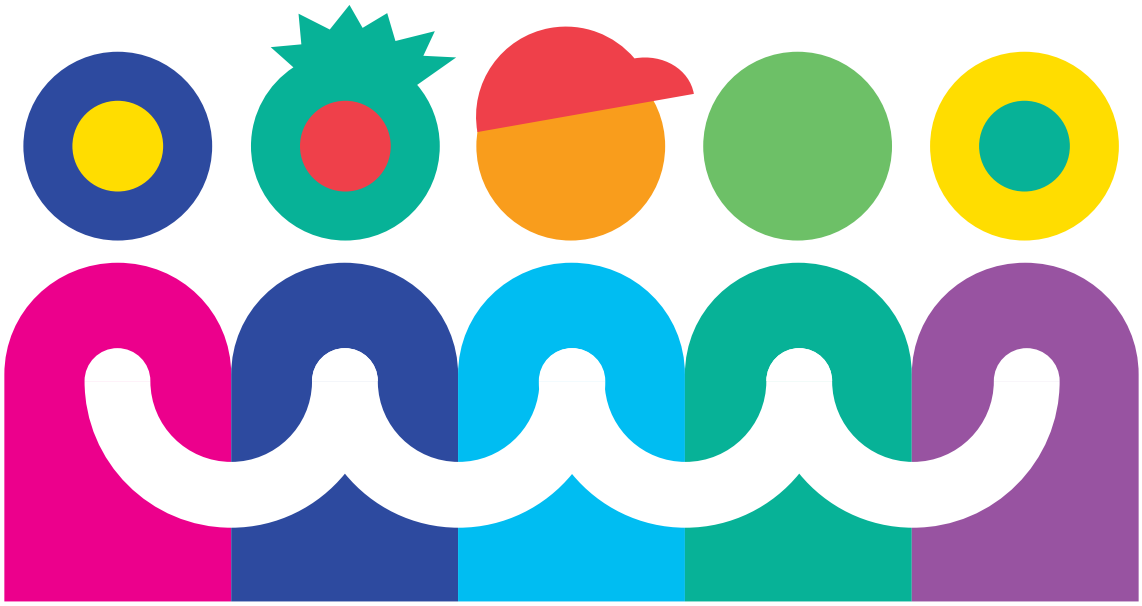
Rutgers | For sexual and reproductive health and rights



Bringing us closer to SDG 2030

A Multi-Component Systems Approach to Enhance *and* Sustain Adolescent Sexual and Reproductive Health, Rights, and Wellbeing at Scale

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A Multi-Component Systems Aproach
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Content

Abstract

This white paper argues for wider-scale adoption of new program paradigms for Adolescent Sexual and Reproductive Health and Rights (ASRHR) that are systems-oriented and can be implemented at scale. Current ASRHR programs operating in lower and middle-income countries tend to be small-scale and not designed to work across the socioecological system to concurrently address individual, structural, and societal challenges that inhibit ASRHR.

Achieving the Sustainable Development Goals by 2030 requires wide-acting programs that frame adolescent sexual and reproductive health, rights, gender equality, and wellbeing within the reality of complex social systems and structures. The Multi-Component Systems Approach or MCSA developed and tested at scale, and researched and evaluated by Rutgers and partners in 11 countries over the past eight years (2011-present), provides a new program model. Experience shows that the MCSA is feasible to implement by country-level alliances comprised of NGOs, including youth led organisations, that address different aspects of young people's SRHR in a complementary and comprehensive way. It achieves impressive results measured by gains in adolescent knowledge, agency, and use of ASRH services, and increases in community and governmental attitudes supportive of young people's right to ASRHR. The evidence shows that reinforcing sexuality education and ASRH services while concurrently amplifying governmental and societal support for young people, explicitly linking actions that work across components, the MCSA fosters systems inter-relatedness and reinforcement of actions across health and education sectors and government and civil society, which leads to normalization of ASRHR across the social and systems ecology.

Problem Statement

The world is experiencing the biggest adolescent cohort in history at a time of great social, environmental, economic, and technological changes. By 2030, signaling the end year for achieving the United Nations' Sustainable Development Goals (SDG), societies will be in the hands of these current adolescents as they become adults. **How we define investment solutions today will influence how well young people can address the challenges that await them as adults.**

Health represents a critical pathway to SDG fulfillment; governments, donors, and civil society are rightfully emphasizing adolescent health and wellbeing. Yet individual adolescents' health and wellbeing are only part of the equation. To prepare the future generation for the opportunities and challenges that lie ahead, we need to invest in programs that conceptualize and act more broadly. We need programs that frame adolescent sexual and reproductive health, rights, gender equality, and wellbeing within the reality of complex social systems and structures and that use a socio-ecological systems lens. We need programs that are designed for large-scale impact while recognizing local contexts.

