have low self-esteem, no future expectations and nothing else to do except have a baby (UNFPA 1999).

Intra-family violence:

Girls subject to domestic violence often see pregnancy as a way to escape from the family home (MECD & UNFPA, 2003; Montenegro, 2000).

Machismo:

Young men are still influenced by the cultural factors behind machismo, and young women have insufficient power in relationships and lack experience and skills to negotiate use of condoms.

"Cultural pregnancy":

In families where the mother, sisters and friends have had early pregnancies it is considered the norm.

Inadequate access to SRH services:

Even those who do have access to IEC still have a high pregnancy rate due to lack of access to services and family planning methods, especially services which are attractive and satisfy their particular needs. Obstacles to access are psychological (shyness, fear of being reprimanded, or that their parents will find out) and economical, particularly in the case of family planning methods. Service quality and attention is better for the higher income groups, even in the public sector

"The strange thing is that even we girls who have information are getting pregnant"
(FGD Jinotega)

"There are contraceptives available, but we don't have any money to buy them"
(FGD, Ocotal)

"There's discrimination by social class, income, and against rural people" (FGD, Jinotega)

In summary, major advances have been made since ICPD in establishing young people's sexual and reproductive rights in Nicaragua, and many young people are aware of their rights. However they still have great difficulties in exercising them. There is inadequate access to IEC and services, few opportunities for real participation, and discrimination against youth, especially girls. Priority SRH issues for young people are teenage pregnancy, STIs, GBV and drug abuse.

SECTION 2: THE STRATEGIC PRIORITIES OF THE COUNTRY PROGRAMMES

2.1 The Strategic Priorities and Objectives of the UNFPA Country Programme

2.1.1 Relevance

Overview of UNFPA assistance to Nicaragua and its strategic focus on young people since ICPD

UNFPA support to Nicaragua commenced in 1973, with specific projects administered by UNDP. Between 1984 and 1992 the Nicaraguan programme was administered from the UNFPA office in Costa Rica. A country office was set up in Nicaragua in 1993. There have been 3 country programmes (CP) since ICPD: 1994-1997; 1998-2001; and the current programme 2002-2006. Programme budgets and sources of funds are shown in figure 1.

Figure 1
Country programme funding 1994-2006, US\$ millions

Sub-programme	1994-97			1998-2001			2002-2006		
	Reg	X-bi	Tot	Reg	X-bi	Tot	Reg	X-bi	Tot
SRH	5.8	1.5	7.3	5.1	3.0	8.1	1.3	9.7	11.0
Population & Development	1.5		1.5	1.3		1.3	3.2	1.1	4.3
Advocacy							0.5	1.7	2.2
Multi-sectoral	0.7		0.7	0.4		0.4	0.5		0.5
Total	8.0	1.5	9.5	6.8	3.0	9.8	5.5	12.5	18.0

Notes:

Reg= UNFPA Regular funds

X-bi= Multi-bilateral funds

Actual spending 1994-97 and 1998-2001; budget 2002-2006 approved by the Executive Board (of this total US\$14m have been programmed to date)

Source: UNFPA country office

1994-97 programme:

The 1994-1997 programme was formulated before ICPD, during the conflictive period after the Sandinista government lost power in 1990. Its principal objectives were:

- To strengthen institutional capacity to formulate population policies and programmes and include demographic variables in development planning; and
- To reduce maternal mortality and fertility through increased demand for services and improvements in service quality and contraceptives supply.

Activities were concentrated on maternal and child health (MCH) and family planning, and support for the 1995 Census (the first since 1971). Adolescents and rural women were identified as principal target groups. Adolescents' rights are not specifically mentioned in the programme document, but the content reflected a rights-based approach. The programme worked with the public sector and NGOs, who executed 52% and 12% of the budget respectively. UNFPA itself executed 35%, mainly due to large amounts of money spent on procurement of contraceptives. The country office in partnership with UNFPA New York generated a high level of interest and participation in the ICPD and Beijing conferences and follow-up activities, particularly among civil society organisations.

1998-2001 programme:

The 1998-2001 CP was formulated post-ICPD and set its objectives, strategies and activities firmly within the Cairo framework. The overall objectives were:

- To contribute to universal access to SRH, with specific objectives to increase the utilisation of RH and family planning services; and
- To increase political support and national technical capacity to include population and gender in poverty reduction and sustainable development programmes.

The CP included 3 sub-programmes: increased access to SRH services, dividing the sub-programme into separate components for adults and for adolescents (“SRH Sub-programme”); strengthened national capacity for service provision and IEC (“Human Resources Sub-programme”); and strengthened national capacity to implement a NPP and to develop and use a socio-demographic evidence base (“Population and Development Strategies Sub-programme”). Advocacy, IEC, gender and the Cairo framework were cross-cutting themes. The programme was implemented through the MoH and local government, with UNFPA responsible for procurement, advocacy and technical assistance. NGO participation was low as UNFPA considered the public sector to be its first priority and was reluctant to work with NGOs who had uneasy relations with the government of the day (UNFPA Mid-term Evaluation, 2000).

The adolescent component of the SRH sub-programme was designed to improve both supply and demand for services and IEC. Supply-side work focussed on developing “differentiated” services for adolescents in MoH health units, building on work carried out along these lines in the Bertha Calderón Women’s Hospital (HBC) Adolescent Clinic during the previous programme. To increase demand for IEC and services the programme developed a model of youth clubs and community outreach work to be implemented at local government level. These models are discussed in detail in sections 5 and 6 of the report.

The programme started with a new Country Representative and a number of new professionals in the UNFPA staff team. Its start coincided with a change of national government in Nicaragua, and with adoption of a logframe methodology in UNFPA. The programme’s strategy was to motivate and support positive change at policy level and implement demonstration projects which could be replicated in other areas of the country. Activities were geographically focussed to ensure that demand and supply elements were complementary.

Some significant problems arose during implementation, including Hurricane Mitch in late 1998 which caused widespread destruction in the programme zones, repeated attacks on UNFPA in the media by fundamentalist religious groups with political influence in the key partner Ministries, and a reduction of UNFPA regular funds due to the USA’s failure to pay its full quota. A thoughtful mid-term evaluation carried out by the country team with support from the UNFPA Country Support Team (CST) based in Mexico recommended a series of actions to take the work forward despite the reduction in funding. Recommendations for the adolescent component included more advocacy work with the MECD to introduce sex education into schools, reduction of targets and consolidation of geographical areas for demonstration projects, and the need to address sustainability issues.

Despite the difficulties, many of UNFPA’s key successes in supporting development of a legal and policy framework for implementation of the ICPD POA provisions for young people were carried out in this programme period. UNFPA supported the establishment of the Youth Secretariat (SEJUVE), which has become one of its principal partners in the current programme. The demonstration projects also had successful outcomes and some important lessons were learnt for expansion of adolescent IEC and services.

2002-2006 programme:

The current CP has a broad general objective:

- To improve the quality of life through poverty reduction and sustainable development, supporting the exercise of SRH rights and improving the effectiveness of relevant national and local policies.

There are 3 sub-programmes: reproductive health; population and development strategies; and advocacy. Young people do not have a separate component in this CP although they are a major target group. Most of the work with young people is included in the RH sub-programme, but activities in the other two sub-programmes also directly benefit young people. The programme has 7 expected outputs of which 2 are directly related to young people (behaviour change through community outreach work, informal and formal education; and increased coverage and quality of separate services for adolescents in MoH health units). The other expected programme outputs are improved emergency obstetric care (EOC), implementation of the NPP, behaviour change for adults to reduce STIs and GBV, improved quality and availability of RH services, and a strengthened logistics system for contraceptives supply.

The principal programme partners are the public sector at national and local government level, with an expanded range of national government partners including SEJUVE. Key areas of work for young people include support for sex education in the non-formal education sector through SEJUVE and NGOs, support for development of a sex education curriculum in schools through MECD, strengthening SRH services for adolescents in the MoH, and development and implementation of norms and protocols for adolescent services in the MoH. There are 8 projects (3 implemented by NGOs) aimed at improving supply and demand for IEC and services for young people.

The programme budget has increased through successful fund-raising by the country office for implementation of a National RH Programme (NRHP), also known as the “Mini-SWAp”. Canada, Norway, Luxembourg, UK and the Bill and Melinda Gates Foundation have channelled large proportions of their funding for SRH in the MoH through UNFPA, which has been coordinating the Mini-SWAp administration. This represents a major increase in the overall UNFPA budget, as shown in figure 1. However, it is currently unclear as to whether the Ministry of Health will go for the Mini-SWAp in SRH or directly for a full sector-wide approach as supported by DFID and other international donors.

A change of government in January 2002 and subsequent instability of staff in the key partner ministries has delayed the start of programme implementation, but significant progress has been made in the area of formal education.

Discussion

All the CPs since 1994 have referred specifically only to adolescents (i.e. 10-19 age group), sub-dividing them into 10-14 and 15-19 year olds, who are considered to have different needs. Young people over 19 are covered by projects in the adult programmes including work in the industrial free zones (“maquilas”), the police and the army where many workers are under 25. This approach reflects the general lack of protection for 19 to 24 year olds in the Nicaraguan legal structure prior to the LPIYD.

All CPs since 1994 have emphasised young people’s rights and have tackled some of the major obstacles to exercising rights identified in Section 1 of this report. They have focussed on reducing problems of high rates of adolescent pregnancy, STIs and the risk of HIV/AIDS. Improved access to IEC has been a strategic focus, together with promotion of “differentiated services” for adolescents in the public sector (see Section 5). Advocacy and support for youth policy development have assumed a major role in the last two CPs, although this work

has opposed by fundamentalist religious groups in key government positions, particular during the previous administration. The country office has been astute in taking advantage of any opportunities for policy change that do occur, such as creation of SEJUVE and increased possibilities for introduction of sex education in the school curriculum, and has advocated for change.

CP focus and balance between young people and other priorities

Historically the CPs have been developed within the context of the contemporary situation and needs in Nicaragua. The earlier programmes were developed in a politically and socially conflictive context where neither basic services nor information on population were available. They concentrated on MCH, family planning and strengthening national capacity for integrating population issues into development planning, and had less emphasis on young people.

Since ICPD programmes have been developed in consultation with key government partners, and have been based on analysis of needs in Nicaragua and identification of areas where UNFPA has a comparative advantage. The programmes have worked within a rights framework and have been oriented towards achieving ICPD POA goals, with far more emphasis on young people than earlier programmes. About one-third of the current programme resources are allocated to young people in comparison with one-fifth in the previous programme. This changing focus has resulted from analysis of the acute need to reduce adolescent pregnancy and STIs, development of the concept of the “demographic bonus” in which young people represent an opportunity rather than a problem or a risk, and the availability of multi-bilateral funding for adolescent projects.

The current programme focuses on improving the demand and supply of SRH IEC and services for all target groups, but proposes a more integral approach to tackle the major obstacles to SRH and rights for young people. This is reflected in its support for policy change and development of mechanisms to enable young people to exercise their rights, such as sex education in and out of schools, work with SEJUVE and the youth Ombudsman, and development of special services for adolescents in MoH units. At project level, the programme support for municipal-based youth clubs offers young people opportunities for more integral development (see Section 6).

The programme works at central government level in Managua and in municipalities in the north and centre of the country and the Atlantic coast. The geographical focus was originally based on poverty criteria, which opportunely coincided with priority areas when additional external resources became available after Hurricane Mitch. The current programme works in the same municipalities to give continuity and develop the demonstration models further. This focus does not prevent UNFPA from including projects in other municipalities if they are within its overall programme framework and donor funding is available.

The current and previous programmes have focussed more on work with the public sector rather than civil society groups, in particular NGOs, although 3 out of 26 projects were executed by NGOs in the previous programme and 2 NGOs participate in the current programme. The emphasis on public sector work was due to the need to strengthen the public sector at both policy and operational level, but may also reflect a response to the strained relations between NGOs and the previous government and the consequent difficulties UNFPA may have had in pursuing its public sector programme had it continued to support NGOs. This may have reduced its capacity for advocacy on SRH rights, where Nicaraguan NGOs are strong and are prepared to take the lead.

Proportion of the UNFPA CP devoted to policy development, service strengthening and education and information.

The current CP budget is split between RH (61%), population and development policy (24%), advocacy (12%) and multi-sectoral activities (3%). The country office estimates that staff time is allocated in much the same proportions. In a resource-poor environment such as Nicaragua it is hard to say whether this is consistent with country needs, as more is always needed. UNFPA has actively sought multi-bilateral funding and its increased budget for this programme reflects its success in obtaining additional support. Most multi-bilateral funding goes to the RH programme.

UNFPA's strategic sectoral role in relation to young people

Through advocacy, technical support and some funding UNFPA has played a strategic role in development of the NPP Action Plan, the Childhood and Adolescent Code, the LPIYD and Youth Development Policy, and the Law of Equal Opportunities for Men and Women which is currently under debate in the national Parliament. UNFPA participated in stakeholder committees and in several cases paid the consultants who drafted the laws and policies.

It also played a major role in ensuring that population and demographic concepts were included in the PRS and the subsequent NDS, and has taken the lead in motivating donor coordination for development of the NRHP (see next section). In these activities the country office has made good use of the CST whose experienced consultants are able to work at high level in partner ministries.

It has also played a strategic role in providing support for development of mechanisms for implementing laws and policies, particularly in areas that affect young people's rights and SRH. Examples include strengthening SEJUVE, the Nicaraguan Women's Institute (INIM) and the Children and Youth Special Ombudsman, technical support for the introduction of sex education to the school curriculum, and strengthening Municipal government support for youth development.

UNFPA has known how to use its comparative advantages in work with the public sector, but the current and previous programmes have given lower priority to using those advantages to strengthen civil society groups, specifically NGOs. Although UNFPA has worked successfully with national universities to introduce post-graduate courses in SRH, its support to NGOs who are prepared to take a leading role in advocacy for adolescents' SRH and women's rights has been limited. The NGOs interviewed during the evaluation stressed their interest in the technical support of UNFPA and in its access to decision-makers in key positions in the government.

Addressing the diverse needs and empowerment of young people

The CP and country office staff show a clear understanding of the factors which influence young people's RH and rights. The programme includes work with male and female groups, older and younger adolescents, rural and urban groups, and adolescents in and out of school. Within the programme, projects are designed to meet the specific needs of different groups.

The programme identifies its principal target group as adolescents 10-19 years, but it does include work with young people 20-24 years in projects such as SRH IEC and services in the maquilas, IEC work in the army and police colleges, and work with SEJUVE.

Actions at policy level have supported empowerment of young people. UNFPA has used its influence and technical support to ensure that policies refer explicitly to rights and has

assisted in setting up mechanisms such as SEJUVE and the youth Ombudsman to help young people exercise their rights. One disappointing failure has been UNFPA's inability to convince the MoH to retain sexual health explicitly in the NRHP, although the content of the programme does in fact include sexual health without naming it as such. At operational level, UNFPA is supporting young people's empowerment in the development and application of norms for service provision to adolescents in MoH health units. The norms clarify young people's sexual and reproductive rights and explain how service providers should respect them. The projects UNFPA supports at municipal level are also rights-based and field visits during the evaluation showed they are successful in promoting young people's empowerment. However the number of direct beneficiaries is relatively low.

2.1.2 Integration of Rights

UNFPA considers that sexual and reproductive rights are the basic foundation of all the CP sub-programmes, projects and activities including those related to young people. The purpose of the RH sub-programme for example is clearly framed in terms of rights and gender equity ("The purpose ... is to support the full exercise of sexual and reproductive rights by the Nicaraguan people and to achieve gender equity throughout their lifespan"). Within the young people's programme rights of access to services and information, and the right to participate are included in every activity. Other rights such as non-discrimination are included where appropriate and wherever there is an opportunity to introduce them.

Policy-level work supported by UNFPA has shown clear advances in knowledge and awareness of rights and gender equity issues in Nicaragua, and a willingness to put these concepts into practice. A questionnaire developed by UNFPA NY to evaluate progress since ICPD was recently completed by the country office in partnership with a group of 18 public sector and civil society organisations, and showed significant advances in the legal structures, policies and practices to protect adults' and young people's rights and promote gender equity and empowerment of women.

At project level, the starting-point of IEC materials and methods used in the AMUNIC projects for example (see section 6) is rights and gender equity. The MoH norms for service provision to adolescents which has received substantial technical input from UNFPA also emphasise rights and gender equity throughout, and the draft teachers' manual for sex education in schools includes clear explanations of rights and gender issues (see section 5 and 6). Discussions with UNFPA staff, partner organisations and young people who participate in the projects showed a high level of awareness of rights and gender issues amongst all groups.

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

2.1.3 Sustainability

UNFPA has developed strategies for sustainability of activities, although in the public sector these usually involve the partner picking up the tab once project funding ends. The MoH is expected to cover the cost of separate services for adolescents, Municipal governments have committed themselves to supporting the adolescent clubs, and the army and police will continue to meet the costs of educational work in their colleges. In the HBC Adolescent Clinic UNFPA has helped develop a strategy for income generation through provision of private fee-paying services to better-off groups. UNFPA has provided some support to

strengthen partners' capacity to formulate projects and seek additional external funding. Given the low budgets of public sector partners and the need for additional resources for young people's programmes better capacity of partners to raise external funding for themselves may be the best way to ensure sustainability.

Work in the private sector maquilas has included analysis of the cost-savings which SRH services can generate (for example, less maternity leave for pregnant women) and presentation of the analysis to the entrepreneurs.

Most NGO partners (with the exception of MSN's DFID-funded project) have only received funding for specific items such as training courses, conference attendance or publications in the current programme, so sustainability issues do not arise.

2.1.4 Summary

Prior to ICPD UNFPA's priority areas in Nicaragua were MCH, family planning and NPP development. Since 1994 the strategic focus has shifted with adoption of the Cairo SRH and rights framework and a heavier commitment to work with adolescents 10-19 years. Young people aged 20-24 have not been identified as a specific priority target group. Financial resources for adolescent work have increased from US\$1.6m for the 1998-2001 programme to almost US\$5m for the current programme, and now take up approximately one third of the total country programme budget. There is now a full-time staff member working exclusively on adolescent work, and other professional staff spend between 10% and 20% of their time on adolescent issues. UNFPA estimate that in total one quarter of the staff time is used on adolescent work in the current CP.

The country office strategy is to work at central government level to contribute to development of a legal and policy framework that respects young people's rights. This is complemented by work at both central and local government level to support development of mechanisms through which young people can exercise those rights. At central level this area of work includes support for development of a school curriculum in sex education, development of norms for adolescent services in MoH, support for the youth Ombudsman, etc. At local level mechanisms for exercising rights are developed within a demand-supply paradigm with "demonstration projects" implemented by local government to raise demand for IEC and SRH services, and by the MoH to improve the quality and accessibility of services.

The strategy is aimed at the key issues facing young people in Nicaragua, and UNFPA has made important contributions at policy and central government level. At local level the supply-side demonstration projects are now beginning to have an impact on MoH practice nationally, but the demand-side projects need more analysis of lessons learnt and cost-effectiveness to assess their potential for replication and adoption on a wider scale. UNFPA is planning to analyse these experiences and expects to have some results by September 2003.

At national level UNFPA has used its comparative advantages effectively, although cautiously at times due to the sensitive socio-political environment in which it works. It has not exploited these comparative advantages for alliance-building with civil society and the NGO sector who are willing to take the lead on SRH and rights advocacy and would benefit from UNFPA's technical support and access to decision-makers.

2.2 The Strategic Priorities and Objectives of PROFAMILIA's National Programme

2.2.1 Relevance

Brief historical overview of PROFAMILIA's programme and strategic approach since ICPD

The Nicaraguan FPA, La Asociación ProBienestar de la Familia Nicaragüense or PROFAMILIA, has been associated with IPPF since its inception in 1970. It is a non-governmental organisation which began operating under the name Asociación Demográfica Nicaragüense. Its early work was centred on the collection and analysis of demographic data as well as provision of family planning methods (temporary and permanent). At the end of the 1970s the name was changed to PROFAMILIA and the focus shifted to the provision of family planning and health services. PROFAMILIA was the first organisation to introduce family planning to Nicaragua and during the 70s was the only source of family planning methods in the country.

Due partly to this historical legacy, the organisation has been associated mainly with the provision of contraceptives. This has broadened over recent years with more emphasis on other aspects of RH in addition to family planning. From 1998 PROFAMILIA began to follow a policy of diversifying the range of services offered at the clinics including Pap smears, x-rays, ultrasound and other diagnostic services, and focussed more on increasing the up-take of temporary methods of contraception as opposed to permanent methods which had been emphasised during the 1980s and 1990s. This period also saw a significant investment in the development of a social marketing programme and a stronger focus on working towards financial sustainability, encouraged largely by PROFAMILIA's principal funder, USAID.

Since 1992 PROFAMILIA has received most of its funding from USAID⁴. From 1992-1997 USAID gave PROFAMILIA a grant of US\$8.5m to expand its clinic network from two clinics in Managua to a network of twelve Regional Centres covering most of the west and central parts of Nicaragua. During this time PROFAMILIA also established an extensive network of community-based promoters, whose chief role was to distribute family planning methods and provide basic information on reproductive and sexual health in rural and urban areas. For the period 1998 to 2003 PROFAMILIA received an additional grant of US\$10m from USAID. After Hurricane Mitch in 1998 USAID gave PROFAMILIA a further grant of US\$5.6m (of a total of US\$30m for the health sector in Nicaragua⁵). Activities carried out with this money included construction of six new clinics that would function under a social franchising model, with the aim of achieving financial sustainability. These three grants from USAID came to a generous total of US\$24.1m over an 11-year period, and as discussed later in this report have meant that PROFAMILIA has not developed capacity to generate funding from other donors.

Management of the new social franchise clinics was transferred to PROFAMILIA at the end of 2001 bringing the total number of Regional Centres to seventeen (Managua Regional Centre has 2 clinics, and Granada has shut). In practice the new clinics did not function as social franchises but used different contractual procedures for medical staff that have now been adopted in all clinics, using an incentive-based salary scheme.

⁴ PROFAMILIA has received a grant of US\$8.5m from 1992-1997, followed by a further grant of US\$10m to September 2003 (the latter includes a one-year no-cost extension).

⁵ These funds were part of USAID's project: Programa de Reconstrucción y Recuperación Post-Huracán Mitch, and amounted to a total of US\$130 for Nicaragua covering all sectors. The contract with PROFAMILIA was part of a contract called "Estrategias de Mercadeo Comercial (EMC) or commercial market strategies.

The youth programme

The youth programme was developed in Managua in 1989 under the name “Programa de adolescentes y jóvenes” in response to the growing need for educational, recreational and cultural development of young people in a context of low employment opportunities. The objectives of this early programme were to provide a space where young people could learn, enjoy themselves and develop a life plan, and where they would also have access to information and communication on SRH. The clubs formed groups of promoters, mainly in marginal urban areas. The majority of the promoters were medical students at the university in Managua. It was not until the development of the strategic plan in 1997-98 that provision of services for adolescents and young people was introduced as a specific objective of the organisation.

In March 1998, based on the experience in Managua over the previous nine years, the adolescent programme was expanded to all of the regional centres of PROFAMILIA (12 clinics at that time⁶) using a model of youth clubs, affiliated to the clinics but with their own logo and slogan “Amigos para crecer”. Each club is managed by an ‘Orientadora’ (Coordinator). The ‘Orientadora’ is a member of the clinic staff, and trains groups of volunteer youth promoters using a set curriculum called “Saber para Crecer” (knowledge for growth). Each pair of promoters then organises and provides information to a mini-club (see section 5) using a cascade model of learning. The youth clubs use a room or space in the clinic or, if there is insufficient room, hire an additional space nearby.

In 2002, IPPF (with funds from the Netherlands Trust Fund) financed a one year adolescent project called ‘Dual Protección’ (dual protection). This project is taking place in Rivas and Chinandega, which are border areas with Costa Rica and Honduras respectively, and where the rates of sexually transmitted infections and HIV/AIDS are the highest in the country. This project uses the same youth club model as the rest of the PROFAMILIA programme.

Today PROFAMILIA provides integrated clinical services through 16 Regional Centres (17 clinics), eleven of which have youth clubs attached. It also maintains a network of 758 volunteer community promoters and 183 community-based distributors (most of them pharmacies). It runs a social marketing programme which promotes the Body Guard condom, the DuoFem pill and will soon include a brand of injectables, and manages a communications programme that includes TV, radio and other mass media. There are currently about 600 youth promoters.

Structural changes in PROFAMILIA’s overall programme

At central level PROFAMILIA has undergone many structural changes in the last five to six years. Various departments and divisions have been streamlined and PROFAMILIA has been slimmed down to its present structure, which can be seen in the organogram in figure 7. An evaluation by PopTech on behalf of USAID in 1997 resulted in a significant restructuring and development of a new mission, objectives and strategic plan. A further evaluation by the same organisation in 2001 resulted in yet another restructuring and once again, a new mission, vision, objectives and Strategic Plan (2002 – 2005). There have also been a number of changes of Executive Director and members of the governing board. PROFAMILIA is still very much in a process of transition, as can be seen in the action plan of the Strategic Plan, which includes many fundamental changes to be made in the Statutes, organisational structure, and roles.

⁶ The clinic in Granada has since closed. The social franchising clinics do not have youth clubs with the exception of two: Esteli and Somoto, and activities for youth were not part of the social franchising model used.

The new mission of PROFAMILIA is:

“PROFAMILIA is a non-Governmental organisation that contributes to improvement of the health of Nicaraguan families through projects, programmes and education services, investigation and the delivery of integrated health services with quality and warmth.”

Until 2002, the mission statement included an emphasis on family planning, which has now been dropped.

The vision is:

“By the year 2005, PROFAMILIA will be a leading NGO in the provision of integrated health services with wide national coverage, with an emphasis on reproductive health, and on financially sustainable services provided with quality and warmth”.

There are four long-term institutional objectives:

- To contribute to reduction in the total fertility rate and reduction in growth of the Nicaraguan population, particularly among the urban and rural poor with little access to education.
- To promote healthier families through the provision of accessible, quality family and RH services, particularly among the poor.
- To develop an organisational structure that will strengthen the management of the organisation in accordance with its mission and vision.
- To develop strategies, mechanisms and activities that will lead to financial sustainability of the organisation in the medium term.

The language used to express these objectives, particularly in the first bullet point above, is not that used at Cairo: the language of free choice and meeting unmet needs is noticeably absent.

The focus on young people: balance of resources both within the youth programme and in the overall PROFAMILIA programme

The development of the youth programme in Nicaragua responded to the very high incidence of adolescent pregnancies - the highest in Central America⁷ - and the widely-recognised need by organisations working in SRH services to increase the provision of services and information to young people. A further important factor was the lack of spaces for young people to meet or activities for them to participate in, and the growing incidence of gang-related violence and drug and alcohol abuse among young people. The early programme in the 1990s worked mainly with young medical students as promoters, but in 1998 the programme expanded to all of the Regional Centres and began to work with a wider range of young people from the age of 10 to 24 years.

Information education and training are provided to young people through the PROFAMILIA youth clubs. SRH services are provide to young people in the same way as services for adults (i.e. through its clinics and community-based distribution), and has not adopted the model of ‘differentiated’ service provision of some Ministry of Health facilities where services are provided to adolescents in a separate clinic. Young people have a designated space for their clubs either within or outside the clinic where they can organise activities and participate in training provided by the ‘Orientadora’. Each club has a mini library of documents and materials (often a bookcase) on young people’s SRH.

⁷ According to the ENDESA 2001 (DHS), 27% of young people have either had a pregnancy or are pregnant by the age of 19 years.

The current programme has developed over the last five years and now has an integral approach, addressing problems such as self-esteem, values, communication (including parental communication), sexuality and sexual roles, SRH rights, biological and psychological changes in adolescence, adolescent pregnancy, family planning methods and STIs. The range of issues covered by the programme has broadened since the Cairo + 5 conference and was based on a review of needs and existing activities in Nicaragua and the Central American region.

The youth programme has its own strategic plan 2002 – 2005, developed in August 2002. It also has its own mission, vision and objectives. The Mission is:

The adolescent and young people's programme of PROFAMILIA Nicaragua, through the development of its youth clubs, contributes to the development of young people, with an emphasis on personal development, sexual and reproductive health, the promotion of a full, healthy and beneficial lifestyle, that will help young people to define their own goals and strategies, building self-esteem, and empowering and reaffirming their personal values.

The vision is:

By the year 2005, the adolescent and young people's programme of PROFAMILIA Nicaragua will have a wider and more efficient network of young people, in the field of sexual and reproductive health and personal development, providing young people and young adults through the its youth clubs, with information and education with quality and warmth.

The youth programme has one full-time manager at central level in Managua and one 'Orientadora' in each of the Regional Centres, except for the Centres taking part in the IPPF Dual Protection project where there are two. Each youth club has a number of promoters which varies from club to club but is usually at least 30.

This is a low-cost programme and does not consume a large percentage of PROFAMILIA's overall resources. The average direct monthly operating cost of each youth club is approximately US\$600. It is difficult to estimate the indirect expenditure on the youth programme as a whole as it is subsidised by other parts of the programme. Indirect subsidies include space for youth clubs to function within the clinics, support from trainers at head office and supervision, monitoring and support visits by members of the Medical Services Division. The social marketing of the Body Guard condom also contributes indirectly to the youth programme as it aims to increase demand for condoms among the 15-24 age group.

Direct expenditure on the youth programme and other PROFAMILIA activities is shown in figure 2. PROFAMILIA have four key strategies: provision of health services to the general population; the CBD network; youth clubs; and social marketing. The expenditure was higher in 2000 as additional training costs were incurred with introduction of a new youth manual for promoters in all youth clubs, and an additional US\$20,000 was spent on promotional materials. Even with this slightly higher level of spending in 2000, given that the youth programme is considered a key strategy, it has received a low percentage of the total budget (4%-6% in the last 3 years).

Figure 2

Actual expenditure by activity, PROFAMILIA programme 2000 – 2002 (US\$ equivalent)

Component / Year	2000		2001		2002	
	US\$ '000s	%	US\$ '000s	%	US\$ '000s	%
Youth Programme	193	6	100	4	113	4
IEC and Soc Mktg	653	20	487	19	447	15
Clinic Services ¹	1,367	42	1,127	44	1,440	47
Head office	1,047	32	866	33	1,053	34
Total Costs	3,260	100	2,580	100	3,053	100

Notes: (1) This includes the network of community promoters and distributors

Source: PROFAMILIA reports

Coherence between PROFAMILIA's youth programmes and its other programmes

The mission and objectives of the youth programme are coherent with PROFAMILIA's general mission and objectives. Whilst the mission and vision of the adolescent programme are broader and include reference to sexual health which is absent in the overall mission and vision, they incorporate similar organisational goals and objectives within the same time-frame of 2002 – 2005. Both aim to provide services with 'quality and warmth'. However while the adult programme focuses on service provision, the youth programme concentrates on providing information and education, and this is reflected in their respective mission and vision statements.

The adolescent programme is physically integrated with the rest of PROFAMILIA's programme as it used the existing structure of eleven clinics (known as Regional Centres) as the basis for its expansion in 1998. Youth clubs are all situated in or close to the Regional Centres. The orientadoras are usually involved closely in the functioning of the clinic (i.e. in the monitoring of quality of care and in staff meetings) and clinic staff provide some support to the clubs although they are not involved in day to day running of youth activities. There is no explicit policy of integration of the youth programme into PROFAMILIA's other activities and the extent of integration often depends on the personal interests of clinic staff.

The six new clinics built as "social franchises" post-1998 do not have space for a youth club or for special youth services or activities, with the exception of the clinic in Esteli which had a youth club before the new social franchising clinic was built and has continued youth activities on a separate site, and the clinic in Somoto where the clinic director has raised external funding to set up a club. There are no plans at present to incorporate youth activities into the other four "social franchise" clinics.

While the adult and youth programmes work reasonably well together on a day-to-day basis in the non-franchised clinics there is a fundamental difference. PROFAMILIA's adult programme is focussed on service delivery on a fee for service basis with a view to achieving financial sustainability. The youth programme on the other hand is focussed on information and education with little expectation of cost recovery as young people are unlikely to be able to pay for services. The youth programme is PROFAMILIA's principal "social" programme in the competitive world of financial sustainability.

Budget allocations to policy/advocacy, services and IEC

The youth programme budget is not divided into the categories of IEC, policy/advocacy and services. The direct costs shown in figure 2 are spent largely on IEC work through the youth clubs, with some service provision in the Dual Protection project clinics. Indirect costs of the youth programme were estimated at approximately the same level as the direct costs, but as mentioned above it is difficult to say how accurate this estimate may be. Indirect costs

include supervision and monitoring of youth club activities, regular training for the “orientadoras”, a portion of PROFAMILIA’s Head Office budget for IEC materials which are also distributed to the youth programme, and the costs incurred in participation in workshops and commissions discussing policy, much of it on youth-related issues. Some funds are also spent on contraceptives for the youth programme. The large majority of both the direct and indirect costs are spent on IEC-related work which is the main focus of the youth activities is IEC.

PROFAMILIA’s role in influencing/implementing national sectoral/sub-sectoral programmes on young people

PROFAMILIA does not have an explicit advocacy strategy to influence national sectoral or sub-sectoral programmes but does have some influence through personal contacts⁸ with decision-makers and membership of various commissions and networks where the Ministry of Health is usually present.

PROFAMILIA is a member of most of the commissions and networks that are concerned with young people and SRH. Chief among these are the National Commission for Integral Attention to Adolescents and Youth which is organised by the MoH and the Inter-agency Commission on SRH, which is now run by Johns Hopkins University and includes around 30 NGOs and some public sector agencies (firemen, police, MoH and others). The latter focuses on IEC/BCC issues for young people. PROFAMILIA is also a member of the Adolescent Network for SRH and Rights, where three of the PROFAMILIA youth promoters are also members.

In practice these commissions and networks may not have a great deal of influence on national programmes. Most people consulted agreed that they provide a forum for exchange of information and play a limited role in encouraging co-ordination and collaboration between members, but have little influence on policy development.

Responding to diversity of needs, and empowerment of young people

The key issues in young people’s SRH and rights in Nicaragua are outlined in section 1. Staff at PROFAMILIA, both at central level and in the clinics, demonstrated a good knowledge of these issues, as did the youth participants interviewed during the evaluation.

While PROFAMILIA staff have a good understanding of these problems and the diversity of youth needs, the principal way that the organisation reaches out to young people is through schools. The majority of PROFAMILIA youth promoters are school or university students and work with their peers, from the age of 10 upwards, to provide information on a wide range of SRH topics. Given that there is no formal sex education in schools at present in Nicaragua other than basic information on the physiological changes that occur during adolescence, PROFAMILIA is playing a much-needed and difficult role in providing access to this information, both in the public and private education sectors. Not all youth clubs have been successful in gaining access to schools as this depends to a large extent on personal relationships between the orientadoras, the local Education authority and school head teachers.

Most of the youth clubs try to do some work in marginal urban and semi-urban areas, but often with just one or two promoters whilst 25-30 work in schools. Out-of-school youth often work in the informal economy and therefore have little time to attend sessions of the mini-clubs. The youth programme model proposes attendance by mini-club members at regular education sessions during a three-month period in order to cover the whole syllabus. This is

⁸ The Medical Director was for many years the Vice-Minister of Health

not easy for young people who are working. Promoters find it difficult to enter the marginal areas at night when many young people would be available as it may be dangerous. However, two of the stronger programmes (Ocotal and Chinandega) have been working in the poorer areas and have also provided information to young people in young offenders institutes and prisons, as well as to the police and the Women's Police Stations ("Comisariás de la Mujer"). In Ocotal the police have accompanied the youth promoters in dangerous areas of the town. Most of the youth clubs do not reach rural areas, except Matagalpa where promoters travel out to the villages, though this activity has a limited scale.

While PROFAMILIA does not specifically target high risk groups, such as those with problems of alcohol and drug problems, many of the orientadoras who are trained counsellors or psychologists do provide counselling for them. However PROFAMILIA is not really equipped in terms of training, capacity and back-up services to deal with this type of problem and would do better to establish close links with organisations already working with high-risk groups. PROFAMILIA *could* play an important role as an entry point to the relevant support network.

The evaluation team observed that PROFAMILIA's training and orientation process as set out in the manual "Saber para Crecer" does lead to the empowerment of youth promoters. The promoters interviewed were confident, good public speakers, and knowledgeable about the key issues. However the number of young people who are empowered by the programme remains fairly small (approximately 600 at present) and cover a limited geographical area and social group. The two Regional Centres implementing the Dual Protection Project (Chinandega and Rivas) have had wider coverage due to the availability of additional financing which has paid for two orientadoras in each programme and a large number of free contraceptives for young people. This project has made a concerted effort to work with different community groups and not just in schools.

While many of the youth promoters that the Evaluation Team met had been with the programme for as many as 5 years, PROFAMILIA is now implementing a new model in which clubs will recruit and train a new group of promoters every three months, who will then have a three-month period in which to orient their peers in their mini-clubs. This model will lead to greater coverage of young people but may result in a decline in some of the more positive aspects of the programme. These include the empowering effects of a long-term association with the programme and with the orientadoras, and the accumulated experience and expertise of long-term promoters in adolescent-to-adolescent methodology.

2.2.2 Integration of Rights

There is no mention of young people's rights in the mission, vision or objectives of the youth programme or PROFAMILIA's overall programme (see 2.2.1 above). It is interesting to note that in 1992 (pre-Cairo) when PROFAMILIA embarked on its USAID funded project "Service and Regional Expansion" the organisational mission statement did include a reference to rights, as follows:

"PROFAMILIA is a private national organisation whose mission is to foster family planning and reproductive health awareness and use **as a fundamental right** of all individuals"

This statement changed however after the USAID mid-term evaluation in 1997, which resulted in a new mission and objectives and the reference to rights disappeared.

Although PROFAMILIA's mission, vision and objectives are not explicitly rights-based, the overall mission of the organisation and the youth programme are to provide services and information on SRH, which are essential for the exercise of rights.

Gender

Gender issues are integrated into PROFAMILIA's work, and the head office training team is in the process of rolling out training for all staff members on gender. A designated staff member reviews all new documentation and materials for their gender sensitivity. PROFAMILIA runs a 6-week training course for third year medical students which includes sections on gender and adolescent, and youth-friendly services.

There is no specific chapter on gender in the youth promoters' manual but gender issues are covered in most chapters and discussed in relation to rights, sexual roles of men and women and sexuality.

PROFAMILIA collaborates with other NGOs which provide training sessions on gender, and attend workshops when the opportunity arises.

PROFAMILIA clinics all have a male clinic offering STI and HIV counselling and testing, vasectomy in some clinics, detection of prostate cancer, general medicine and diagnostic services. PROFAMILIA could perhaps be doing more to encourage young men to attend these clinics by publicising them through the youth clubs and other youth activities. PROFAMILIA is also working with the Association of Men against Violence, providing materials for studies and surveys of the male population.

PROFAMILIA has an equal opportunities employment policy and does not discriminate in its employment practices. Clinic directors are predominantly women (10 women vs 6 men), the 'orientadoras' are all women and there are roughly equal numbers of male and female doctors.

2.2.3 Sustainability of the Youth Programme

In the past the youth clubs have attracted small amounts of external funding, including US\$10,000 from Johns Hopkins University, US\$10,000 from the University of Michigan and US\$ 74,840 from the Netherlands Trust Fund via IPPF London office for operational costs and/or specific activities or IEC materials. With the exception of the Dual Protection Project funded by the Netherlands Trust via IPPF, on-going finance for the youth programme is covered by the organisation's normal sources of funds for the programme in general (own income, IPPF and USAID – see figure 3). The strategy proposed for financing the youth programme in the medium to long-term is to cross-subsidise it from profits of the clinics and social marketing programme. The direct costs of the youth programme (including salary of the youth programme manager and direct operating costs of the youth clubs but excluding indirect subsidies from other parts of the programme) currently represent 4% of PROFAMILIA's total operating budget.

Figure 3 shows PROFAMILIA's sources of funds, including donations of contraceptives from USAID and IPPF, for the 3 years 2000-2002 and donations for capital investments from USAID. The total budget (figure 3) and expenditure (figure 2) differ as the contraceptives and capital investment are not included in the figures for actual expenditure by activity.

In the period 1992-2003 PROFAMILIA has received US\$24.1m from USAID for operating costs and programme development for the organisation as a whole. This funding is now coming to an end, as USAID considers PROFAMILIA should have been able to build a self-financing clinic and social marketing network with these large injections of donor funding. IPPF/WHR has also provided funding at a much smaller scale, and does not expect to be able to increase its financial input significantly due to lack of available funds. However IPPF/WHR does intend to increase the level of TA to PROFAMILIA, particularly with respect

to the need to downsize after September 2003 and to support projects that reflect IPPF's new global focus on the 5 'A's (adolescents, access, etc).

Cost recovery in the clinics has been increasing during the last 3 years (figure 4) and a number of clinics are now almost financially sustainable. However the current rate of cost recovery is only around 50 percent for the programme as a whole due to high head office costs (30% of total operating budget). Strategies to increase sustainability include cost reductions in head office and the clinics, and generation of additional income through productivity incentives to medical staff and contracting services to the national health insurance scheme.

PROFAMILIA is currently in a difficult financial situation and will have to make significant efforts to increase the sustainability of the organisation as a whole. This is clearly a key factor for sustainability of the youth programme. Although senior staff have declared their strong commitment to maintain the current level of funding for the youth programme which only represents a small proportion of the overall budget, PROFAMILIA will need to look for additional external funding in the short-medium term to maintain its youth activities, until such time as they can be cross-subsidised by the clinics and social marketing activities.

Figure 3
Source of funding for PROFAMILIA (2000 – 2002)

Source of funding	2000		2001		2002	
	US\$m	%	US\$m	%	US\$m	%
Sales of products and services	1.2	30	1.5	27	1.9	49
Social franchising clinics (USAID)	-	-	1.9	33	-	-
USAID	2.3	56	1.9	33	1.6	42
IPPF	0.3	7	0.3	6	0.3	7
Other	0.3	7	0.1	1	0.1	2
Total	4.1	100	5.7	100	3.9	100

Note: These figures show the total grants to PROFAMILIA. They include donations of contraceptives and capital investment, which are not included in the figures for actual expenditure by programme activity shown in figure 2. In 2001 USAID accounts for 66% of total funding due to an additional grant for reconstruction post-Hurricane Mitch, a portion of which was invested in the 6 new "social franchising" clinics.

Figure 4
Level of cost recovery of PROFAMILIA (Regional Centres and organisation)

Year	1999	2000	2001	2002
	%	%	%	%
Regional Centres	51	65	68	77
PROFAMILIA (including HQ)	30	39	44	46

2.2.4 Summary

PROFAMILIA's principal focus is SRH and family planning service delivery on a fee for service basis through a national network of 16 Regional Centres. PROFAMILIA has done very limited work on policy development or advocacy. The organisation has been heavily funded by USAID since 1992. This funding is now coming to an end and PROFAMILIA will have to concentrate on achieving financial sustainability through income generation and cost reduction and/or seek other external funding.

The youth programme is attached to the clinics but in contrast to PROFAMILIA's other activities it focuses on IEC rather than service provision, as few young people can afford to pay for services. It is a low-cost programme which uses a youth club model, peer promoters and outreach work, mainly in schools. The programme has an integrated rights-based approach to young people's SRH and is effective in empowering young people who participate as promoters. Its coverage of rural and marginalized urban groups is low.