Rutgers has been leading large-scale, innovative initiatives in collaboration with partners in multiple countries that are designed to address the complexity of issues that adolescents confront and which also confront the programs designed to develop capacities of young people. This paper brings together evidence from recent literature and shares findings of eight years of research, monitoring, and evaluation to argue for a new program paradigm and share a successful model developed by and refined by Rutgers and partners.

Background

> Current program responses are not well-aligned with the complex range of issues that influence adolescent health and wellbeing in lower and middle-income countries.

A recent review on adolescent sexual and reproductive health and rights nicely summarizes the state of adolescent sexual and reproductive health (ASRH) in lower and middle-income countries LMIC (Chandra-Mouli et al., 2015). Twenty years after the International Conference on Population and Development (ICPD), there is widespread agreement on the benefits of investing in adolescent health, particularly ASRH, to foster adolescent transitions to adulthood. Well-designed ASRH programs can lead to improved health outcomes, a stronger set of life skills, increased agency, and the development of more gender-equitable views and behaviors that equip young people to navigate adolescence and adulthood while avoiding consequences of early pregnancy and life-changing conditions such as HIV infection. A complex set of factors play significant contributory roles in health outcomes. Social factors, including gender-based discrimination, violence, and social marginalization, operate at individual, community, and society levels. Structural factors also contribute, including the lack of availability of and access to youth-friendly services. In the quarter-century since the ICPD, governments and nongovernmental organizations (NGOs) in many low- and middle-income countries have implemented ASRH programs and projects. While the evidence is slowly accumulating about effective interventions and promising approaches, many ASRH efforts are small in scale, and short-lived.
Many promising efforts are poorly documented and evaluated. While research has yielded a better understanding of the needs and issues of young people, only a small proportion of studies are aimed at developing and testing interventions to improve ASRH.

The time to invest in new program paradigms is now

In 2019, adolescents between 10 and 19 years comprise about one-fifth of the world's population. Now in their second decade, by 2030 when the Sustainable Development Goals are to be met, these young people will be between 23 and 32 years old. They will be the young professionals, the entrepreneurs, the farmers, teachers, nurses, social workers and doctors, the technicians and young politicians, the performers, designers and brave new thinkers, visionaries and young leaders of faith – and of course most will be parents themselves. The ability of these young people to successfully fill the roles that are so central to national progress and human development, and their capacity to avoid the pitfalls that can dim or destroy their hopes, depends a great deal on how we invest in and protect their growth and development – including health and social and gender equity - during the coming years.

SOURCE - Adapted from "Adolescence in Tanzania," UNICEF and Republic of Tanzania, 2011, pg2

The article's four key program recommendations offer a way forward and reflect a socioecological lens:

1. Systematically link the provision of sexuality education to sexual and reproductive health services;
2. Build awareness, acceptance, and support for youth-friendly ASRH education and services;
3. Address gender inequality in terms of beliefs, attitudes, and norms; and
4. Target the early adolescent period (10-14 years).

The SDGs provide a roadmap to guide addressing ASRH issues holistically.

The opportunities and challenges that young people face, though, are occurring in the context of a rapidly changing social, environmental, technological, and economic world.
The Sustainable Development Goals (SDGs) shared agenda to end poverty, fight inequality and injustice, and protect the planet can also help to guide the way forward in ASRH. The broader sustainability agenda intentionally addresses the root causes of poverty by acting systemically, catalyzing mutually-reinforcing efforts to social development that work for and include all people, so none are left behind. A priority area of the UN's Global Strategy for Women's, Children's and Adolescents Health (2016–2030) is adolescent health as a focus on the adolescent phase of the life course is crucial for building a solid foundation for the SDGs.
The principles underpinning sustainable development are similar to those for ASRH and Rights or ASRHR - anchored in equity, rights-based and gender-transformative approaches, meaningful youth engagement, partnership-driven, and striving for program effectiveness at scale (Kuruvilla et al., 2016).

The time is now for innovative, sustainable ASRHR program approaches that can operate at scale.