The youth programme has benefited greatly from the availability of PROFAMILIA's physical infrastructure in the clinics which provide space for youth clubs, and from the established organisational structure which provides management, monitoring, supervision and access to IEC materials and training. In common with the adult programme, PROFAMILIA's youth programme is not focussed on policy development or advocacy.

In practice the youth programme has been funded largely through the USAID grant and the IPPF donation for the Dual Protection Project since clinic income reverts to the clinics. Sustainability of the youth programme will therefore be dependent on PROFAMILIA's capacity to achieve financial sustainability for the organisation as a whole once USAID funding ends later this year, and its capacity to raise additional external funding for the youth programme.

SECTION 3: INSTITUTIONAL ARRANGEMENTS

3.1 UNFPA Country Office

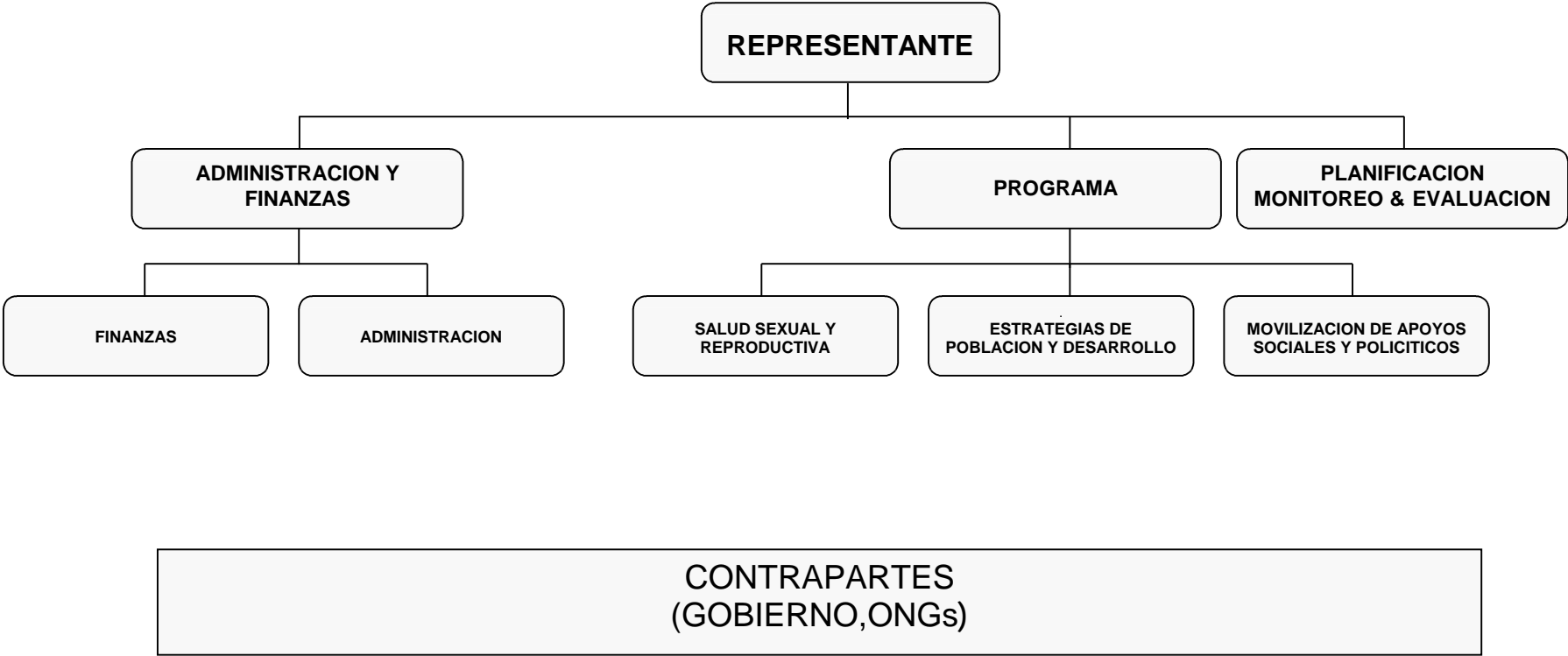
3.1.1 Relevance

Organisational structure

The country office has 3 divisions: Programmes, Planning Monitoring and Evaluation, and Administration and Finance. The Programmes Division is in charge of 3 sub-programme teams. See figure 5 on the following page.

Figure 5

FONDO DE POBLACION DE LAS NACIONES UNIDAS NICARAGUA



There are 23 full-time staff, 2 volunteers and a Junior Programme Officer. The Programmes Division has 15 staff, including the Country Representative (4 in Programme management, 6 in RH, 3 in Population and Development Strategies, and 2 in Advocacy). Monitoring and evaluation (M&E) has one person, and Administration and Finance has 6. Taking into account that the work of the sub-programmes overlaps and therefore in practice professional staff spend time on various sub-programmes, the staff allocation to each area of work corresponds reasonably well with the balance of the programme budget.

The large majority of the staff are Nicaraguan, and have suitable qualifications and experience for implementation of the country programme. The officer responsible for adolescent work had 12 years experience in this field working with international NGOs before joining UNFPA 5 years ago, and is well-qualified to take the programme forward.

Resource allocation and financing of young people's RH activities

As of May 2003, a total of US\$4.98 million has been allocated to the young people's programme for the period 2002-2006, including US\$1.54 million for 4 multi-bilaterally funded projects specifically for adolescents and US\$0.82 million of UNFPA regular funds which include the continuation of a project not finalised in the previous programme. These figures include the salaries of country office staff assigned to the adolescent programme. The US\$4.98m allocated to the young people's programme represents 36% of the total US\$14m of the CP allocated to date. (The amount allocated to date is less than the US\$18m approved for the CP by UNFPA Executive Board, as the Nicaragua country office has not yet obtained firm commitment for all the projected multi-bilateral funding.)

The country office has included a further US\$0.15 million for projects in the maquilas and Río San Juan in the figures although these projects are not restricted to beneficiaries under 25 years (see figure 6).

The country office also estimated that 32% of the resources of other multi-bilaterally funded projects (i.e. US\$2.47 million of a total of US\$7.76 million) are used for work with adolescents. This figure is included in the table although it is only a rough estimate of the real resource allocation.

Figure 6
Financial resources for young people's RH activities 2002-2006, US\$

Identification	Source	Amount US\$
Multi-bilateral funds, adolescent projects:		
NIC/02/P01	DFID	584,322
NIC/01/P03	DFID	433,440
NIC/99/P01	UNFIP	370,341
NIC/02/P07	Finland	150,000
Sub-total multi-bilateral, adolescent-only projects		1,538,103
Regular Funds, adolescent projects:		
NIC/02/P09	UNFPA Regular Funds	447,583
Staff and office costs, other projects	UNFPA Regular Funds	374,142
Sub-total Regular Funds		821,725
Multi-bilateral funds, projects aimed mainly at young people		
Young people and AIDS	UNAIDS	50,000
Mobile populations	UNFIP	100,000
Sub-total multi-bilateral funds, projects mainly for young people		150,000
Multi-bilateral funds for projects with adolescent component (30% of total project funds included in this table)		
INT/00/P9C	Bill and Melinda Gates Foundation	238,563
NIC/02/P02	CIDA (Canada)	909,500
NIC/02/P03	NORAD (Norway)	969,770
NIC/02/P08	Luxembourg	355,080
Sub-total multi-bi projects with adolescent component (30% of total project funds)		2,472,913
GRAND TOTAL FOR WORK WITH YOUNG PEOPLE		4,982,741

Source: UNFPA country office

This represents 36% of the US\$14m programmed (as of May 2003) for the CP over the 5-year period. (Note: the overall CP budget approved by UNFPA Executive Board is for US\$18m. As UNFPA has not yet been able to obtain commitment for the whole of this total from its multi-bilateral donors, current programming is based on committed funds of US\$14m). UNFPA estimates that 26% of the time of key professional staff is also spent on

the young people's programme, making the budget allocation and the staff time allocation compatible.

As the overall number of young people UNFPA expects to reach with these projects is not clear it is not possible to judge how appropriate the allocations may be. Clearly some activities such as support for the introduction of sex education in schools and development of norms for attention to adolescents in the MoH will have far-reaching impacts and alone could justify the average budget of around US\$1 million per annum. It is hard to compare the cost-effectiveness of different activities in the programme as the type of results vary from project to project, with a more profound impact on individuals but a higher per capita cost in the demonstration projects. Sections 5 and 6 discuss this point further.

M&E

Monitoring methods include monthly meetings with partners to discuss progress, quarterly and annual reports, and frequent field visits by country office staff. As UNFPA defines its role as "accompanying" project development no formal monitoring instrument has been developed, but the system is said to identify needs for technical assistance and lessons learnt. During monitoring visits the UNFPA staff and partners agree on key issues which need work or follow-up. Financial monitoring is more rigorous, with monthly and quarterly reports on each budget line and an annual audit. UNFPA provides feedback to partners on their written reports.

6-monthly evaluations of projects and sub-programmes are carried out using a type of strengths, weaknesses, opportunities and threats (SWOT) analysis used in conjunction with a lists of specific questions for each sub-programme and quantitative revision of indicators. Each period's resulted are compared with the previous period to identify progress. The same system is used annually in conjunction with revision of progress towards the CP logframe indicators to evaluate the whole programme. The system was developed to strengthen analytical capacity, as partner reports were usually too descriptive and verbose. Partners and UNFPA staff like the method, which is highly participative.

Various methods are used for final project evaluations. Multi-bilaterally funded projects are evaluated by the method specified in the project document. This can take the form of a follow-up to the baseline study, although UNFPA has found that this can be costly and does not always produce the information required. External consultants are used for evaluation of multi-bilateral projects.

CP evaluation is carried out at mid-term and at the end of the programme period. These evaluations used to be done by external consultants, but UNFPA has found it is more effective to do them internally, with support from the CST and UNFPA New York. Although this consumes a good deal of staff time and effort it is thought to be a very valuable experience and will be repeated for this current programme.

UNFPA staff and partners consulted during the evaluation said they find the M&E methods useful and indicated that they use the results for project and programme development. The overall mid-term evaluation of the 1998-2001 CP was used to develop strategies to overcome the shortfall of UNFPA regular funds due to non-payment of the US quota, for example. In the adolescent programme these strategies included reduction in targets and in geographical coverage for projects. UNFPA has also used M&E results in the design of follow-up projects in the adolescent programme, and to identify the characteristics of municipalities which lead to success or failure, using this as an input to decision-making on the geographical focus of project work. It has also used the method in conjunction with AMUNIC (see section 6) to identify key methodological factors in success of the particular approach to youth work and the need to ensure participation by all local actors. Project

partners say they use the results of the 6-monthly SWOT analyses to monitor the changes and improvements from period to period.

Partnerships and collaboration

Government:

UNFPA works in a politically-sensitive environment heavily influenced by fundamentalist religious groups who hold key positions in partner Ministries. Although many staff in Government partner organisations (MoH, MECD, SEJUVE, INIM) are sensitive to young people's sexual and reproductive rights, their approaches have been and still are restricted by political considerations and government policy. One public servant interviewed during the evaluation said that her institution's philosophy and approach to young people's rights coincides closely with that of UNFPA, but the public sector must follow government policies which differ from UNFPA's from time to time.

UNFPA is very aware of the political context in which it operates. The country office has been swift to take up opportunities when they arise, but has maintained a relatively low profile on controversial issues to avoid head-on clashes which may be counter-productive. It prefers to nudge reforms along the right path rather than take a strong stance which could provoke a negative reaction. Public sector organisations at local level can often be more flexible and progressive, and UNFPA has worked at local level where appropriate. It has been successful in broadening the approach of local governments to SRH rights and adolescent development, and many now work within the ICPD rights framework.

Civil society:

Civil society partners are more progressive and their approach to rights is similar to UNFPA's. In contrast to government partners, civil society organisations think UNFPA could take a stronger advocacy role and consider that its approach is somewhat timid at times, given its mandate, size and access to decision-makers. Nicaraguan NGOs have been key actors in advocacy and discussion of SRH policy reform in this country, and in the absence of a stronger advocacy programme by UNFPA they would appreciate more technical assistance and resources from UNFPA to strengthen their own work. They recognise the value of UNFPA's work in policy development and appreciate UNFPA's efforts to facilitate their participation in inter-sectoral working groups and committees to discuss policy reform and practice in relation to sexual and reproductive rights.

Multi- and bilateral donors:

UNFPA's approach to rights is similar to that of the majority of donors and multi-laterals who work within the ICPD framework.

Coordination with other organisations in the UN system is variable, some reporting good coordination at country representative rather than technical level, and others taking the opposite view. In practice there is some coordination at the programme planning stage and on-going dialogue and mutual support during implementation to try and avoid overlap and duplication. Coordination with the rest of the UN system agencies could usefully be strengthened to avoid duplication and ensure complementarity of activities and approaches. More coordination and experience-exchange with organisations such as PAHO and UNICEF who are working directly with young people and supporting similar models would be particularly fruitful.

UNFPA has taken the lead in promoting coordination of donors funding SRH in the development of the "National RH Programme", also known locally as the "Mini-SWAp". Norway, Canada, UK, Luxembourg, Bill and Melinda Gates Foundation and Finland are involved in this initiative and propose to channel a total of US\$9.5 million to the MoH through UNFPA. These funds represent the bulk of the multi-bilateral funding included in the 2002-

2006 UNFPA CP. Progress to date on the Mini-SWAp has been slow due to changes in key MoH staff and growing interest within the Nicaraguan government for a full SWAp in the health sector. As a full SWAp would take some years to implement UNFPA has proposed that the NRHP continue as a pilot exercise. However, the UK has now put its support behind a full SWAp and so there remains a question mark over this level of multi-bilateral funding for UNFPA.

Opinions on the effectiveness of the Mini-SWAp and UNFPA's role are very variable, some donors considering that UNFPA is doing a good job under difficult circumstances due to the frequent changes of Minister and senior staff in the MoH, and others considering that it has not made significant progress and could have done better. Opinions also differ within the MoH itself. The issues of whether the Mini-SWAp is in fact really a SWAp and whether it should continue at all given the government's new interest in a full SWAp approach are somewhat controversial at present. UNFPA is interested in continuing to coordinate the flow of donor funds for SRH to the MoH, and there is some value in this approach, which should avoid duplication. On the other hand, ownership of the National RH Programme needs to be clarified as it currently only includes those projects whose funds are channelled through UNFPA, despite the fact that the MoH receives significant funding for SRH from other bilateral donors. The Government of Finland's SRH project for example, the design for which was based on MoH policy and is implemented by the MoH Departmental offices, is not included in the NRHP reports prepared by UNFPA as the funds are not administered by them.

USAID and UNFPA both donate contraceptives to the MoH, and have worked together to coordinate supply since the early 1990s. They are currently working on a joint exercise to strengthen the logistics system for contraceptives supply.

Collaboration and coordination between UNFPA and PROFAMILIA

UNFPA's principal partners are the public sector, at central ministry and at municipal level, with some participation by civil society. UNFPA and PROFAMILIA participate in the same SRH committees, networks and inter-sectoral working groups together with a wide range of organisations from the public and NGO sectors, donors and multi-laterals. Apart from these groups, PROFAMILIA has been less active in seeking working partnerships, although it is now beginning to develop such links through Nicasalud and has given support to training activities in the public sector. PROFAMILIA's principal partner to date has been USAID, its major funder.

To date there has been little direct contact between UNFPA and PROFAMILIA, and they do not work in coordination. This can lead to duplication of efforts and lost opportunities for lesson-learning and analysis. The evaluation noted for example that the adolescent promoters' manuals and other IEC materials developed by the two organisations cover much of the same content. In the field, PROFAMILIA youth promoters use both sets of material. UNFPA projects have developed other materials which could be usefully included in the portfolio of the PROFAMILIA promoters. Both organisations are promoting work through youth clubs, but have worked independently without any joint analysis or lesson-learning. Other areas where cooperation would be useful were discussed by UNFPA and PROFAMILIA during the evaluation de-briefing session. These included experience working in schools, which PROFAMILIA has achieved despite the MECD restrictions on sex education, and comparative analysis of the effectiveness of the two organisations' models for service provision for young people (see section 5).

The two organisations have different roles at strategic level, PROFAMILIA concentrating on IEC for adolescents and service provision for adults who can pay, whilst UNFPA is focussed on policy change, strengthening of free services for adolescents within the MoH, introduction

of sex education in the schools and development of demonstration projects at community level. UNFPA and PROFAMILIA could usefully develop closer links and take advantage of their complementarity to strengthen both organisations' work.

3.1.2 Integration of Rights

Country office definition and conceptualisation of rights

The country office has fully adopted the Cairo definitions of rights and integrated them into its programme norms, processes and activities. All UNFPA's partner organisations and project participants interviewed during the evaluation were aware of sexual and reproductive rights and the key role they play in UNFPA's work.

Young people's RH and rights as reflected in internal UNFPA policies and practices

UNFPA's internal policies are non-discriminatory and fully respect adults' and young people's sexual and reproductive rights.

3.1.3 Capacity

Capacity and skills of CO staff to manage, promote and support the concept and practice of young people's RH and rights, and to support policy development and lobby effectively within the national policy and legislative sectors

The country office staffing structure and qualifications of key people were discussed in section 3.1.1. Key staff are well qualified and have a good track record of developing and managing rights-based projects for young people. They also have wide experience in supporting policy development and lobbying at national level.

CO staff understanding of socio-cultural and economic factors influencing young people's RH and rights

The large majority of the country office staff are Nicaraguan and understand clearly the socio-cultural and economic factors which influence young people's RH and rights and their ability to exercise those rights. The Adolescent Programme Officer for example has worked for over 15 years in the public and NGO sectors in adolescent SRH programmes. The country office has commissioned important research and project baseline studies which explore adolescent SRH issues and determinants of adolescent SRH in depth, including a recent study of adolescent pregnancy in rural areas which underlines the lack of alternatives for rural youth ("What else can I do except have a baby?").

UNFPA recognises the importance of sex education in the formal school system and in community-based education systems to ensure young people have access to information on SRH and rights, and is fully aware of the social, cultural and political constraints that have restricted this access in the past. Recent changes in the strategy of UNFPA work with young people and a growing emphasis on an integrated approach which includes development of life skills as well as SRH information and services show a clear understanding of the complexity of the social environment and the impact of low self-esteem and lack of future expectations for young people. In the area of service provision UNFPA's focus on work with low income groups who use public sector services indicates the country office awareness of the economic constraints on young people's access to SRH.

Group discussions in the stakeholders' workshop and the FGD during this evaluation confirmed that many of the obstacles young people face in exercising rights have

socio-cultural or economic bases. Among the key socio-cultural barriers is young people's fear of gossip and lack of confidentiality when seeking information and RH services:

I'm afraid of what people say, because if I want family planning and go to the health centre all the village knows about it (FG Somoto).

Economic obstacles and social class are also very important for young people from the low income groups covered by UNFPA's programme:

Family planning methods are available, but we don't have the money to buy them (FG Ocotal).

Institutional arrangements and mechanisms to enable young people to participate in planning, implementation, monitoring and evaluation of CP projects/sub programmes

UNFPA country office staff are aware that young people should participate in all stages of the project cycle and have a clear mandate to foster participation. In practice there is a high level of participation in processes at local or project level, including quarterly planning, development of IEC materials, implementation of activities and evaluation. The extent and effectiveness of this participation depends on the attitudes of people in partner institutions as well as the capacity of the young people themselves to take a protagonist role.

Participation in project design and decision-making is still low. Country office staff have identified a number of obstacles to full participation, including the lack of youth organisations with capacity to be interlocutors, young people's lack of time (many study full-time), and the time-scale and requirements of donor agencies, which make full participation difficult. Participatory planning and decision-making is a lengthy process, and there is often insufficient time available before project deadlines.

UNFPA is working bottom-up to encourage full participation at local and project level, hoping that this learning process will lead to a higher level of participation in project design and decision-making in the future. It encourages partner institutions to increase participation wherever possible. In the area of project design, young people themselves generate ideas for new project proposals, and UNFPA prepares the project profiles and full project documents to present to donors.

The stakeholders' workshop also identified obstacles to full participation, and suggested solutions (see annex 2).

Capacity of staff to use evidence-based planning, and to promote lesson learning and best practice in planning, implementation, monitoring and evaluation of the UNFPA CP

Country office staff have capacity to use evidence-based planning but practice has lagged behind, partly because of the difficulty of collecting valid data in Nicaragua and lack of appreciation by partners of the importance of an evidence base. The MoH has only recently started to disaggregate its statistics by age group and collect specific data on adolescent service users. UNFPA project baseline studies collect information on knowledge, attitudes and practice which could be used for detailed project planning, however to date these studies have been used to set baseline values for project impact indicators and not as planning tools. The principal current projects were designed on the basis of a literature review of project models in other countries rather than on detailed investigation or research. The CST does use evidence-based planning and could support the country office to develop their skills in this area.

Efforts to promote lesson-learning and best practice have been sporadic and *ad hoc*. Most projects hold periodical meetings of partners from different zones for training and for information exchange, and participants reported that these meetings are a valuable opportunity to learn from others' experience. There is little analysis or documentation of lessons learnt. For example, the majority of project participants, and UNFPA country office staff themselves, reported that popular theatre had been one of the most effective IEC methods, but there has been no systematic data collection and analysis of this experience and much valuable information has been lost. All project participants interviewed during the evaluation were keen to develop better mechanisms for lesson-learning and information exchange, and UNFPA is well-placed to foster this.

Capacity building and support provided by the regional Country Support Team (CST) to the Country Office

The country office has requested CST help in policy work, development of the school curriculum in sex education and programme evaluations. The experienced CST consultants are able to negotiate at Ministerial level and carry out high quality technical work in a sensitive political environment. Senior government officials interviewed during the evaluation mentioned the high quality and effectiveness of the CST consultants' work. The Country Representative would appreciate more support from the CST but recognises that there are high demands on consultants' time.

A CST member interviewed during the evaluation said the Country Representative has been very astute in his use of the CST, calling them in immediately when a political door has opened and an opportunity for key developmental work arises. Examples include work with MECD, and integration of population and development issues into the PRS and NDS. Prior to 2001 CST consultants also provided support for development of the two principal models for adolescent work – differentiated services in public sector health units, and IEC work at municipal level (see sections 5 and 6). However, the CST did not have capacity to provide sufficient support for adolescent work during the period 2001-2003 as a number of consultants retired and their posts were not filled. Recent appointment of an adolescent specialist should remedy this situation.

3.1.4 Summary

UNFPA's heavier emphasis on adolescents in the current CP is reflected in the growing allocation of financial and staff resources. One third of the CP budget and one quarter of staff time are allocated to adolescent work. The staff are well-qualified and experienced, and understand the local context and the obstacles young people face in exercising their SRH rights.

Evaluation criteria and methods are qualitative rather than quantitative and include evaluation of processes rather than focussing on results. This may be more appropriate in work with young people where qualitative indicators of success are important and quantitative indicators (such as reduction in adolescent pregnancy rates) have attribution problems. UNFPA does analyse results and lessons learnt with its implementing partners, but the results have not been widely disseminated and there is some reluctance to analyse the lessons learnt from less successful activities which could be very useful to other organisations working with young people.

Country office staff are aware of the need for participation by young people throughout the project cycle, but practical and structural difficulties have limited participation in the project design stage. Young people participate in implementation and to some extent in evaluation, although this tends to be as respondents rather than as protagonists.

There is close collaboration with government partners and the country office has been successful in facilitating reforms in the policy and legal framework despite some specific differences in criteria and approach. Collaboration with civil society has been a relatively low priority although UNFPA's priorities and objectives are closely aligned to those of many civil society groups who are keen advocates for SRH rights. Relations with multi-lateral organisations and donors are good, but in some cases could be strengthened at operational and technical level to take advantage of synergy in projects and approaches.

3.2 PROFAMILIA

3.2.1 Relevance

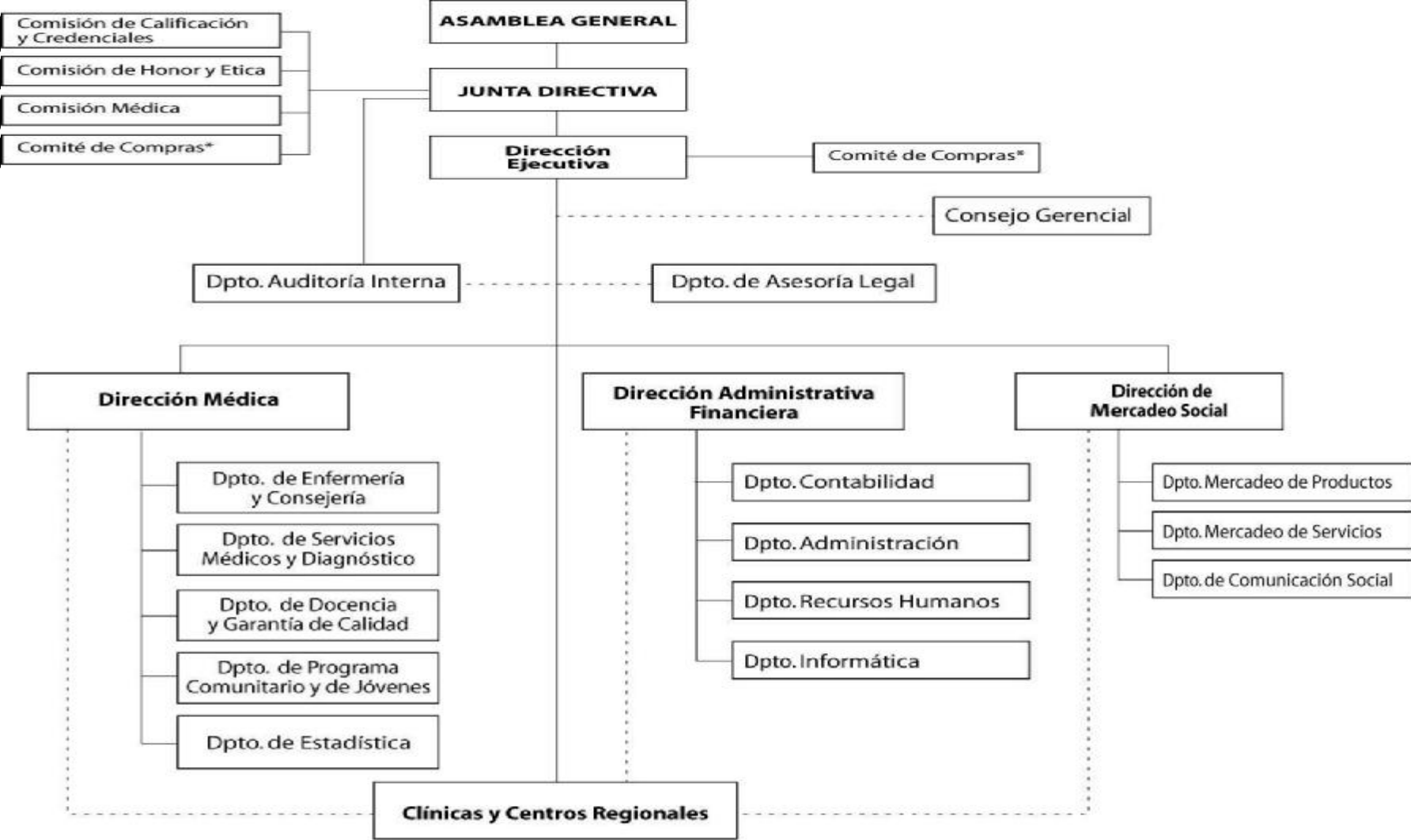
PROFAMILIA's constitution and organisational structure

PROFAMILIA's Articles of Association and Statutes (which were revised totally in December 2002) describe the organisation as a non-profit making and non-governmental organisation, apolitical and with social and educational goals. The revision of the Statutes explicitly refers to the need to provide health services that are efficient, effective and self-sustainable, reflecting the new focus on financial sustainability. Despite the recent revision, the Statutes still retain their family planning and demographic focus with no reference to SRH, even though the revision took place well after ICPD and Cairo+5. PROFAMILIA's national strategy to achieve financial sustainability through clinic fees and social marketing is compatible with its constitution.

The organogram (figure 7) shows PROFAMILIA's organisational structure, which has been streamlined with closure of M&E and Regional Centres Departments and allocation of their responsibilities to other Departments. Despite simplification of the structure, the number of employees at Head Office is high (60 to oversee 16 Regional Centres) and has increased from 51 in 1997 when the changes were made. Total head office costs have remained at just above 30 percent of the total costs of the organisation for the last three years. USAID's mid-term evaluation at the end of 2001 criticised PROFAMILIA for continuing to be top-heavy and costly. Experience in management of a special package of funding post-Hurricane Mitch when a nine-person team set up and ran six new clinics shows that PROFAMILIA can operate more economically.

Figure 7

Organogram of PROFAMILIA



* De acuerdo a políticas establecidas

The Strategic Plan 2002 – 2005 states that there are plans to further simplify the structure to take account of the on-going process of decentralisation. At present, the organisation remains highly centralised in terms of both operational and financial decision making.

Level of resource allocation and financing of young people's RH activities

Direct costs of the youth programme in 2002 were US\$113,000. This represents roughly 4% of PROFAMILIA's total costs for 2002. Estimates of indirect subsidies to the youth programme (buildings, staff time, utilities, monitoring costs etc) almost double this level of expenditure to 7% of total costs, which is still low given the importance attached to the youth programme by the senior management. However, with the cessation of USAID funding in September this year even this low level of expenditure may be unsustainable. The budgeted expenditure for this year (2003) is a total of US\$104,672, including US\$43,252 from regular funds and US\$61,420 for the Dual Protection project (from the Netherlands Trust Fund via IPPF).

Results available from the Dual Protection project show that with additional funding the youth clubs can reach more young people, both within the school sector and outside⁹. Promoters have worked with firemen, policemen, parents, teachers and other groups in the community to explain the project goal and objectives. As a result, in some of the poorer neighbourhoods where the project is working the local health clinic or the local authorities have lent the promoters spaces for meetings, training and talks.

The need to achieve financial sustainability for the organisation as a whole means that it is extremely unlikely, in the absence of additional external funding for specific youth-focused interventions, that the present level of financing will increase or indeed be sustainable. Given that it will be a number of years (at least) until the clinics are able to cross-subsidise the youth programme, PROFAMILIA needs urgently to concentrate on seeking additional external funding for the youth activities. At the time of writing no additional funds had been obtained.

M&E

PROFAMILIA used to have an M&E Division. Simplification of the head office structure has meant that responsibilities for M&E are now shared among the other Divisions but are principally undertaken by the Medical Services Division.

Monitoring and Supervision

Monitoring and supervision takes place at various levels. Head Office staff from the Medical Services Division visit all sixteen clinics once every two months to monitor and supervise all activities including the youth programme. This usually takes a half-day. Actions to be taken and responsibility for taking them are agreed with the clinic team, and monitored from Managua until the next visit. The manager of the youth programme at head office is responsible for monitoring the whole youth programme but does not always participate in the clinic monitoring visits.

At Regional level the Clinic Directors are responsible for monitoring and supervising the services provided in their clinic. There is a supervisor for the team of adult community promoters based in the clinic and the 'orientadoras' are responsible for supervising the youth promoters. The current system is very time intensive, particularly for head office staff. With the planned decentralisation, Clinic Directors will be trained in monitoring and evaluation and

⁹ The final evaluation will not be done until the end of this year it is too early to evaluate the impact. However, the numbers of young people involved in the project are much higher and many of the groups reached are outside the formal school sector.

will then set their own targets for their staff. This has hitherto been the responsibility of head office.

The Dual Protection Project has its own monitoring format developed with assistance from IPPF/WHO and PROFAMILIA submits six-monthly progress reports. The clinics in Chinandega and Rivas record data on service use for monitoring purposes that includes the type of service, age group (10-14, 15-19 and 20-24 years) and the number of references to the clinic from the youth programme. The number of condoms distributed (both male and female condom) is also monitored. This data will enable PROFAMILIA to analyse the effectiveness of the youth programmes in these two locations, but not to compare the Dual Protection Project with other youth clubs since this data is not currently recorded elsewhere.

Monitoring of Quality

There is a Quality Circle of clinic staff in each clinic. Short forms designed to seek the views of clients are available in all PROFAMILIA clinics. These are filled in by the client and posted in a box. Once a month, the Quality Circle analyses the forms and discusses any problems that have arisen and how to solve them.

According to the clinic staff a significant number of clients cannot read or write and their opinions are therefore lost. Clinic staff try and help these clients to respond to the questions but it is unlikely in this situation that they will be completely honest about their feelings. In one clinic visited by the evaluation team the youth promoters carry out regular rapid surveys of clients' views using the existing quality forms. This is a good way to supplement the information gained from the monthly analysis of the forms and could be introduced in other clinics.

PROFAMILIA has also developed a National Guarantee of Quality programme or Quality Standard for the clinics that defines the quality parameters for all aspects of service provision. The definition of quality is broad and includes all aspects of service provision, from asepsis and technical quality through to youth-friendly service provision. The standard will be audited along with PROFAMILIA's other standards once every six months.

Every two years PROFAMILIA undertakes a survey of both internal and external customers. This is a costly operation but is meant to provide information for lesson-learning and planning. The last survey took place in 2001 and provided information for the Strategic Plan 2002 – 2005. It is unclear whether the survey due this year will be carried out in the current climate of uncertainty regarding external funding.

The current monitoring system takes up a large proportion of Head Office staff time, particularly in the Medical Services Division, and could be streamlined. The volume of information from the clinics will increase with introduction of the Quality Standard system, and it is unclear how this will be integrated with the existing information from clinics and bi-monthly monitoring visits.

Effectiveness and Impact

Until now PROFAMILIA has only monitored process indicators such as number of services provided and number of products sold, and this was criticised in the mid-term evaluation by USAID, who proposed the use of impact indicators. Until the new MIS system is developed (see below) it is unlikely that PROFAMILIA will be able to develop such indicators. There is a set of new targets in the Strategic Plan 2002 – 2005, including a contribution towards a 0.1% reduction in total fertility rates (TFR) in areas covered by CBD promoters, 5% increase in the use of modern contraceptives, 2% increase in early diagnosis of cervical and breast cancer, and 85% financial sustainability. To overcome problems of attribution PROFAMILIA will use couple year protection (CYP) and market share figures from the DHS as proxies for TFR.

PROFAMILIA has done a number of ad-hoc evaluations of different parts of the programme including the effectiveness of two youth manuals, and knowledge of youth before and after a short workshop, but these have not been useful for analysing the overall programme effectiveness.

Clubs which participate in the Dual Protection Project monitor the number of young people referred to PROFAMILIA clinical services, which gives an indication of the project's effectiveness in increasing access to services. This data is not recorded elsewhere in the youth programme but would be useful. A KAP survey was applied to youth promoters, mini-club members and PROFAMILIA staff at the beginning of the project and will be applied once again at the end of the one-year project and will enable PROFAMILIA to assess the project's impact on knowledge and behaviour change, but only over a 12-month period making it difficult to assess real impact.

MIS System

The current MIS system was described by a senior member of staff as 'rudimentary at best'. The system does not capture data on age of clients so it is impossible to identify the proportion of young clients in the female or male clinics from the consolidated data. A new system is currently being designed with technical support from Management Sciences for Health and will consist of a large database and a series of reports. Once this is applied in all the clinics management will be able to capture data on age, gender, service etc.

IPPF is also working on a global Integrated Management System (IMS) that will enable all FPAs to record specific information about programme activities, objectives and achievements and to assess their programmes against universal and global indicators of SRH (which will include strategic planning, shared working evaluation and user participation). This is designed to enable all FPAs to share information on best practice, experiences and lessons learnt. It is not clear when Nicaragua might take part in this development or how it will be integrated with PROFAMILIA's own new MIS.

PROFAMILIA's partnerships with government, donors, civil society and the private sector and their respective approaches to RH and rights

Ministry of Health

As the second largest provider of FP in the country, PROFAMILIA should have a close and productive working relationship with the MoH. However SRH service provision is a sensitive subject in Nicaragua and in practice PROFAMILIA-MoH relationships are somewhat covert (described by MoH officials as a "secret romance"). This means that synergies that could be gained through closer co-operation are missed.

In 1998 the MoH and PROFAMILIA signed an agreement of mutual support¹⁰. PROFAMILIA intends to re-define and strengthen this agreement in 2003. PROFAMILIA also provides copies of all its materials, norms, standards and training manuals to the MoH and trains MOH doctors as and when requested.

PROFAMILIA's approach to SRH and rights for young people could be said to be complementary to that of the MoH. The MoH has few resources available for community outreach and IEC work with young people, whereas PROFAMILIA does provide information and education on SRH and rights, and fills this gap. Unlike the MoH, PROFAMILIA youth promoters are able to enter state and private schools for IEC work on RH and rights. As PROFAMILIA does not provide free services, staff and promoters mostly refer young people

¹⁰ As the Evaluation Team did not have access this agreement it is not clear exactly what it includes but we understand that it is fairly general in nature. It would also appear that most of the support is provided by PROFAMILIA for MOH.

who need services to the MoH. This mutual support seems to work well at the Municipal level, where most of the PROFAMILIA clinics visited have a good working relationship with the MoH health facility.

Apart from the question of cost of services, PROFAMILIA and MoH also use different models of service provision for young people. While the MoH uses the 'differentiated model' whereby young people are seen in separate clinics within the main health facility, PROFAMILIA treats young people in its clinics alongside adults (see section 5).

Donors

PROFAMILIA's only close relationships with donors are with its two principal funders: USAID and IPPF. It is difficult to state whether these relationships are appropriate for the organisation's objectives since to a large extent it is the donors themselves (mainly USAID) who have set the agenda and objectives for PROFAMILIA in terms of diversifying services and financial sustainability. In the light of the cessation of USAID funding it is clear that PROFAMILIA should have been developing relationships with other donors to obtain additional funding and spread its risks. With a large grant from USAID PROFAMILIA may have been less likely to attract other funding in a situation where many organisations are competing for limited funds. IPPF/WHO for example gave more of its international funds to Haiti which did not have access to alternative funding.

With regard to young people's RH and rights, PROFAMILIA signed the Mexico City Accord in order to receive USAID funding and is thus contravening the policy of IPPF, its second funder. IPPF's Vision 2000 objectives and policy state that FPAs should be highlighting the reality of unsafe abortion, ensure that women have access to treatment for complications arising from unsafe abortion, and offer women post-abortion counselling, in line with the ICPD POA and the Beijing agreements. This is an important issue for younger women in Nicaragua given the high rate of teenage pregnancies. IPPF has not yet decided what measures to take with FPAs who signed the "Gag-rule" and continues to fund PROFAMILIA.

Civil Society

Due to its generous financing from USAID and its focus on service delivery PROFAMILIA has had little need to collaborate with other civil society organisations at central level. PROFAMILIA does participate in NGO networks (see 2.2.1 above) and attends workshops and training sessions when invited, but does not initiate activities and (according to other NGOs consulted in the evaluation) does not always play its part in following through with its share of the approved actions. PROFAMILIA's chief role has always been as a service provider, while many other organisations working in SRH have pursued a strategy of advocacy with a stronger focus on grass roots work. NGOs working in a similar way to PROFAMILIA are viewed more as competition than as potential collaborators.

On a local level PROFAMILIA clinics have a much closer working relationship with other NGOs and share materials, training sessions, ideas and other resources. PROFAMILIA clinics are members of local commissions, which are effective structures for collaboration at local level.

PROFAMILIA is now more actively seeking collaboration with other civil society groups and recently became a member of NicaSalud, an umbrella organisation of 21 national and international NGOs which receives finance from USAID to fund and oversee projects proposed by its members. In 2001 NicaSalud had US\$1.6m to distribute for projects in child health, SRH and HIV/AIDS, water and sanitation and infectious diseases. It has recently been designated as the organisation through which financing from the Global Fund will be channelled to NGOs in Nicaragua. This will significantly increase available funds. As a member, PROFAMILIA is entitled to submit project proposals for funding. NicaSalud also provides training and capacity building and supports members in developing project

proposals. PROFAMILIA has submitted one proposal so far and this was rejected. PROFAMILIA could benefit from TA in proposal development, as its funding arrangement with USAID has meant that it has not had to submit proposals for funding for many years and it has little capacity in this area. IPPF could also provide this type of TA.

Private Sector

PROFAMILIA is in the process of implementing a pilot project whereby five clinics (Tipitapa, Sebaco, Boaco, Rivas and Jinotega) will undergo a process of accreditation to become approved health service providers (Empresas Médicas Previsionales - EMPs) for the Nicaraguan Social Security Institute, INSS. Once accredited, the clinics receive a per capita monthly payment for insured clients who choose them as their medical services providers. It will be interesting to see whether this strategy leads to increased financial sustainability in the medium-long term, since under this system a large part of the risk is transferred from INSS to the service providers and a number of EMPs have closed down or amalgamated their businesses to survive. One of the main policies of USAID in Nicaragua during the next 5-year funding period (2003 – 2008) is to strengthen the INSS system to include informal sector workers, making this an expanding market opportunity for PROFAMILIA.

3.2.2 Integration of Rights

PROFAMILIA has not undertaken a specific exercise to define young people's sexual and reproductive rights in the Nicaraguan socio-economic context. While there is a clear understanding of young people's RH and rights within the organisation, rights have not been specifically incorporated into working norms, processes and practices at central level (with the exception of a number of new training modules) and there is little institutionalisation of rights outside the youth programme.

PROFAMILIA has an equal opportunities employment policy. There are no other specific employment policies that refer to gender equality or to the right to live without discrimination (for instance for PLWHA).

An important breach of young people's rights is the fact that PROFAMILIA cannot deal in any way with abortion counselling or post-abortion care as a result of signing the Mexico City Accord (see above).

The youth promoters' manual includes a chapter on rights with clear descriptions of key SRH rights in line with the definitions agreed at Cairo. The manual covers all the rights set out in the IPPF Charter on Reproductive and Sexual Rights (Vision 2000) as they apply to young people.

3.2.3 Capacity

Capacity of staff (competence, skills and commitment) to manage, promote and support the concepts and practices of young people's RH and rights

Commitment

At clinic level there is a high level of commitment to young people's RH and rights. The 'orientadoras' in each of the youth clubs are very committed and many of them are working seven days a week¹¹. Staff turnover is low amongst the 'orientadoras'. Many of them have been with the programme since its inception, have grown with the programme and are now very experienced in their work.

¹¹ 'Orientadoras' find it easier to train the promoters at the weekends when they do not have other activities such as school or work – this is also more acceptable to their parents.

The commitment among other clinic staff varies. Since all doctors are paid according to the number of fee-paying clients they attend there is no motivation to provide services for young people who cannot pay unless the doctors are personally interested and motivated to support this group. The majority of those consulted by the Evaluation Team voiced their support for young people's RH service provision and some were providing services free to young people despite the contracting arrangements.