Given the recommended pathways to move forward ASRH within an SDG framework, we need to move away from typical ASRH approaches that are not holistic or systemic, as such approaches lead to short-term impact with little-to-no sustained social development effect. While Comprehensive Sexuality Education (CSE) can have positive impacts on individual skills, attitudes, self-esteem, and wellbeing, focusing on CSE alone will continue to fall short of the desired impact on the relational level (e.g., use of contraception; SGBV). CSE should be complemented by other level inputs in services and at community levels, recognizing the role of societal and other institutional actors that need to be mobilized.

Socioecological approaches will remain even more critical in the next decade. The available evidence shows that systems-oriented, multi-component strategies are more effective than single-component approaches in leading to sustainability, reaching a more diverse group of adolescents, and creating reinforcing synergies across and between levels (Martens, 2012).
Practically, the more likely option to implementing multi-component approaches is via organizational partnerships that combine their ambition, expertise, and reach in diversified partner initiatives to achieve sustainable, high-quality programming in ASRH and other health domains.
The balance of evidence from published literature is clear that alliance or partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private, and nongovernment agencies, do work. They work by tackling the broader determinants of a population's health and well-being sustainably while also promoting individual health-related behavior change (Gillies, 1998, Martens, 2012).

A promising solution to work at scale

Rutgers – Who we are and what we do.
With over five decades of in-country and over two decades of international experience, providing technical assistance, research, and providing technical assistance and capacity strengthening on advocacy, research and implementation, initially as the World Population Foundation (WPF) and the Rutgers Nisso Groep, the Dutch Expert Centre on Sexuality, which merged in 2010, Rutgers is an international centre of expertise on Sexual and Reproductive Health and Rights (SRHR) based in the Netherlands.

Rutgers' international standing in ASRH is recognized by its consultative status on the Economic and Social Council (ECOSOC) of the United Nations, where Rutgers is called upon to submit statements and speak at special sessions of the United Nations, such as the Commission on Population and Development (CPD) and the Commission on the Status of Women (CSW)[1]. In their first worldwide review in 2010, UNESCO cited the Rutgers CSE curriculum The World Starts With Me as one of only 18 genuinely comprehensive programs[2]. Rutgers is also an Association Member of the International Planned Parenthood Federation (IPPF) and has worked closely with IPPF at central and country levels to advance the acceptance of sexual rights and gender equality, particularly on behalf of and with young people[3].

1 See CSE description in http://www.rutgers.international/what-we-do/comprehensive-sexuality-education/depth-world-starts-me

2 See description of Rutgers' CSE contributions in https://unesdoc.unesco.org/ark:/48223/pf0000183281

3 See IPPF membership role in https://www.ippf.org/about-us/member-associations?f%5B0%5D=region%3A10&f%5B1%5D=status%3A1&page=1

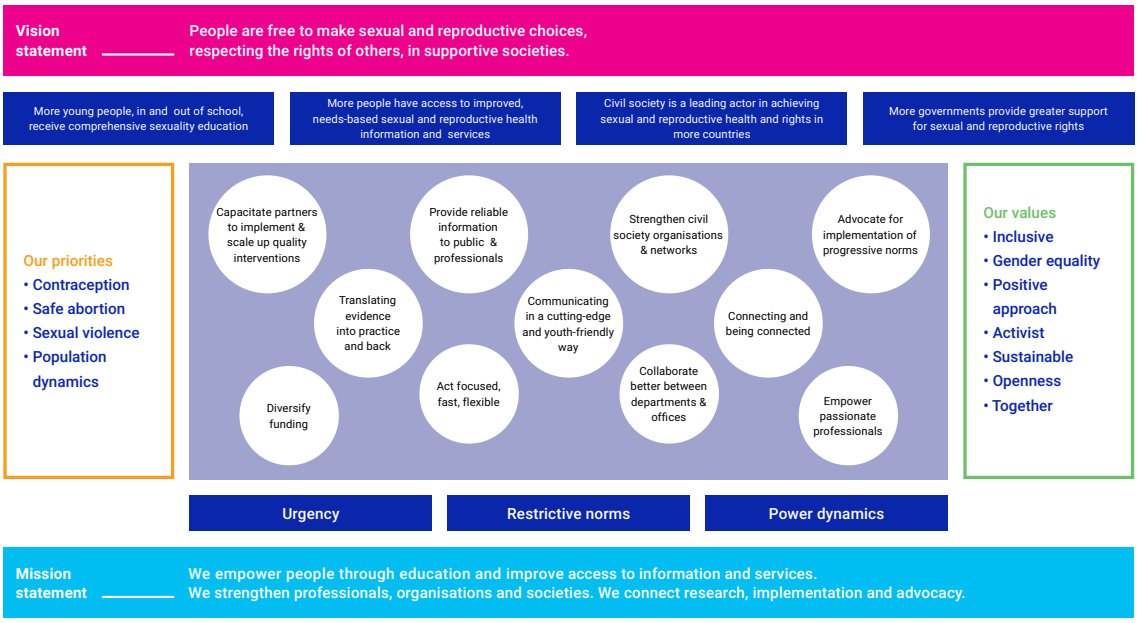
Rutgers' social development philosophy,[4] summarized in Figure 1, attests to a commitment to think holistically and to work to address the root causes of poor ASRH. Rutgers' positively approaches sensitive issues and has gained a wealth of experience in making sexuality and sexual and reproductive rights a topic of discussion within different cultural contexts. The approach is also grounded in a set of youth-centered and youth- appreciative values focused on equity, the inclusion of the diversity of young people, particularly those who are socially marginalized, and gender equality. Young people are at the center of Rutgers-led programs, not only as beneficiaries but as meaningful actors in program design, implementation, research, and monitoring and evaluation. The holistic nature of a Multi-Component Systems Approach and the use of Alliances to implement it means that young people are engaged in governance, alliance coordination, service delivery, and community mobilization.