At central level there is commitment to maintain the young people's programme despite the focus on financial sustainability, and this is stated in the Strategic Plan 2002 - 2005. The youth programme helps to project a social image for PROFAMILIA (which might otherwise be absent) and it also advertises the clinic services in the towns where there are youth clubs. At only 4% of total programme spending for its direct costs, it may be worthwhile PROFAMILIA retaining the programme on purely financial grounds, as its social goal may increase PROFAMILIA's chances of receiving funding from other donors. At Director level the Directors of Medical Services and Social Marketing are fully committed to the youth programme, but the Financial Director is more concerned with costs and income and his commitment to the youth programme is relatively low.

Skills and Competence

Many of the 'orientadoras' in the youth programme are trained counsellors and psychologists. Interviews and observations by the Evaluation Team showed they are skilled at their work. All 'orientadoras' said that they received strong support from their clinic directors.

The youth promoters receive a thorough orientation on reproductive rights and they in turn pass this information onto their peers. The youth promoters consulted by the Evaluation Team had good understanding about rights and were able effectively to transfer this knowledge in the mini-clubs. The learning methods are participative and include games and group activities so that information can be easily transmitted and retained. All youth clubs also have an IPPF video showing examples of how rights are often contravened but can also be respected. Most youth clubs visited have wall posters that list young people's rights.

At central level there is a skilled IEC and social marketing team which can produce materials in house (see section 6). The management of the youth programme also appears to be competent and is supported strongly by the whole Medical Services Division, including two expert trainers. Two out of three Directors at central level are skilled and competent to contribute to the youth programme.

Understanding of socio-cultural and economic factors influencing young people's RH and rights

Those who have a direct link with the youth programme, such as the manager of the youth programme, the 'orientadoras' and youth promoters all demonstrated a high level of knowledge of the key socio-cultural and economic factors related to young people's RH and rights, as did senior head office staff. There is an induction training programme for all new staff that includes information on the young people's programme, its goals and objectives.

In general the problems of high teenage pregnancy and early motherhood, poverty and unemployment among young people, lack of access to RSH services, affiliation to gangs, substance abuse and alcoholism are well known throughout Nicaragua, particularly among the many NGOs working in this sector and have been well report in the media.

Participation of young people in policy-making planning, implementation and M&E

At present there is no representation of young people in the policy-making fora of PROFAMILIA, either in the Executive Board or in the General Assembly of members (i.e. young people are not members). There is no active participation of young people in decision-making process at Head Office, and no institutional mechanisms through which young people are enabled or encouraged to participate.

Real participation of young people in policy-making in PROFAMILIA is still a long way off. IPPF has asked PROFAMILIA to consider how to involve young people in the Assembly and that is currently being discussed. IPPF/WHR policy is to encourage participation of young people throughout the functioning of the FPAs from design through to implementation for programming and on the policy-making structures, including the Executive Board and General Assembly. In 2002, IPPF/WHR passed a resolution (7/2002) stating that FPAs should have at least a 20 percent representation by young people on their Executive Boards, with the objective that each FPA have at least one young person on their boards. At present, young people participate on the Executive Boards of roughly half of IPPF/WHR affiliates in Latin America. A paper written by a young member of the PROFAMILIA Colombia Board illustrates the positive experiences of young people on decision-making bodies of FPAs in Colombia, Paraguay and Mexico. All these countries have a number of socio-cultural barriers to real participation by young people similar to those in Nicaragua, and these examples demonstrate that they can be overcome.

Young people do not actively participate in the monitoring and evaluation process, apart from some clinics where they support the monitoring of quality of care. There is no involvement of young people in the network of adult community promoters although youth promoters encourage their peers to use them for supply of FP methods. In practice this is often difficult since the community promoters are often well known figures in the communities and may know the young person's family.

Young people do participate actively in the validation of IEC materials, although they do not participate in the initial design. Young people are consulted in the development of all materials that are designed for a young audience, including the social marketing materials for the Body Guard condom, which has a target age of 15 – 24 years. Photographs of some of the youth promoters also appear in the IEC materials and young people have participated in radio and television adverts. Young people were also closely involved in the development of their training manuals "Saber para crecer" and "Necesito saber...Necesito crecer".

Within the youth programme young people plan, organise and fundraise for their recreation activities, including national festivals which have been carried out in previous years. However they are not really involved in the decision-making process since the 'orientadoras' set targets with head office staff at the beginning of the year for the number of mini-clubs and talks to be implemented by the youth promoters. Young people do plan where and how to carry out their mini-clubs and they liaise with school heads and other local people about programme activities. This participation is clearly a key element in the programme's success.

Willingness and capacity to reach marginalised and excluded young people (please see sections 2, 5 and 6 where this question is also covered)

PROFAMILIA does not have an explicit strategy to reach marginalised and excluded young people and works mainly through the school system. However in a country where 46% of people are living below the poverty line (see section 1), a large proportion of the young people involved in the PROFAMILIA youth programme in the state schools are undoubtedly poor. Some young people with specific problems, such as alcoholics or gang members, are

contacted through the mini-clubs but there is no concerted attempt to reach these groups and PROFAMILIA is not really equipped to support them.

The Dual Protection project is working in two border areas where rates of HIV/AIDS and STIs are among the highest in the country, there is a flourishing commercial sex trade and the constant movement of vehicles and people across the borders into Honduras and Costa Rica has fuelled drug trafficking. By focusing on working in marginal urban areas as well as schools, it is likely that the project does reach some young people caught up in commercial sex or drug-trafficking. However, statistics are not available.

One youth club has held mini-clubs in the prison, where young people are usually kept separate from other prisoners. This work could be evaluated and repeated in other clubs if found to be successful. This type of work requires confident and experienced youth promoters. PROFAMILIA's new model of recruiting promoters for only 6 months may mean this work cannot be continued (see section 2.2.1).

PROFAMILIA plans to reach out to young people of 16 – 21 years who already have responsibilities (such as a job or children) and who need information and services on SRH, but this initiative is still in its infancy.

Capacity of staff to promote lesson learning and best practice

The principal way in which PROFAMILIA promotes lesson learning internally is through workshops and meetings. The 'orientadoras' have traditionally met up every month for a workshop in Managua, although lately this has been reduced to every two months. These are training workshops but are also used as a forum for the exchange of views and working methods and enable participants from the different Regional Centres to discuss examples of successful interventions. All 'orientadoras' consulted said that this was very important to them. Other categories of staff also have similar meetings.

PROFAMILIA also promotes internal lesson learning through the M&E system which generates action plans, and through a new system of five-year planning cycles to develop the Strategic Plan. The latest Strategic Plan 2002 – 2005 contains a detailed and honest SWOT analysis that was done through document review and wide consultation among PROFAMILIA staff. The aim is to use the strategic plans as a tool for lesson learning. This system was developed after criticism by USAID of the lack of strategic planning and lesson learning in its mid-term report of 2001.

One of the roles of IPPF/WHRO is to promote lesson learning and promotion of best practice among the FPAs (see comments below).

PROFAMILIA's capacity to pursue, acquire and manage financial resources

(See section 2 for the levels of external funding)

As PROFAMILIA has been heavily financed by USAID since 1992 (see section 2.2.1) and has not needed to seek additional funding during the last eleven years its capacity to pursue and acquire funding is relatively low. PROFAMILIA had expected USAID funding to continue despite the current contract coming to an end, and was therefore unprepared for the fact that all funding will cease in September 2003. (The contract actually ended in December 2002 but PROFAMILIA were granted a no-cost extension).

PROFAMILIA submitted a proposal to NicaSalud (see 3.2.1) in 2002 but was unsuccessful. As USAID funding covered its needs PROFAMILIA staff have not had to develop the skills to prepare projects and proposals for other funders in an extremely competitive environment.

NicaSalud will provide training and support in proposal development at the member's request but PROFAMILIA did not ask for help.

Through the USAID grant PROFAMILIA has had two major opportunities to generate income and achieve sustainability: the first was investment in social marketing; and the second the social franchising model (six new clinics). Lack of good financial planning and management has meant that PROFAMILIA has been unable to take advantage of these opportunities, although the 6 new clinics do generate more surplus on clinical services than the older clinics.

Financial management is currently highly centralised and very little autonomy given to the clinic directors to manage their own resources. However PROFAMILIA is undertaking a process of decentralisation that should devolve certain aspects of financial decision-making to the Regional Centres.

Capacity building and support provided by IPPF Regional Office to PROFAMILIA

IPPF/WHR, along with the IPPF HQ, is in a period of transition. It has a new Executive Director (Carmen Barroso) and is currently undergoing an internal consultation process to define its role, and identify how to accomplish its social objectives and promote financial sustainability among its members. A new global focus on 5 'A's will emphasise attention to marginalised groups (adolescents, access, etc.). IPPF will be introducing an accreditation process in 2003 to be rolled out through the FPAs at a rate of 5 FPAs per year. It is not certain when Nicaragua might join this process, or how those FPAs that have signed the Mexico City Accord will participate (see below).

There are currently three main divisions at IPPF/WHR: Institutional capacity building unit; the Integrated programme unit; and the Evaluation department. Each country FPA has a designated Programme Officer who is in charge of planning and managing the support that the country will receive. The Programme Officer usually visits once or twice a year. Nicaragua has received very few general monitoring visits over the years, but has received specific project-related support for the Dual Protection project (see below) and earlier for the STI/HIV Integration Project (see below).

IPPF funding including donations of contraceptives represents roughly 8% of PROFAMILIA's total income (only around 3% in cash). This means that although PROFAMILIA is part of the Federation it has been more concerned to maintain good relations with USAID, and chose to sign the Mexico City Accord although this contradicts IPPF policy. IPPF are currently considering what their official reaction will be to countries that ignored this policy. IPPF uses the UN categorisation system which defines Nicaragua as a Category A country along with Haiti (as the two poorest countries in the region). IPPF plans to increase TA to PROFAMILIA and has set up a multi-disciplinary country team to coordinate a more intensive programme of support (only two countries in the region have teams allocated to them). However with limited and declining funds IPPF/WHR is unlikely to be able to increase significantly the financial support for PROFAMILIA.

IPPF has more influence over PROFAMILIA where it is funding a specific project such as the Dual Protection Project and the HIV Integration Project which was a south-to-south initiative whereby Bemfam in Brazil provided technical assistance to, among others, the FPAs in Nicaragua and Trinidad. For these projects, regular monitoring and technical assistance are programmed at the outset of the project. PROFAMILIA is very happy with the support that it has received on Dual Protection to date, particularly on monitoring and evaluation, which is judged to be of high quality.

IPPF has provided general training in IT systems, in financial management, and in inventory management that has strengthened capacity at the head office level, although it is largely geared towards the fulfillment of IPPF reporting requirements. IPPF/WHR also facilitates the exchange of information and lessons learned between the different FPAs in the region, usually through annual workshops. Last year for instance there were regional workshops on youth friendly services, on gender and rights and on the evaluation of youth programmes. PROFAMILIA has also participated in IPPF/WHR training seminars on pertinent topics (Evaluation, Integration of STI/HIV, Youth Dual Protection, Youth-friendly services), and IPPF is expecting to increase this training next year when PROFAMILIA has less resources available due to the termination of USAID funding. The FPA in Mexico (MEXFAM) has produced some very good IEC materials that other NGOs in Nicaragua are using. Both PROFAMILIA in Colombia and MEXFAM's youth programmes are very successful and could provide useful technical assistance to PROFAMILIA. There are other interesting models throughout Latin America among the different FPAs, such as that of INPPARES (the Peruvian FPA) which has a Youth Empowerment System called 'Yes!' designed to reach young people living in marginalised neighbourhoods of Lima through a system of health posts. IPPF could foster more south-to-south exchange of different models among the different FPAs and thereby encourage lesson learning and best practice. This could be achieved effectively through programme-to-programme support (i.e. in-depth visits by a team from another FPA to PROFAMILIA lasting several weeks or secondments) rather than through regional workshops, where impact is often limited to the feedback that the person attending gives to others on his/her return.

IPPF/WHR also acts as a conduit for documentation between the FPAs and from IPPF central office in London to the FPAs. IPPF/WHR recently gave PROFAMILIA a number of self-assessment modules (for instance on integration of HIV into RH service provision and the integration of gender). There is also a youth friendly exit survey that has been translated into Spanish. It is unclear exactly how IPPF/WHR will monitor the use and effectiveness of these checklists. Many of these documents have been available for some time but are only now being introduced to PROFAMILIA. Due to the extent of funding from USAID, PROFAMILIA has perhaps not received as much technical support and documentation from IPPF/WHR as it might have done.

3.2.4 Summary

PROFAMILIA has been adjusting its organisational structure and arrangements to face the current financial crisis, but the structure remains top-heavy with 30% of total costs spent in Head Office. The M&E system is time-consuming and the MIS is cumbersome and is currently being overhauled. Availability of large amounts of funding from USAID over a long period of time has weakened PROFAMILIA's drive and capacity to generate new resources and expand its donor portfolio. IPPF has provided some technical support and funding, but not at the scale of USAID. PROFAMILIA's partnerships with government, civil society and the donor community outside USAID and IPPF have been low-key.

The direct costs of the youth programme represent only 4% of PROFAMILIA's budget. Indirect costs can only be estimated, but may reach a further 4%. The youth programme does not generate any income and with the exception of the Dual Protection project is financed largely through funds from the USAID and IPPF donations. It is not a core function for PROFAMILIA and although it contributes to the organisation's social goals it does not contribute financially, which is an important consideration in the current drive for sustainability. PROFAMILIA has not been as proactive as it needs to be in exploring opportunities which could generate additional donor funding for the youth programme. Staff working directly on the programme are competent and committed and top management expresses its support. However support by other staff is variable, with low awareness or interest in young people's SRH rights by a small number of staff in Head Office. The majority

of the youth programme's work is in schools and urban communities, and although it does reach the poor it does not see its role as reaching out to marginalized groups. Young people participate actively in programme implementation and in validation of IEC materials, but there is no participation in decision-making and institutional mechanisms to foster participation have yet to be developed.

SECTION 4: ENABLING POLICY DEVELOPMENT AND REFORM

4.1 UNFPA Country Programme

4.1.1 Relevance

CP focus on policies and legislation which relate to young people's RH and rights

This is a major area of UNFPA country office work in Nicaragua, as discussed earlier in this report. Policy and legislation work is carried out by the Population and Development Strategies sub-programme. The RH and Advocacy sub-programmes also work in this area and the sub-programmes are closely linked, especially at municipal level.

As described earlier, much of the necessary legal reform work has now been completed and UNFPA has played an important role in supporting this. However a lot remains to be done in policy development and implementation of the legislation. Specific projects and activities related to young people's RH and rights in the current CP include support for the Children and Adolescents' Ombudsman, work with MECD on the school curriculum in sex education (see section 6), support for SEJUVE in sex education for the non-formal sector, support for the development of the NRHP (see section 3) which includes young people as a key target group, implementation of norms for adolescent service provision in MoH health units (see section 5), and continuing support for inclusion of SRH indicators in monitoring of the implementation of the NPP and the NDS. UNFPA is also supporting work on the Law of Equal Opportunities for Men and Women, which relates closely to young people's rights.

Understanding of policy and laws affecting young people's RH and rights among country office staff and agencies supported by UNFPA

UNFPA staff understand policies and laws affecting young people's rights, as do existing partners many of who have received information and/or training from UNFPA. Interviews with youth participants in the projects and FGD also indicated a good level of understanding amongst the programme beneficiaries. Recently UNFPA has supported an NGO partner to include a module on sexual and reproductive rights in the human rights course of the University of Central America (UCA) law degree, which will ensure that future generations of lawyers have a good grounding in the subject. What may be lacking in some partner staff is a clear vision of obstacles young people encounter in exercising their rights.

4.1.2 Efficiency

Resources and staff time directed to policy reform efforts

The Population and Development Strategies sub-programme has a budget of US\$4.3 million for the period 2002-2006, 24% of the total country programme budget. The sub-programme has a staff of 3. Staff from the other sub-programmes also spend time on policy reform, as do the Country Representative and members of the CST. Given the importance of this area of work in the CP, the resource allocation is appropriate.

UNFPA influence on development of national policy and guidelines (through technical support and advocacy) to promote young people's RH and rights

UNFPA has played an important role in policy development since 1994, as discussed in earlier sections of this report. Key areas of assistance have included participation in development of the PRS and NDS to ensure policy development is based on population issues; TA in development of the Action Plan of the NPP; support to the MoH in development

of the NRHP and norms for attention to adolescents; support to INIM in developing a programme for young women in conjunction with SEJUVE and technical support to their advocacy efforts to promote rights; support in the establishment of SEJUVE; and support to MECD in development of the school curriculum in sex education.

4.1.3 Effectiveness

Perception of key partners of the extent to which UNFPA is having an impact on national policies, protocols and standards/norms for reproductive health?

Key partners interviewed during the evaluation all agreed that UNFPA has made an important contribution to policy development and implementation. The Vice-Minister of Health said that UNFPA's support has been crucial in definition of policies and in the progress which has been made to date in SRH, and has been instrumental in opening doors and promoting actions at inter-institutional, local and community levels. The proposed NRHP has been drafted within the ICPD framework. The Vice-Minister of MECD considers that Nicaragua could not have implemented the ICPD POA without UNFPA's support. The Nicaraguan Women's Institute (INIM) consider that UNFPA's TA and support has been a key factor in enabling the Institute to develop and implement its agenda, and has been an important ally in forums and discussions on the ICPD programme. SEJUVE is also highly appreciative of UNFPA's support and its assistance in enabling the Secretariat to develop its plans, form alliances, and obtain the necessary training to take their programme forward. All multi-lateral organisations and most bilateral donors interviewed during the evaluation concurred that UNFPA has been a key actor in keeping the ICPD agreements on the public agenda and in supporting development of policies and norms which follow the principles and criteria of ICPD. Civil society partners acknowledge UNFPA's important contribution, but as mentioned earlier feel that it could have done more in providing access to technical support and resources to strengthen their capacities and programmes.

4.1.4 Summary

Enabling policy development and reform has been one of the key contributions of UNFPA in Nicaragua, with important successes in ensuring inclusion of SRH rights in national policies for population, poverty reduction and SRH for adults and young people. UNFPA has kept young people's rights on the public agenda, and its role in motivating government and providing technical support to establish the legal and policy framework for implementation of the ICPD POA is recognised by government ministers, multi-lateral and bi-lateral partners and civil society.

4.2 PROFAMILIA

4.2.1 Relevance

Policy and legislation reform

Along with other civil society groups and NGOs, PROFAMILIA participates in the national level commissions set up by MoH and/or MECD to discuss policy issues, but these commissions are largely consultative. PROFAMILIA is essentially a service delivery organisation and concentrates on that activity rather than devoting time and resources to advocacy. The power of the Catholic Church and the conservative lobby in Nicaragua are such that organisations such as PROFAMILIA often choose not to speak out publicly or advocate for change, particularly in an area as sensitive as young people's SRH and rights. Any real influence that PROFAMILIA has on development of policies and laws is probably

largely based on personal contacts with decision-makers which provide the opportunity for informal lobbying.

Understanding of the policy and laws that affect young people's RH and rights

The principal policies and laws affecting young people's sexual and reproductive health and rights are reasonably well understood at head office level among staff involved in the youth programme. Several members of the Medical Services Division are participating in commissions to develop plans for implementation of policies, such as the Education and Population Commission that is currently working on development of an action plan to implement education in SRH for young people outside the formal education sector.

In the Regional Centres the 'orientadoras' and youth promoters all demonstrated good knowledge of the principal policies. However the level of awareness of clinic directors and doctors depends on their personal interest in young people. PROFAMILIA does not include training on young people's SRH and rights for staff outside the youth programme, so knowledge on these issues is not institutionalised. It may be advisable to include a module on young people's SRH and rights in staff induction training.

Although the 'orientadoras' demonstrated a good understanding of the local mechanisms for protection of young people's rights, in practice the mechanisms are inadequate and many infringements of rights (particularly intra-family violence and sexual abuse) go unreported.

Young people's participation

PROFAMILIA does not work specifically to help young people identify and articulate their needs and rights in relation to policy and legal reforms in Nicaragua. The youth clubs do however educate young people about their SRH and rights and their relation to other human rights. The clubs also identify young people suffering abuse or other infringements of their rights and refer them to the most appropriate support networks that exist (Women's Police stations, the Ombudsman, NGOs, community organisations and women's groups). Many of the youth clubs visited cited examples of young people involved in the club who had suffered abuse or violence at home.

4.2.2 Efficiency

Resources allocated to policy reform/advocacy

As stated in 4.2.1 above, PROFAMILIA does not work specifically in policy reform and advocacy and does not therefore allocate resources (either time or financial) to this activity. The amount of time spent by head office staff and by the 'orientadoras' at meetings of commissions and networks where the implementation of relevant policies and laws might be discussed is not specifically planned and tends to be allocated on an ad-hoc basis when a meeting is convened.

4.2.3 Effectiveness

Technical support and advocacy to influence national policy/laws

See 4.2.1 above.

Development of professional norms/standards, tools/guidelines for RH, and IPPF best practice

PROFAMILIA considers that its quality of service is better than the MOH and therefore requires a different set of norms. They are in the process of developing a series of norms or minimum standards for each aspect of service delivery, including quality of care, surgical methods of family planning, emergency obstetrics and nursing. They have provided support to MOH on development of national norms such as the national standard for emergency obstetric care, and the Regional Centres use the national standards for the provision of non-surgical family planning methods. Given the quality of services provided at Regional Centres, PROFAMILIA could be a demonstration model for MoH and thus influence the standard of SRH services in the public sector, but this would require more detailed documentation and evaluation than has been done to date.

PROFAMILIA carries out free training for MOH doctors in quality of care and FP technologies in Managua on an as-needed basis. Training includes a component on adolescent and young people's RH (youth friendly service provision, young people's RH and rights, and counselling). This demonstrates that PROFAMILIA's services in SRH are considered to be a benchmark for quality service provision.

Those PROFAMILIA norms which have been fully documented have been shared widely with professional associations, MOH and other service delivery NGOs. The only norm that specifically deals with services for young people is the PROFAMILIA National Guarantee of Quality Programme which includes a module on youth friendly service provision. In-house compliance with the PROFAMILIA norms is audited twice a year by the head office team.

IPPF/WHR has developed a number of tools to enable FPAs to assess the gender sensitivity of SRH and HIV services and to assess the extent to which HIV/AIDS prevention, diagnosis and care is integrated into SRH service provision. There is also a self-assessment module for youth programming. These were introduced to PROFAMILIA by IPPF during this evaluation and it is too early to assess how useful they will be. IPPF (London office) has also developed a Best Practice Guide to the Federation's International Youth Work, which is a youth-focused guide to integrating SRH issues and rights within youth work. The Evaluation Team was unable to find a copy of this document at PROFAMILIA but it would undoubtedly be useful to the programme. IPPF's Youth Manifesto developed in 1998 was also bought to PROFAMILIA during this evaluation and distributed to all the clinics.

4.2.4 Summary

Policy development and reform is not a major activity for PROFAMILIA which concentrates on service delivery rather than advocacy. Staff working on the youth programme are well aware of policies and laws related to young people's SRH rights, but knowledge among other staff members is more varied.

PROFAMILIA can and has made a contribution to the development of national norms and models of best practice for RH service delivery. It has trained MoH staff in quality of care. Due to high levels of USAID funding IPPF has perhaps not given PROFAMILIA timely support for development of this area of work, which could represent a major contribution to improvement in the quality of care for young people at national level.

SECTION 5: STRENGTHENING RH SERVICES

5.1 UNFPA Country Programme

5.1.1 Relevance

CP support to RH services for young people

One reason young people do not use RH services in Nicaragua is the poor human and technical quality of service provision. Services traditionally have not been user-friendly for young people, staff have not been trained for work with young people, physical conditions and equipment are often very poor and consumables are scarce.

To help overcome these problems UNFPA has supported development of “differentiated services” for young people in the MoH. The first stage of the programme was development of a special clinic for adolescents in the Bertha Calderón Women’s Hospital (HBC) in Managua. The project started in 1995 and continued to receive TA and financial support from UNFPA until 2001 (financial support in the 1998-2001 CP was US\$321,000). UNFPA continues to provide TA. The clinic was set up within the hospital grounds but with a separate street entrance, and was staffed by hospital workers. The centre’s work and its user profile have evolved during the last 8 years, and the project has been an important learning process for the MoH and for UNFPA. Evaluations carried out in 1997 and in 2000 showed that originally the project had a medical focus and the majority of users were pregnant girls. Since 1997 the clinic has been attending about 800 adolescents each month. Development of counselling, IEC and community outreach work, staff training and lesson-learning led to a more integral and preventive approach to adolescent SRH and services are now used by other groups including young men. The centre has now become a reference centre for other MoH units and for NGOs and is a national training centre in RH services for young people. Development as a national training centre started during the 1998-2001 programme. After a slow start (25 health staff trained by the year 2000) training increased and 105 staff had been trained by the end of the programme. The average number of annual trainees is now about 60 MoH staff who are trained in adolescent counselling.

The model of differentiated services for adolescents and lessons learnt from the HBC clinic have been applied in a number of MoH health centres in Managua and elsewhere. The degree of “differentiation” depends on the capabilities and resources of each health unit. The Adolescent Clinics may or may not have separate entrances, but generally have a defined space where only adolescents are attended by specially trained staff. If the health unit can afford it staff are allocated exclusively to adolescent work, but demands on MoH services are high and staff often have to divide their time between adolescent and adult clinics. The clinic staff spend time on counselling and IEC work as well as medical consultations, and a psychologist is sometimes available. Some clinics have set up clubs for adolescents with different needs, generally related to their medical condition or the stage of their pregnancy (Pregnant Girls’ Club, Post-partum Club, Asthmatics’ Club, Diabetes Club etc.). A few clinics have adolescent promoters for community outreach work. The number of users varies from clinic to clinic, depending on the size of the health centre catchment area. Of those visited during the field work, the Estelí clinic is now attending 1,000 adolescents per month, and Somoto 300. The number of users has risen in Estelí by over 50% in the last 12 months (from 2215 users in the first quarter of 2002 to 3003 users in the first quarter of 2003), which indicates that the model is encouraging adolescents to use the services. Most consultations are for general medical services, with around 10% for SRH. The large majority (80%) of the SRH services are counselling rather than gynaecological checks (data provided by SILAIS in an interview during the evaluation). In Somoto there is a much higher proportion of SRH

consultations (over 50% of the total), of which two thirds are family planning consultations and one third ante-natal control or post-partum follow-up checks. Some male adolescents are also now using the clinic.

UNFPA is currently supporting development of a second-level referral system between adolescent clinics in rural health centres and a special adolescent facility in Matagalpa Regional Hospital. It is also promoting linkages between the Municipal Adolescent Clubs (see next section) and MoH adolescent clinics.

UNFPA has supported staff training in integrated adolescent services in the MoH and other organisations during the current and previous CPs. The MoH developed a preliminary Programme for Integral Attention to Adolescents in 1996 (with support from PAHO) and has drawn up guidelines for counselling, but a complete set of norms for adolescent services was only developed this year with support from UNFPA, PAHO and GTZ. The manual of norms is designed for provision of integrated services. It is rights-based and has a gender focus.

UNFPA support for the HBC clinic, staff training and development of norms has been a key input in development of an alternative service provision model for adolescents in the MoH. Completely differentiated services in a separate physical facility are costly and may not be feasible in smaller health units. They also require adjustments in productivity measures for staff as adolescents need more consultation time. However, there are many types of differentiated services which can meet young people's needs. Services can be differentiated by location, opening hours, time spent on consultations, availability of information and counselling, price, staff approach, etc. It would be useful at this stage to analyse different types of differentiated services, their impact on user numbers and satisfaction, and their cost-effectiveness. The evaluation team recommended that this analysis be carried out in partnership with MoH and PROFAMILIA who use a different service provision model. Both organisations welcomed the suggestion.

UNFPA are also providing technical and administrative support to a project in which a mobile team of nurse-educator and psychologist takes IEC and very basic first level services to adolescents in schools and youth organisations (MSN). The project team organise IEC sessions and provide preliminary consultations to adolescents, referring them to MoH units for medical services if necessary. The project was developed from lessons learnt in a previous mobile services project which found that the large majority of adolescent consultations did not require facilities for physical examination in a clinical setting. In fact the clinical setting inhibited potential adolescent service users, many of whom seek psychological help and/or information and family planning methods rather than medical services. This project started 18 months ago. During the first 6 months of 2003 worked with 4,000 adolescents in IEC/BCC activities and provided services for 700.

UNFPA is also supporting service provision in the maquila industrial area of Managua, providing RH services with flexible opening hours for young factory workers (CEPS). The innovative aspect of the project is its insertion into an industrial setting where workers' rights are not given a high priority. This is the only project supported by UNFPA which extends beyond the adolescent (10-19) user group and also caters for young adults (20-24). The project provides IEC/BCC through a network of promoters who provided one-to-one counselling and events such as theatre and a mobile cinema in the work centres. The promoters reach an average of 1,200 women per month, and events are attended by an average of 2,000 per month. The majority of these people are under 24.

CP contribution to service strategies which are responsive to the diverse needs of young people

Most UNFPA support is focussed on low income groups who use public sector services. Initially HBC services were used almost exclusively by pregnant girls. Lesson-learning from the project led to a more integrated and flexible approach which takes account of the diversity of young people's needs, and HBC services are now used by a wider group including young men. Adolescent clinics in other health centres also cater to a range of adolescent groups. The differentiated services model can be highly responsive to diversity of needs if staff are trained and have a sympathetic personal approach to young people, and if functional parameters such as clinic location and opening hours are flexible and appropriate for the user group. Many of these themes are covered in the Manual of Norms. The degree of flexibility in MoH units is linked to the health sector decentralisation process and also depends on the awareness and commitment of senior health centre staff.

Use of an evidence base for the design and evaluation of UNFPA support to service delivery

As the MoH has only recently started disaggregating user data by age group it has been hard for UNFPA to develop and use a quantitative local evidence base for design and evaluation. The original concept of differentiated services in HBC was developed from experience elsewhere in Latin America, and the model has been extended to other health units without a detailed quantitative analysis or examination of its costs and benefits. As mentioned, both UNFPA and PAHO have contracted consultants to evaluate the HBC project, but the evidence base is still anecdotal. Health centres with adolescent clinics are now collecting data on service use, which had risen significantly in the clinics visited during the evaluation.

UNFPA is now using quantitative baseline studies at the start of multi-bilaterally funded projects, which could be used as an evidence base if follow-up studies are carried out at the end of the projects. However this could be costly.

5.1.2 Integration of Rights

Incorporation of rights and gender equity concepts

Service delivery projects supported by UNFPA include training for staff in rights and gender equity. These concepts are now incorporated in the MoH norms for attention to adolescents. Monitoring of application of the norms will be necessary, particularly the right to information in the resource-poor environment of the MoH where counselling and IEC take up additional staff time.

UNFPA has supported development of a Master's course in SRH which includes modules on rights and gender. As most graduates from the course are in management positions in the public and NGO sectors this should have a long-term impact on ensuring that rights and gender equity become an integral part of service delivery to all users, including young people.

5.1.3 Capacity

Competencies and skills of service providers

Participants in the stakeholders' workshop and FGDs identified privacy, confidentiality, friendliness, professionalism, opportunity for dialogue and clear explanations, as the principal service characteristics which young people value.

Comments in the FGDs and observations during the evaluation showed that MoH staff are able to provide youth-friendly services when they have received training and are aware of young people's needs, but where staff are untrained and overworked (which is still often the case) services are not acceptable to young people:

"The service is dreadful, there are no medicines, if you go to the health centre they treat you badly and there's no professional ethic" (FG Somoto)

"There's no privacy. I went to the health centre with my grandmother. The nurse came into the consulting room and interrupted, chatted to the doctor and then stayed there listening to everything" (FG Somoto)

"There's no professional ethic. A friend of mine did a pregnancy test and everyone found out about it" (FG Somoto)

"The doctor speaks his own language – they talk to impress you" (FG Jinotega)

"I went to the hospital for counselling on how to use family planning methods and the person who was explaining to me went so fast I wasn't there for more than 5 minutes" (FG Estelí)

Differentiated services for adolescents are relatively new and are still only available in a few MoH health centres. The norms manual has only recently been completed and has not yet been widely disseminated. Many staff still have not received training in attention to young people. UNFPA is aware that work in this area is still in its infancy and more resources will be needed for MoH staff training and monitoring to ensure good quality youth services are available throughout the country.

In the NGO sector, staff in the CEPS and MSN adolescent projects supported by UNFPA have been thoroughly trained and are experienced in providing appropriate services for young people. Other civil society organisations such as SI Mujer which have worked with UNFPA in the past have wide experience in IEC and service provision for adolescents, and have collaborated with UNFPA in training programmes for MoH staff. Civil society organisations are an important resource which UNFPA could strengthen and assist in forming working relationships with the MoH programmes.

5.1.4 Efficiency

UNFPA support for the development of accessible, quality services to young people

UNFPA supports MoH development of accessible quality services through assistance in development of norms and differentiated services, staff training, development of the Master's course in SRH and specific service delivery projects mentioned in previous paragraphs.

Young people's participation

The MoH institutional structure does not lend itself to participation by youth or adults in service delivery design. Young people did not participate in design of the model of differentiated services, and the Manual of Norms was written by health workers and technical consultants with no participation by young people. There are opportunities for more participation at local level where staff and clinic managers are closer to their users and more responsive to young people's needs. NGOs supported by UNFPA are more able to encourage youth participation in design. The MSN and CEPS projects were developed on the basis of feedback from youth participants in the preceding projects.

Young people are more involved in monitoring and evaluation, but generally as respondents rather than analysts. The HBC has a suggestion box where users can comment on the service delivery, and young people are interviewed during periodic project evaluations.

Monitoring systems and evaluation of cost-effectiveness

These are weak areas in UNFPA-supported programmes. The MoH uses the number of service users and repeat users as a surrogate for quality and accessibility, whilst the Army Medical Corps says lower rates of STIs coupled with higher demands for condoms from the troops are indicators of service accessibility. UNFPA financed an evaluation of adolescent service quality in HBC in 2001, and the results are being used to improve quality where feasible.

UNFPA has not evaluated the cost-effectiveness of any of its service delivery projects for young people. Although it may not be easy to quantify costs and benefits due to the lack of disaggregated cost data and difficulties in developing qualitative indicators of achievements, cost-effectiveness analysis and comparisons of activities within and between projects would be an important input for UNFPA and its partners.

5.1.5 Effectiveness

CP support to government to improve service delivery and adopt best practice

Measures to improve service delivery through staff training, differentiated services and development of norms have been covered in previous sections.

UNFPA has not supported experience exchanges or comparative analysis of alternative models of service delivery. PAHO carried out a comparative analysis of 3 models in 2000 (HBC, the MoH adolescent clinic in Estelí, and SI Mujer's Adolescent Programme). This gave some interesting qualitative insights into the strengths and weaknesses of the 3 models, but UNFPA country office staff and MoH service providers consulted during the evaluation were not aware of the study and had not used it to develop their own service provision programme. As mentioned earlier, more quantitative analysis of this type would be an important input to development of evidence-based best practice and could be promoted by UNFPA.

5.1.6 Sustainability

UNFPA has worked with the MoH and the Army to ensure that they could sustain service delivery after project funded ended. 80% of the costs of the HBC project are now funded by MoH and the remaining 20% by Treasury funds. Adolescent clinics in other MoH units are financed by regular MoH operating funds without additional subsidy. UNFPA has also been working with HBC to investigate other ways to generate income for the adolescent clinic, such as charging for training courses and providing fee-paying services to better-off adolescents. The Army finances the additional costs of SRH services for the troops itself, but considers that this is really a cost saving as condoms are cheaper than STI treatment.

UNFPA has not strengthened the capacity of any of its partners to formulate projects for additional external funding.

5.1.7 Summary

To overcome obstacles of access to quality services for young people UNFPA has developed a model of differentiated services for adolescents in MoH health units, supported development of norms for adolescent services and contributed to staff training.

There has been some analysis of the number of adolescent users in differentiated services, and variations of the original model are already being replicated in a number of MoH units. Observation and interviews during the evaluation suggest that the model can be effective in removing obstacles for young people, especially when staff are trained for work with adolescents and they are aware of young people's special needs.

The lessons learnt from this initiative and its cost-effectiveness should be analysed more systematically and the opportunities for different ways to provide special services for adolescents in a resource-poor setting should be explored further, taking into account the service quality criteria which are most important to young people (human quality, attitudes of service providers, privacy, confidentiality etc) and the sustainability of service provision.

5.2 PROFAMILIA

5.2.1 Relevance

Strengthening RH services for young people

All PROFAMILIA's Regional Centres treat young people and adolescents in the clinics but the number and age of clients are not recorded in the current MIS system so it is impossible to know exactly how many young people are accessing services. Age data is recorded at the clinic level and most clinics estimate that the number of young people receiving services is roughly 10 percent of total medical consultations provided (not including appointments with the nurse about family planning). Results of a quick check of monthly registers at the clinics coincided with this estimate. Figure 8 shows estimated numbers of young people between 10 and 24 years attended in the clinics. Most of these young people are in the 19 – 24 age group, female and married, and many of them go to the clinic to see a gynaecologist.

Using an estimate of 10 percent of general medicine, gynaecological and paediatric consultations plus 10 percent of family planning appointments with the nurse, the estimated number of young people receiving services at PROFAMILIA's clinics is shown in figure 8.

Figure 8

Estimate of the number of services provided to young people by PROFAMILIA (all clinics) 1998 – 2002

	1998	1999	2000	2001	2002
Medical Services and FAMILY PLANNING	70,264	103,777	136,320	108,597	111,255
Services for young people 10 – 24 years (est.)	7,026	10,378	13,632	10,860	11,126

Note: The number of IUD appointments has been subtracted from the medical services category as few young people require an IUD now injectables are available in Nicaragua.

In general PROFAMILIA has been much more successful in getting information to young people than in getting services to them. The two principal barriers to access for young people are the price of medical services and cultural constraints.

Price constraints

PROFAMILIA clinic prices are moderate but beyond the reach of many young people who are still studying and dependent on their parents' income, or working for low wages in the informal sector of the economy. The youth promoters and their family members receive approximately 50% discount on services (equivalent to the staff discount), but the remaining young people who are members of the mini-clubs (i.e. the majority of young people associated with the project) do not receive this discount. Some of the doctors interviewed by

the Evaluation Team were treating young people free, but this can only ever be the exception to the rule since the doctors are paid on the basis of the number of fee-paying clients that they see. Young people who are treated free are often not recorded in clinic statistics. Young people who cannot pay are usually referred to the MoH adolescent clinic. In contrast to provision of RH services for adults where PROFAMILIA reduces pressure on the MoH by providing services for the lower-income groups who can pay, PROFAMILIA's youth programme may actually increase pressure on MoH adolescent services as its IEC programme increases demands. The number of referrals is not registered at present. It would be useful to collect this information. PROFAMILIA does provide a proportion of free contraceptives to young people in all the youth clubs.

Socio-cultural constraints

Most of the youth promoters' work is carried out in schools. PROFAMILIA is one of the few organisations able to gain access to schools for SRH IEC, but does not allow its youth promoters to distribute contraceptives to avoid jeopardising the IEC work. Young people participating in the mini clubs are referred to the clinics for family planning methods but this represents an additional barrier for them to overcome in accessing contraceptives. PROFAMILIA's adult promoters sell family planning methods in the community, but most adult promoters are community leaders or authority figures and unmarried young people (especially girls) find it hard to approach them.

Dual Protection project

The two clubs participating in the Dual Protection project collect detailed statistics on age and sex of users and the type of services provided to young people. Figures for the first 6 months of the project in Chinandega are shown in figure 9. Most young clients are female and use gynaecological services, reflecting the pattern throughout PROFAMILIA clinics. Some 60 percent of consultations are in the 20 – 24 age group with a further 30 percent in the 15 – 19 age group. Over two thirds of consultations were repeat visits. This is a promising start, although efforts will have to be made to attract more young men. The project could provide useful lessons for increasing access to services for young people in other PROFAMILIA clinics.

Figure 9

Consolidated Service Figures for Chinandega Dual Protection Project September 2002 – February 2003

Young Clients attending Chinandega Clinic							
Total Services	M	F	10-14 yrs	15-19 yrs	20-24 yrs	Gen Med	Gynae
647	40	607	83	177	387	130	474
Methods of FP distributed to Young People							
Condom –masc	condom – fem	Pills	Inj	IUD			STI test
367	8	104	74	2			8

The two clubs also record the number of referrals of young people made to the clinics and these are shown in figure 10 below. These figures show that after a shaky start the two youth clubs are referring an increasing number of young clients to the clinics. It is likely that these are the youth promoters who receive services at a discounted price and who are more familiar with the clinic environment.

Figure 10
Number of referrals made by Chinandega and Rivas youth clubs for clinical services
 September 2002 - February 2003

Month	Rivas	Chinandega	Total
Sep	8	10	18
Oct	15	15	30
Nov	30	23	53
Dec	15	10	25
Jan	27	25	52
Feb	60	89	149
Total	155	172	327

Discussion

PROFAMILIA provides services to young people in its normal clinics. PROFAMILIA management maintain that the high level of service quality (particularly doctor-patient interaction and choice of specialists) and the good physical conditions of the clinics are sufficient to overcome young people's desire for separate clinics. They claim that the MoH differentiated service model was designed by adults without consulting young people, and that services can be differentiated in many ways other than having a separate space (eg opening hours, human quality of attention, cost etc) to make them more attractive to young people.

Clearly PROFAMILIA will be operating under severe resource constraints in the near future and in the absence of external funding this may be the only way it can provide services for young people. However now there are differentiated services in the MoH there is an opportunity to investigate young people's attitudes to the two models of service provision, as well as their ability and willingness to pay for perceived higher quality services. It would be particularly interesting to carry out this research in conjunction with the MoH and UNFPA.

Response to the diversity of needs

The model of service provision for young people is a fee-paying service that is integrated with services for adults. Once a week, most clinics run a male clinic that offers the usual range of services but focuses on STI tests and treatment and vasectomy. PROFAMILIA has not as yet made a specific attempt to attract young men and boys to these clinics although they may be informed about them through the youth clubs. There are no specific approaches for marginalized groups although young people with problems receive counselling and support from the youth clubs should they present themselves.

The youth clubs work primarily in schools. Most clubs try to do some work in marginal urban areas but this is a small part of their activities (1 or 2 promoters compared with 25 to 30 in schools). Out-of-school youth are usually involved in some form of informal-sector work and therefore have little time to attend sessions of the mini-clubs for the three-month period necessary to cover the whole IEC syllabus.

The Dual Protection Project is attempting to reach poorer neighbourhoods through the development of links with community groups, the police and local health and education authorities. They have had more success than the other youth clubs in working outside schools and in distributing condoms to young people. However, since the number of referrals is not recorded for youth clubs other than those in the Dual Protection project it is impossible to compare the effectiveness of the two approaches.

While PROFAMILIA does not specifically target high risk groups and is not really equipped in terms of training, capacity and back-up services to deal with them, PROFAMILIA plays a role as entry point to the relevant local support networks.

IPPF support for service strengthening

IPPF provides part of its grant to PROFAMILIA in the form of contraceptives. This donation will become increasingly important to PROFAMILIA as the large proportion of its family planning methods are currently supplied by USAID. Although PROFAMILIA has 2-3 years' stock in its warehouses these will run out eventually and PROFAMILIA will have to buy or finance these products from elsewhere.

IPPF is also encouraging PROFAMILIA to start providing emergency contraception (EC) and is able to provide considerable TA in this area. EC is particularly appropriate for young people and its introduction would have a positive impact on PROFAMILIA's youth work. There has been strong support by some of the PROFAMILIA senior management for EC but the Executive Board has resisted introducing it as they fear it may be confused with abortion in Nicaragua. The WHO has now recommended that a single dose is sufficient for preventing pregnancy, so the method could be easily included in PROFAMILIA's existing distribution network. This has been done in other Latin American FPA's including PROFAMILIA Colombia which distributes some 25,000 EC per month in a financially sustainable operation. Nicaragua is the only local producer of EC in Central America and Puntos de Encuentro, a Nicaraguan NGO, is taking the lead in Nicaragua for the Latin American Consortium on Emergency Contraception which met for the first time in Quito in 2002. There is a high degree of local interest in this product and PROFAMILIA could play an important role in distribution.

IPPF provides TA to the Dual Protection project in the area of M&E (designing survey forms, adapting registration forms and supporting analysis) and have also worked with the two project teams to encourage them to distribute more contraceptives to young people. IPPF considers that the number of referrals to the clinics could be an important measure of impact of the youth clubs' work.

The potential for more IPPF support in experience exchange and lesson learning has been discussed in earlier sections.

5.2.2 Integration of Rights and attention to marginalised groups and young males

In PROFAMILIA young people have the same rights as all other clients visiting its clinics. Although these rights do not apply specifically to young people the FGD showed that many of them such as the right to privacy and confidentiality are important to young people. This information is printed on posters and put up in the reception areas of the non-franchise clinics.

The newly completed quality programme discussed earlier includes a list of indicators for monitoring quality, and a number of these refer to specifically to youth friendly service provision, focussing on the interaction between doctors and young people. These norms are audited twice a year when a team from head office spend a day in each clinic observing all aspects of service provision.

Most of the PROFAMILIA clinics run male clinics once a week offering a wide range of services including counselling, STI/HIV tests, STI treatment, tests for prostate cancer and vasectomy, as well as general health services. The numbers of clients in the male clinics is still low, and there is no particular effort to encourage young men and boys to attend. The

marketing of male clinics is not integrated with IEC for the youth programme and the number of young male clients attended is not recorded.

Figure 11

Number of men attending the male clinics of PROFAMILIA (all Regional Centres)

	1997	1998	1999	2000	2001	2002
Male clinic appointments	460	1,153	2,028	4,093	4,082	3,358

Note: These figures do not include men who attend for a specific service outside the male clinic such as an x-ray. Up to 2000, the numbers increased at a fast rate as new male clinics opened. There are now male clinics in most of the 16 Regional Centres.

PROFAMILIA is also currently working the Association of Men Against Violence to support a survey of male attitudes towards violence in the family and in relationships.

5.2.3 Capacity

Providers' skills and competencies

PROFAMILIA is currently planning to roll out a programme for training all medical staff in youth friendly service provision. Most of the doctors consulted were providing some services for free on their own initiative, which indicates a degree of support for young people's services amongst the medical staff. The Evaluation Team was told that acceptance of young people and recognition of their SRH needs is an important quality for new doctors and assessed as part of the employment process. However, this is not a written policy.

Where youth clubs are located inside the clinic there tends to be a conflict of interest between staff who want to maintain a calm quiet atmosphere for adult clients and young people who are often boisterous and noisy. In the absence of separate facilities for the clubs more staff training and awareness-raising on young people's needs may help them negotiate mutually acceptable solutions.

Whilst PROFAMILIA provides privacy in consultation for all adults and young people, there is less privacy in the reception and waiting-room areas where young people fear they may be stigmatised by staff and gossiped about by other clients. Staff need to be aware of this and look for solutions to make young people feel more at ease.

5.2.4 Efficiency

Accessibility and quality of services for young people and participation

The PROFAMILIA youth clubs are contributing to improved access to services through the awareness-raising IEC programme (see section 6) although the number of referrals is not recorded, as mentioned above. Although few youth promoters have been very successful at distributing methods of family planning, they do tell their peers about the PROFAMILIA clinic services and bring large groups of young people to the youth club for talks and activities. These activities may overcome some of the cultural barriers to accessibility for young people, however the cost of services may counteract this, as discussed earlier.

PROFAMILIA is aware of young people's need for privacy and has separate waiting-rooms in the Dual Protection project which is externally funded. In other clinics PROFAMILIA is planning adjustments in opening hours to provide services for young people when demand from adults is low.

The quality monitoring system is described in section 3.2.1 above as part of the overall M&E system. Young people are not generally involved in the design, implementation, monitoring and evaluation of services provided by PROFAMILIA clinics, although in Ocotol the 'orientadora' had supported a group of youth promoters to undertake short exit surveys on quality of services in the clinic. The youth promoters use the existing exit questionnaire form that is available in all clinics for clients to fill in and deposit in a suggestion box. This form is simple to use and does not take up much time. Furthermore, if young people facilitate its application, this overcomes two potential problems: the fact that a sizeable proportion of clients, particularly in rural towns, cannot read or write; and the fact that clients are often assisted by clinic staff to fill in the form which might make it difficult for clients to criticise the services. This easy and cheap system could be expanded to other clinics and is a good way of involving young people in the delivery of services. They would also need to be involved in the analysis of results and the development of appropriate solutions.

5.2.5 Effectiveness

Utilisation of services

This issue is discussed in section 5.2.4. In the absence of quantitative data the evaluation team asked Clinic Directors whether they had identified any trends in service utilisation by young people since the youth programme started, but their opinions were very varied and no conclusions can be drawn.

It is quite likely that the franchising model on which the six new clinics were developed provides limited access to SRH services for young people. The new clinics do not have youth clubs (with two exceptions) and there is no special effort in these clinics to attract young people. Neither is it permitted to stick posters on the walls, so the posters on rights referred to earlier cannot be displayed.

Best practice

PROFAMILIA itself has still not identified best practice for service delivery to young people and therefore does not carry out advocacy work with the government on this issue. As discussed earlier PROFAMILIA has been more successful in increasing knowledge of SRH and rights than it has in service delivery.

5.2.6 Sustainability

The extent to which externally funded services for young people are being incorporated into the FPA's regular programmes.

The only activity in the youth programme which receives external funding directly is the Dual Protection project. Other youth clubs are funded from PROFAMILIA's own resources and its general funding from USAID and IPPF, largely through the USAID donation.

The Dual Protection youth clubs carry out more activities but they receive more funds and their costs are considerably higher than the other clubs. To date PROFAMILIA has not secured additional financing for these two clubs after Dutch funding ends in September this year. If no external funds become available the Dual Protection clinics will revert to the same level of funding as the other clubs, provided that PROFAMILIA generates sufficient funding to maintain its general operations and the rest of the youth programme at its existing level.

Cost-recovery and access for the poor

PROFAMILIA has a policy of cost recovery in all its clinics. Fees are similar in all the 16 Regional Centres, where consultations cost about US\$4 and laboratory tests about US\$3. While these charges are not excessive in comparison with other private providers the cost recovery policy does constitute a barrier to access for the poor and it is noticeable that the very poor are absent from waiting areas in PROFAMILIA clinics. PROFAMILIA's target group are people from the middle and low-middle income groups. Although most doctors consulted did provide some services free of charge, this is the exception to the rule.

In the new Strategic Plan 2002 – 2005 two of the institutional objectives refer specifically to the poor: the first is to contribute to a reduction in the total fertility rate and population growth in Nicaragua in poor urban and rural areas and among those with poor access to education; and the second is to contribute to healthier families by providing access to quality family and reproductive health services, particularly for the poor. However it is unclear with the current push for financial sustainability how PROFAMILIA intends to reach the urban and rural poor since they are least likely to be able to pay for contraceptives or services.

PROFAMILIA is also planning a cost-recovery strategy through accreditation with the INSS, as discussed earlier. This will improve access for salaried workers, and if plans to open up the social security system to workers in the informal economy go ahead access for these groups who are generally lower income will also be improved.

5.2.7 Summary

PROFAMILIA provides services to young people in its normal adult clinics. An estimated 10% of PROFAMILIA's clients are young people, most of them female in the 19-24 age group. The principal barrier to access for young people is the price of services. This barrier is hard to overcome given PROFAMILIA's current financial difficulties. Young people who cannot pay are referred to MoH clinics, and PROFAMILIA does not have any special arrangements to provide services to marginalized groups. There are also cultural barriers to access in the adult clinics, as young people are afraid they will be seen in the waiting-room and may be the subject of gossip. However services are high quality in PROFAMILIA clinics and this may be important in attracting young clients.

A comparison of PROFAMILIA's work with the differentiated services model in MoH would be fruitful for lesson-learning. There is some participation by young people in service quality monitoring, but this is the exception rather than the rule.

SECTION 6: PROMOTING RH INFORMATION AND EDUCATION

6.1 UNFPA Country Programme

6.1.1 Relevance

Use of an evidence base for the design of IEC/BCC approaches

UNFPA's only direct involvement in development of IEC materials and methodologies is in the formal education sector. It provides TA to partners for work in the non-formal sector.

In the formal sector UNFPA used evidence bases such as the DHS, census data and research studies to identify themes which are most important or least well-disseminated amongst young people. It also uses WHO and other medical evidence for design of IEC content on family planning methods and their effectiveness. The approach in Nicaragua is based on experience elsewhere in Latin America, which is being used to develop a feasible methodology for introduction of sex education in a politically and socially sensitive environment. The first stage of the work involved awareness-raising amongst key staff in the MECD, followed by development of a teachers' manual. The next stage will be teacher training and development of curriculum materials.

In the non-formal education sector each partner organisation develops its own approach and the use of evidence bases is fairly limited. There is very little documentation, analysis and dissemination of lessons learnt from different IEC/BCC approaches, and important local information and experiences which could be used for future programme development are lost.

Appropriateness and contextual relevance of IEC

In the formal education sector the teachers' manual produced by UNFPA covers the priority issues facing young people identified in section 1 of this report. UNFPA never produces materials which focus only on abstinence. Sometimes they recommend postponement of the start of sexual activity, but also always include information on all family planning methods. It is UNFPA policy to emphasise understanding of the fertile period so that young people know how to prevent unwanted pregnancies. DHS and other studies in the region show that this is not well understood by young people.

IEC material for community-based education produced with UNFPA support covers the priority issues of early pregnancy, STIs and HIV/AIDS, SR rights, family planning methods and participation. The in-country IEC study shows that the content is accurate and the presentation attractive to young people. IEC material produced by AMUNIC (see below) also covers a wider range of topics of interest to young people in developing life skills.

Contribution to coherent and integrated BCC/IEC policies/programmes which are responsive to young people's diverse needs

UNFPA work in the formal education sector is being carried out by an experienced consultant from the CST and a national consultant and follows a clear strategy as described above.

In the area of community-based education the country office has developed an "IEC strategy" document, but this presents a menu of options for media and messages rather than an overall strategy. UNFPA does not facilitate communication and experience-sharing between its partners, and each partner organisation works independently. Observations and interviews during the evaluation showed that each organisation has developed its own

materials and methods, many of them very good and internally coherent, as described below. However the lack of an overall strategy framework in UNFPA means that the materials developed by different partner organisations often cover the same themes and there is no pooling of experiences and resources. Although UNFPA has not encouraged partners to work together, this has been shown to be possible in Nicaragua: Johns Hopkins University developed a successful integrated IEC/BCC strategy for young people which was launched by the Inter-sector RH Commission which includes 32 national and international NGOs and public sector organisations.

The in-country FG and IEC studies show that young people prefer to receive IEC through radio, TV and personal contacts, especially peer promoters. Adolescent-to-adolescent methodology and participative approaches are preferred, and studies in Nicaragua (Puntos de Encuentro, 2002) show they may be more likely to lead to behaviour change.

UNFPA could play an important role in fostering coordination between organisations to identify best practices in the local context and rationalise the use of resources for development of IEC/BCC approaches. A CST specialist in community-based adolescent education has recently been contracted and could provide the technical support the country office has lacked during the last 2 years.

6.1.2 Integration of Rights

UNFPA's work in the formal education sector starts from the concept of rights to education and information in sexuality and reproduction, without which adolescents cannot take informed decisions. The right to enjoy a complete and responsible sexuality, equality, freedom from violence and reproductive rights will also be included in the texts. The most conflictive theme in Latin America is the right to sexual preferences, which is censored by Ministries of Education and omitted from school texts. This is very likely to happen in Nicaragua.

The in-country IEC study showed that rights have been included in many of the IEC/BCC materials produced by partner organisations. AMUNIC's materials are all rights-based, and the first booklet in their series of publications for youth participants and promoters gives a comprehensive overview of human rights in Nicaragua including rights to liberty and security, to information and education, equality and no discrimination, privacy, liberty of thought, health care, physical and psychological integrity, association and participation. The relevance of each of these to adolescents and their sexual and reproductive rights is explained clearly. Partner organisations normally prepare their own materials, but more substantial publications are reviewed by UNFPA staff who also provide TA if requested.

6.1.3 Capacity

Competencies and skills of UNFPA and partner staff to provide appropriate IEC/BCC to young people.

UNFPA country office staff do not provide IEC/BCC themselves. Work on the school curriculum is being carried out by an expert from the CST whose technical capacity is highly regarded by the MECD and a national consultant.

Staff of partner organisations interviewed during the evaluation showed a high level of competence in content and methodology of IEC work. Many including staff in MoH adolescent clinics have received training with UNFPA support. As mentioned above, most partner organisations prepare their own IEC materials.

Peer educators

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

The clubs started about 2 years ago, and are aimed at adolescents up to 19 years of age, although some 20 year olds still participate. The first generation of promoters are currently training new recruits in content and methodology. Promoters interviewed during the evaluation had good communication skills and a thorough knowledge of SRH and rights themes. A comparative evaluation of the level of knowledge and attitudes of promoters, young people contacted by promoters and young people who have had no contact with the programme showed that the promoters had a significantly higher level of knowledge than other programme participants, who in turn had a significantly higher level than non-participants (UNFPA, 2002). The evaluation team also had the opportunity to speak to a group of promoters' parents in Somoto. The parents had received some training during the project and were very supportive of the work. The youth promoters have also acquired skills in communication on SRH themes with groups other than their peers. Comments from the parents included:

"It's had a real impact on the youngsters' development. If we'd had these opportunities things would be been different for us"

"Now they sit down and talk to us, we were embarrassed to talk to them before"

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

Other projects supported by UNFPA (MSN, MoH) also work with youth promoters. The evaluation team only had the opportunity to speak to one of these promoters who participated in the stakeholders' workshop. Her level of knowledge on SRH and rights and her communication skills with both adolescents and adults were excellent.

6.1.4 Efficiency

Development, distribution and monitoring of IEC materials and media

IEC materials produced for the formal education system are reviewed first by experts and then by a sample of the target groups before being tested in the field. During field testing comments and suggestions are noted and included in the final version of the material.

Pre-testing of materials for the informal sector and community-based education should follow the same procedure but in practice it is less rigorous. Adolescents' comments in FGD and in group discussions during the evaluation showed that they feel they have had a chance for input, that the materials cover their principal areas of interest and are readily understood and/or suitable for group work with peers. In the AMUNIC project the themes to be covered in new IEC material are discussed with adolescents at the planning stage. Drafts are then discussed with youth participants in small groups before finalising the text and presentation.

Details of distribution channels, number of publications distributed and likely overall coverage is hard to ascertain as UNFPA does not keep adequate records. The in-country IEC study indicates that between 1500 and 3000 copies are made of printed materials, which are distributed through youth clubs, local government, schools and NGOs. UNFPA has not collected data on coverage of radio programmes or actual readership of its printed materials. Other studies in Nicaragua (MSI, 2000) suggest that the actual readership may be as high as nine times the number of items distributed in Managua. This figure is likely to be higher in rural areas where printed material is scarce and leaflets are re-read many times by primary and secondary readers.

Monitoring and evaluation processes are always included in proposals for IEC materials production and staff training supported by UNFPA. In practice for community-based IEC work monitoring is included in the normal project monitoring process, through observation and discussion during field visits and written reports.

Young people's participation in the design, review, pre-testing and monitoring of IEC strategies and materials

Young people's involvement in design and pre-testing was discussed in the previous paragraph.

Some of the most effective IEC materials are those designed by the adolescents themselves, which are rarely pre-tested. The newsletters "Argos" and "Alternativas" for example are highly appreciated. Theatre and puppet shows, fairs and festivals which are largely improvised and therefore cannot be pre-tested are also considered to be some of the most effective methods and are very popular with the youth audiences because they are fun. They are also produced on a very low budget. They may not conform to the highest professional standards and have not passed through a formal development process, but their spontaneity and language are often more attractive to young people than materials produced and tested by adults. In the stakeholders' workshop at the start of this evaluation the youth participants made this point clearly: after the formal presentations by adults at the start of the workshop, the adolescents requested a space to mount a group dynamic (on the theme of attitudes and communications on sexuality) which soon had everyone laughing and was a key factor in stimulating fruitful and open discussion in the group work. Young people involved in IEC activities do their own monitoring based on the audience's or readers' reactions and level of interest rather than a standardised procedure. Effective and popular methods and topics are repeated and less successful or interesting ones are dropped. The dynamic in the stakeholders' workshop had been used by them before to break the ice in a formal situation and certainly was effective.

UNFPA are aware of the importance of youth participation in project design, but commented that participative planning is a lengthy process and “Donors’ requirements and timetables conspire against participation” (interview, UNFPA office). In practice the design of UNFPA community-based projects for adolescents is flexible enough to allow a good deal of participation once the projects start, even though adolescents do not participate in writing the original proposal.

Cost-effectiveness

As mentioned earlier UNFPA has not done any analysis of cost-effectiveness due to lack of reliable data and unwillingness to use estimates or qualitative methods. The evaluation team noted that most organisations in Nicaragua who work with young people produce their own materials from scratch rather than adapting existing material to their specific needs. Many of these materials have been developed within the ICPD rights framework and cover the same themes. Several years ago the MoH Adolescent Unit tried to persuade all organisations to use material produced by the Ministry, but had little response. Coordination and exchange between the agencies could lead to considerable savings in materials design cost and ensure effective proven materials are widely used. UNFPA could take the lead in this.

Although quantitative data on costs and coverage are not available, rough calculations show that UNFPA has spent about US\$1 million on its community-based adolescent projects since 1998. Although these projects have generated some important outputs (see section 6.1.5), the estimated coverage of IEC is of the order of 37,000 adolescents attended and 800 promoters fully trained and working in the communities (data provided by UNFPA on the 7 municipalities where activities have continued after project funding for the first phase finished). Likely sustainability of these projects is discussed below. Current UNFPA work on the school curriculum on the other hand should reach over half a million young people every year. Costs to UNFPA include the time of country office staff, the specialist from CST, training and printing costs which are unlikely to come near the US\$1 million spent on community-based work. Once the curriculum is introduced into the schools MECD will ensure sustainability. M&E of the impact of the school curriculum will be an important area of future work for UNFPA. Experienced technical staff from the CST should be able to help the country office develop an effective M&E system.

UNFPA points out that work in formal and non-formal education are not mutually exclusive, and may be complementary. They are aimed at different target groups (in-school and out-of-school), out-of-school youth often being the most disadvantaged and therefore high priority. Whilst this is true, there are a number of NGOs working very effectively in community-based non-formal education who do not have the technical capacity or influence to gain entry to the formal education system. It would be worthwhile analysing costs and coverage more precisely to ensure that UNFPA gives high priority to the most cost-effective activities in which it has a clear comparative advantage.

6.1.5 Effectiveness

Acceptability and effectiveness of IEC/BCC materials

UNFPA-funded projects use mass media and/or printed materials to inform, and participative methods together with personal contact using adolescent-to-adolescent methodology to promote behaviour change.

Only 35% of young people who participated in the FGDs had seen any of the printed materials, even though two-thirds of them were members of UNFPA or PROFAMILIA clubs. Those who had seen the printed material were able to recall the subject if not the detailed

content, and the majority found them acceptable and attractive. The young people had good recall of slogans which they had seen in posters or heard on the radio or television.

The UNFPA country office has not done any formal studies of the effectiveness of IEC materials, although the CST expert said UNFPA normally does evaluate them. Young people from both UNFPA and PROFAMILIA projects who were interviewed during the evaluation had positive opinions on the AMUNIC printed material and said they found it useful for themselves and for their promotional work in the communities. UNFPA intends to support MEDC in evaluating the sex education curriculum at every stage of its introduction, should this be introduced. Teacher training will be evaluated, together with implementation of the curriculum in the classroom. Finally, overall impact on adolescent knowledge and attitudes to SRH and rights will be evaluated.

Parents, local councillors and social services workers told the evaluation team that they had seen positive changes in their children's behaviour since the AMUNIC project started, and parent-child communication had improved, especially on SRH themes and rights. The police also mentioned that the rates of juvenile delinquency are going down in the catchment areas of the clubs, which give young people new opportunities for learning and recreational activities which are hard to find in poor communities. The young people themselves also mentioned changes in their own behaviour.

To promote more use of medical services UNFPA has planned development of youth clubs in municipalities where the MoH already has or is developing an adolescent clinic, and has encouraged the clubs to forge links with the clinics. In two of the locations visited during the field trip the clubs and clinics were working closely together, with youth club promoters encouraging young people they contact in the community to use the clinics. Figures for consultations in the Estelí MoH adolescent clinic increased 50% between 2001 and 2002.

6.1.6 Sustainability

Integration of externally-funded IEC/BCC initiatives and materials into the regular programmes of UNFPA partners.

The AMUNIC project (UNFPA's major activity in the non-formal education sector) included counterpart contributions of a building, utilities and the salary of a youth coordinator from the start. The project has had some important outputs which will help sustain activities after the second stage of funding ends. Young people have given the clubs a high profile in local communities, with support from local government and NGOs. Local governments are now aware of the importance of young people in community development, and are beginning to think of them as an asset rather than a liability. The youth project has also unexpectedly given local governments the opportunity to change their own image and role in the communities, who now see the Town Hall as a social development organisation and a positive force for community change. Some local government officials consulted during the evaluation said that they were continuing to fund activities in the bridging period between the first and second stages of the project, responding to initiatives taken by the young people themselves in local fund-raising for their activities and providing complementary funding where possible. Not all local governments have the resources or the interest to do this, but 7 out of the 18 original municipalities have sustained the project and will continue to do so. In two municipalities visited during the evaluation the young people had lobbied candidates for Council elections to commit themselves to continuing the work if they were elected, and to pass a local government decree establishing the youth centres as a permanent Council activity. Local support committees and training teams with representatives of public and NGO organisations have been set up and assist with youth training and advice. After evaluating the first stage of the project AMUNIC decided to include social development as one of the core elements in its strategic plan, which will enhance prospects for sustainability.

AMUNIC has analysed the lessons learnt from the first stage, and is convinced that the support of all local stakeholders is needed for project success.

At central government level, UNFPA will support teacher training and printing of teachers' manuals and curriculum material. Once this is complete the MECD should sustain the work as a permanent element of the school curriculum.

6.1.7 Summary

UNFPA is supporting promotion of RH information and education in the formal education system through development of a teachers' manual on sex education and sexuality, to be followed by teacher training and development of a school curriculum. The work is being carried out by experienced consultants with the ability to carry the work forward in a sensitive political environment. UNFPA has fully utilised its comparative advantages to address this key issue for young people in Nicaragua, and the work should have an important impact on this and future generations.

In the non-formal education sector UNFPA is supporting a youth club model with community outreach by youth promoters to motivate and educate young people in life skills, SRH and rights. The clubs form links with MoH adolescent clinics and encourage young people to use SRH services. The model has an integral approach to adolescent development and is highly participative, but requires a lot of time, effort and resources from UNFPA, AMUNIC and local government to reach a relatively small number of young people. Several organisations are sponsoring similar models, and experience-sharing and comparative analysis would be useful. UNFPA does not have clear comparative advantages for this type of work, which may be more appropriate for the NGO sector.

UNFPA does not have a coherent strategy for production and distribution of IEC materials. Many organisations working with young people have developed their own materials, often covering the same topics and using similar approaches. There are opportunities for collaboration and cooperation to avoid duplication of effort, and UNFPA could take the lead in this. Materials and media used by the young people themselves have not been well documented but anecdotal evidence suggests that they may be very effective in producing behaviour change.

UNFPA has not analysed the cost-effectiveness of its IEC/BCC work or its comparative advantages for promoting RH and rights in the formal and non-formal education sectors. Such analysis would be useful to ensure that resources are used effectively.

6.2 PROFAMILIA

6.2.1 Relevance

Evidence base

PROFAMILIA has received TA in communications from Johns Hopkins University (JHU) over the last five years. From 1999 – 2001 there was a full-time consultant from JHU working at PROFAMILIA to support the development of the social marketing campaign and since this time there have also been a limited number of TA visits to the organisation by other JHU consultants. The model developed by JHU is comprehensive and aimed at behaviour change. At activity level it comprises three principal elements: mass media (radio, TV, printed materials); interpersonal communications in health units (talks, counselling sessions, information from medical staff); and community mobilisation (community events, promoter network etc.), with the objective of achieving behaviour change in the target population.

JHU's model is based on evidence of the factors and activities which achieve behaviour change in health programmes from all over the world.

Historically, the IEC department was separate from the PROFAMILIA main office and set up under the name DIMECOSA (literally 'tell me something' but standing for Departamento de Mercadeo Social y de Comunicaciones). The idea was that, with technical assistance financed by USAID, this department would become independent and self-financing and would provide services to external as well as internal clients such as the PROFAMILIA clinics and the youth programme. However, this department was integrated into PROFAMILIA at the end of 2001 and now functions as one of the three main Divisions of the head office (the Social Marketing Division).

The DIMECOSA department was also initially responsible for working with CMS (a Washington-based company) to set up the social franchising project (see section 2 above) for six new clinics post hurricane-Mitch. A nine-person team based at CMS was responsible for the planning, construction and operation of these new clinics, many of which were either seconded from or appointed by PROFAMILIA. The plan was to move in stages towards a full social franchising model. Initially this was the idea was put forward by the former Executive Director of PROFAMILIA and a senior director at CMS. USAID financed the proposal. At the end of 2001, the six new clinics were integrated into PROFAMILIA's network of Regional Centres bringing the total number of Regional Centres to 16 (Granada has since shut) and the number of clinics to 17 (Managua Regional Centre has two clinics while the other Centres have one).

Today the Social Marketing Division at PROFAMILIA works on three main activities: social marketing of contraceptive products; IEC activities; and institutional promotion of PROFAMILIA. The Division mounts co-ordinated and targeted campaigns such as the Body Guard launch in 2000, the 'mother, father and child' campaign in 2001 and the Summer Campaign in 2002 to promote condom use (together with the MoH). These have gone some way towards replacing the image of PROFAMILIA as a provider of family planning with that of a provider of family health services and the slogan used in most of the IEC materials since 1998 translates as 'more solutions in just one place', which is marketing PROFAMILIA as a 'one-stop' health facility. Outside these campaigns, the general IEC materials produced by PROFAMILIA are mainly directed either at the social marketing of contraceptives or at advertising the clinics, their locations and services.

The social marketing team market three products: the Body Guard condom; the DuoFem pill; and Depo provera which is still in production. The materials produced for the social marketing campaigns are designed to support the adoption of safer sexual practices (particularly the use of modern methods of FP), but otherwise the BCC content of materials is quite small.

The youth programme itself is based on information, education and communication in the form of a peer education programme. The introduction of the peer education model (which is described in 6.2.3 below) does not appear to have been based on a comparison with alternative models although there are several other organisations (for instance, UNFPA, GTZ, SI Mujer) using the same model in Nicaragua. PROFAMILIA started using a peer education model in its first youth club in Managua in 1992 and, as this proved to be a successful way of communicating with young people, they expanded this programme to all of the Regional Centres in 1998.

Contextual relevance

IEC materials for young people cover social, psychological and physiological changes during growing-up and adolescence, sexuality, how to prevent unwanted pregnancy and STIs

including HIV/AIDS, conception and contraception, gender roles and stereotypes, intra family violence, sexual abuse, decision making, values and self-esteem, and life skills. All these are important topics for young people in Nicaragua and cover the areas of high need identified in section 1 of this report.

Areas where information is not available in materials produced by PROFAMILIA (or UNFPA) include information for young fathers and mothers, young people's responsibilities as citizens and participation in the economic life of the country, employment rights and relationships. These areas will be important as PROFAMILIA plans to start working with young people who already have responsibilities such as children or a job.

All the Regional Clinics have a budget for communications of approximately US\$200 per month for local publicity and all have also received technical support and training from the head office team in mass media and IEC techniques. The Regional Centres put out information on local radio and television and young people (particularly the youth promoters) have been involved in this work. This means that PROFAMILIA's communications efforts are to an extent able to respond to specific issues at the local level. The mobile cinema also arrives in each area twice a month and research in October 2000 has shown that this is the third most important way in which people acquire and retain information on sexual and reproductive health, after the television and radio¹². PROFAMILIA is therefore reaching the rural population with IEC on sexual and reproductive health issues and the network of community promoters increase access to basic services to back up this work. However, there is no specific effort to reach rural adolescents as the youth promoters do not work far outside the town in which they live.

6.2.2 Integration of Rights

The youth manual used for training youth promoters and for work with mini-club members has a comprehensive chapter on rights that provides details of a wide range of rights as they relate to young people's SRH, based on IPPF's vision 2000 document. The information is easy to understand with appropriate examples and there are games and participatory exercises that the youth promoters carry out with their club members.

Youth clubs also have other materials such as a poster produced by IPPF that spells out young people's rights and a video that takes each right in turn and provides an example from a different part of the world. These materials are shared with all young people visiting the clubs. When the Evaluation Team was in the Ocotal clinic a class of some 25 10-12 year olds was shown the video and then able to discuss its content.

Discussion in the stakeholders' workshop and FGDs¹³ suggests that the majority of young people (including those not involved in PROFAMILIA or other youth clubs) are aware of their human and SRH rights, even though they experience obstacles in exercising them.

6.2.3 Capacity

Staff skills and competencies

IEC design work is done in-house by the Social Marketing Division. The team is young, highly motivated and has good design skills. These skills were praised in the USAID mid-term evaluation in 2001 and the report also stated that the PROFAMILIA social marketing

¹² Research carried out in October 2000 among 40 rural communities in four Regional Centres, quoted in USAID mid-term report 2001.

¹³ See report entitled: "Discusiones de Grupos Focales Realizados a Adolescentes y Jóvenes en Salud Sexual y Reproductiva", April to May 2003, Marie Stopes Nicaragua, p.5.

and communications team had drawn the attention of private sector companies, such as Bell South, Tip Top Chickens and Banexpo that were interested in buying their services. Unfortunately, this has not so far occurred although it would be a good way of increasing financial sustainability of this division. Only one of the current team was working for PROFAMILIA during the period of TA with JHU and therefore there is very little institutional memory of this phase and much of the knowledge gained through JHU has been lost.

All the staff involved in the implementation of the youth programme are skilled at communicating with young people and it was evident that the 'orientadoras' have an excellent rapport with the youth promoters and mini-club members. It was less evident that other clinic staff all had such good communication skills in relation to young people and, as stated in section 5.2.3 above the youth programme would benefit from rolling out training in youth friendly service provision throughout the PROFAMILIA clinic network.

Peer educators

The youth programme is based on adolescent-to-adolescent IEC. The model used is peer education and cascade training whereby a group of youth promoters join the programme, receive a period of training and capacity building and then go on to form their own groups (mini-clubs) passing on information on rights and reproductive health. The programme is designed to take approximately three months based on weekly attendance by young people. However, in reality it takes much longer than this to build the confidence of the youth promoters, particularly the young ones from small rural towns. The Evaluation Team talked to youth promoters in five PROFAMILIA clinics and all were highly articulate and knowledgeable about sexual and reproductive health and rights issues for young people.

A new model of attention was introduced in January this year, which involves a three-month training period for youth promoters and a further three-month period for the promoters to orient their peers using the manual, may mean that this high level of confidence among youth promoters declines (see also 3.2.3). Those who have been with the youth clubs for some years will become 'friends of the clubs' while each group of promoters will only be associated with the club for a maximum period of six months. This gives very little time to build their confidence, provide them with training and public speaking skills as well as ensure that the manuals are well understood. At present, the best youth promoters have been working with PROFAMILIA youth clubs for up to 6 years in some cases and have developed a strong loyalty to the organisation and its aims and objectives.

The programme uses two manuals: "Saber para Crecer"; and "Necesito Saber...Necesito Crecer". The first of these is used by promoters to train their peers in the mini-clubs. It is comprehensive and includes a good chapter on rights. There is a gender focus throughout the manual and information on sexuality, growing-up, self-esteem and leadership, among other topics. The second manual is for promoters who are selected to do counselling. These are usually the more confident promoters who have been with the programme a long time.

Interviews and group discussions with the PROFAMILIA promoters during the evaluation showed that they have a good knowledge of the IEC material and good communications skills to pass the knowledge on to their peers.

The orientadoras do a lot of counselling themselves and many of them are trained as professional psychologists and counsellors. They also select and train a number of the youth promoters who have an aptitude for counselling, and they go on to work with young people using the counselling manual "Necesito Saber... Necesito Crecer". These are usually the more confident promoters who have been with the programme a long time. The youth counsellors whom the Evaluation Team met were articulate, enthusiastic about and committed to their work, despite being voluntary and having school work to do. They were

able to communicate well on sexual and reproductive health issues to a wide range of ages from 10 years upwards. There was a high level of loyalty to the youth clubs among those youth promoters who had been involved for some years.

6.2.4 Efficiency

Production and distribution of IEC materials

All IEC materials are pre-tested including those for the youth programme. PROFAMILIA mainly uses focus groups and surveys to discuss potential materials. All materials are validated at least twice with the target audience and this has applied to the development of IEC materials for the youth programme. The reach and recall of the IEC materials and messages is monitored by the head office team. This aspect of PROFAMILIA's work was praised by the USAID mid-term report in 2001, in particular the division's multi-media work was thought to be of very high quality. This is due in large part to the intensive technical assistance provided by JHU.

The materials that promote the Body Guard condom have the highest BCC content in comparison to other IEC materials. PROFAMILIA participated in the MoH's recent Summer Campaign that encouraged the adoption of safer sexual practices and developed a range of products including t-shirts, caps and bags, leaflets and posters. Young people actively participated in the distribution of these materials on the popular beaches as well as giving out a large quantity of free condoms.

The launch of the social marketing products has been delayed in each case (the condoms, pills and depo provera) and with them the accompanying IEC materials. This has been due to a range of factors including lack of government approval for the product (in the case of the Duofem pill), and also in part due to a lack of shared vision between the Social Marketing Division, senior management of PROFAMILIA and the Board of Directors. The USAID mid-term evaluation in 2001 points to a certain confusion on the part of PROFAMILIA management as to the role of the Social Marketing and Communications Division. For instance PROFAMILIA management look to the mobile cinemas to generate income while their principal objective when introduced was to increase knowledge on and demand for sexual and reproductive health services, particularly among rural populations.

With support from JHU, PROFAMILIA developed specific leaflets and booklets for young people on sexuality, STI and HIV/AIDS as well as more general materials advertising the youth clubs, explaining what they do and where they are. The youth programme has its own logo and slogan "¡Amigos para crecer!" (Friends in growth) which is used in all the clubs and clinics. Materials are not directed at specific groups of young people such as young men or pregnant teenagers.

The in-country IEC study reports that PROFAMILIA prints and distributed between 2,500 and 10,000 copies of its written materials. Distribution is through youth promoters, youth clubs and mini-clubs. Manuals are used by the promoters in clubs and mini-clubs.

Participation

IEC is the one area of operations where young people have been involved and had a high degree of participation. All IEC materials for adolescents and young people are validated with groups of youth promoters (see above) and young people were actively involved in the design and development of the training manuals, which have won prizes. Young people were involved from the design stage through validation, as end-users and in the M&E process and this has set a good precedent for a higher degree of youth participation in the future which PROFAMILIA should continue.

There could be more involvement of young people in the decision-making in relation to what materials to develop and how, as opposed to simply in the validation process. Young people could also be more involved as protagonists in the monitoring and evaluation of the materials. The young people met by the Evaluation Team were very keen to be more involved in this way.

6.2.5 Effectiveness

Promotion of behaviour change

The BCC content of PROFAMILIA's general IEC materials is quite low, although it is higher in the materials produced to accompany the Body Guard condom and in those produced with technical support from JHU for the youth programme. Good examples include a booklet entitled "Sexuality is part of our lives.... and is worth nurturing", produced with TA from JHU but which is now quite old and not being re-printed, and three new black and white leaflets on sexual health, sexuality and HIV/AIDS directed at young people.

The leaflets produced for the Summer Campaign have good illustrations of how to put on and use a condom and convey a positive message of safe sexual behaviour. These were distributed with a large quantity of free condoms.

The main mechanisms used by the peer education model are chats, workshops, videos and games with young people. The activities set out in the manual are all highly participative. The level of activities organised by the 600 youth promoters in all the youth clubs over the last five years are shown in figure 12.

Figure 12
Total activities of the PROFAMILIA youth clubs 1998 – 2002

	1998	1999	2000	2001	2002
Workshops	263	542	698	576	582
Participants	4,620	10,764	14,995	12,259	7,727
Chats	608	583	671	517	514
Participants	4,499	12,182	18,243	13,345	15,283
Counselling sessions	1,843	2,779	2,973	2,685	2,517
Meetings (young people)	22	143	201	176	177
Participants	902	5,391	7,649	6,469	5,427
Meetings (family)	N/A	51	68	121	180
Mini-clubs	N/A	227	257	211	147
Participants		3,298	4,000	3,428	2,187
Total participants (not inc. family meetings)	11,864	34,396	47,860	38,186	33,141

Note: The family meetings are largely meetings with the parents of the youth promoters but also with some adult groups in the community.

As with other clinic services there was a peak in the year 2000 and the level of activities has declined slightly since that time. It is interesting to see that the number of meetings with adults to explain and promote the youth programme has steadily increased and this is due to

the realisation that the whole community needs to be involved in the youth programme for it to be successful. The number of mini-clubs has declined significantly since 2000 but will increase again in 2003 due to the revision of the model as described in 6.2.3 above whereby there will be a new set of youth promoters every three months. PROFAMILIA need closely to monitor how this affects the quality of the programme, which at present is judged to be very good.

Behaviour change is very difficult to measure. However, some interesting comments arose in the in-country FGD study on key sexual and reproductive health issues for young people (see section 1). There are no plans at present to measure impact of the youth programme except in the Dual Protection project which will only run for one year and is therefore unlikely to be able to demonstrate behaviour change.

Acceptability and impact of IEC materials

In the FGDs held for the in-country study, the slogans that young people could recall were “Junto decidimos cuando” (together we decide when) which was a Johns Hopkins campaign that PROFAMILIA participated in. Other slogans with good recall were those of the Vive social marketing condom of PSI (“Vive tu major momento”). The PROFAMILIA slogan was not mentioned (friends for growth or “Amigos para crecer”) although is well known among PROFAMILIA youth promoters. The acceptability of the available materials is good among young people that were consulted by the Evaluation Team, particularly among youth promoters that had been involved in the campaigns such as local radio campaigns, or who featured in the pamphlets, demonstrating that a high level of involvement and participation inevitably leads to greater acceptance.

However, the IEC report of the in-country study also points to the fact that, while information is readily available and knowledge of young people on sexual and reproductive health issues is also good, this doesn't seem to be affecting actual behaviour change and this is due to a combination of socio-cultural factors but also due to barriers to access, mainly regarding price of services and products/medicines and poor quality of services at public sector facilities.

6.2.6 Sustainability

If one considers that PROFAMILIA's entire youth programme is an IEC/BCC initiative, then this programme is currently funded in the same proportions as the rest of PROFAMILIA's activities (see section 2.2.3 above). In practice the income from the clinics and network of community promoters is allocated to the clinics and USAID funds are used for the youth programme but this will change post-September 2003 and PROFAMILIA will have to find additional external funding or fund the youth programme from clinic income.

IEC materials developed previously by DIMECOSA and more recently by the Social Marketing and Communications Division have been almost exclusively funded by USAID with technical support provided by JHU (which is also funded by USAID). However, with the cessation of this funding in September, it is unclear what funds will be available for IEC materials for the youth programme as the 2003 budget does not have a specific category for such materials and this is an easy area in which to cut costs. In the light of this situation, PROFAMILIA could use and perhaps adapt materials available from other FPAs in the region such as the Mexican FPA (see 3.2.3 above) whose IEC materials are already being used by other Nicaraguan NGOs.

The USAID mid-term evaluation report in 2001 states that the materials produced by Social Marketing and Communications Division at PROFAMILIA are of high quality, carefully validated and evaluated. The report mentions that there was considerable interest by private

sector companies (see above) in buying the design and production capabilities of the PROFAMILIA team. However, unfortunately PROFAMILIA did not manage to take advantage of this lead and does not currently sell its services outside PROFAMILIA, although the team voiced its enthusiasm for such a strategy. This would contribute significantly to the financial sustainability of the Division.

Use of IEC materials by other agencies

Most organisations in Nicaragua working in SRH and rights for young people have developed their own IEC materials including youth manuals. There are at least 3 sets of very similar youth manuals available in Nicaragua produced by, among others, PROFAMILIA, UNFPA and GTZ. Collaboration in the development of IEC materials has been low, but cost savings could be achieved for everyone with better collaboration.

In terms of multimedia campaigns, PROFAMILIA worked with MINSA on the recent summer campaign to promote condom use and safe sexual behaviour (see above) and this worked well, to increase sales of Body Guard condoms and advertise the PROFAMILIA services as well as promote positive messages about responsible sexual behaviour. This was a good example of collaboration between MINSA and PROFAMILIA that can be repeated.

Other organisations have been involved in the IEC strategy and campaigns developed for PROFAMILIA by JHU, and an Inter-agency SRH Commission to share experiences and continue the work. It is unlikely that the full JHU model will be used as it involves expensive mass media.

6.2.7 Summary

IEC is the main focus of the youth programme. PROFAMILIA received intensive TA from JHU for 5 years and as a result has a professional approach to IEC and marketing, even though staff turnover has led to the loss of most of the individual team members who benefited from the JHU input.

Mass-media IEC materials including printed materials are produced in-house by the social marketing team. They are pre-tested and validated with young people who also participate in the design process. This is the area of PROFAMILIA's work which most encourages participation. The materials are accurate, relevant and attractive to young people but there are insufficient funds to produce enough materials for the needs of the youth programme. Youth programme staff are also skilled and sensitive counsellors.

IEC work is carried out by peer promoters using adolescent-to-adolescent methodology. The current promoter group includes young people with several years' experience who are well-trained, knowledgeable and fully able to transmit information to their peers. As PROFAMILIA is currently changing the youth promoters model and will recruit and train promoters for a much shorter time the quality of IEC work may suffer.

With the exception of the short-term Dual Protection project, the youth programme IEC is funded through PROFAMILIA's regular resources (clinic income, USAID and IPPF) in the same way as the rest of the programme. Its sustainability will therefore depend on PROFAMILIA's ability to resolve its current financial difficulties and move forward.

IEC work developed by PROFAMILIA with support from JHU has been shared with other public sector agencies and NGOs who launched a joint campaign based on the "Together we decide when" slogan. PROFAMILIA has also worked on joint IEC campaigns with the MoH.