Working in MCSA alliances allows Rutgers to maximize country relevance, program effectiveness, and operate at scale.

Rutgers is notable for its innovative work leading consortia from The Netherlands that support alliances in Africa, Asia, and Latin America to maximize in-country ownership with like-minded organizations and individuals to increase the acceptance of ASRHR[5]. Since 2011, Rutgers has worked or is currently working in alliances with over 100 partner organizations in over 20 LMIC in Africa, Asia, and Latin America. Rutgers always strives to work with a multi-component systems approach in all its alliance programs. In-country ASRHR alliances operate at the community, district, and central levels; partners include civil society organizations and government ministries. Alliance structures allow programs to draw on existing expertise in a variety of domains – education, services, social mobilization, and activism – that reflect an integrated systems approach to programming.

FIGURE 1

Empowering young people towards happy and healthy lives



4 See Rutgers strategy document in https://www.rutgers.international/sites/rutgersorg/files/PDF/2017_Rutgers-Strategy_DEF.pdf

5 While this paper builds on research and monitoring and evaluation of ASRHR programs described in Table 1, the MSCA approach is being applied and studied in other Rutgers-led alliance programs that tackle sensitive issues, including GBV (Prevention+), child marriage (Yes I Do), safe abortion (She Makes Her Safe Choice), and youth-led advocacy for SRHR (Right Here Right Now).

These experiences have allowed Rutgers and partners to develop and test an innovative systems-oriented approach – the Multi-Component Systems Approach or MCSA - and use research to refine the approach and build evidence of in-country acceptability as well as program effectiveness, which informs this paper.

The MCSA represents a new generation of program approaches, addressing earlier issues in health programming using a social-ecological lens (Richard et al., 2011), and adding innovations such as attention to building community social capital and meaningfully engaging youth beyond roles as program recipients. The systems approach intentionally creates within and between-layer synergies that together lead to the sustained program, policy, and services effects while concurrently fostering ASRHR-enabling environments. These multiple levels of program action generate more options for young people to maintain good SRH and gender and SRH rights awareness, access services when needed, reducing risks to pregnancy, STIs, and sexual violence while building developmental assets that will follow young people into adulthood.

The breadth of experience - working over eight years to successfully implement large-scale ASRHR programs involving multi-partner alliances in countries as diverse as Bangladesh, Ethiopia, Ghana, India, Kenya, Malawi, Senegal, Tanzania, Indonesia, Uganda and Pakistan – has created a body of collective learning and evidence from implementation and targeted research that makes the MCSA experience compelling. See the research summary table, on page 12.

TABLE 1

Building Evidence and Understanding of the MCSA: Operations Research 2011-2018

Unite for body rights (UBFR) 2011-2015	Access, services, and knowledge (ASK) 2013-2015	Get up speak out (GUSO) 2016-2020
Focus Initial development and concept operationalization of the MCSA and alliance approaches	**Focus** Continued MCSA refinement, with a particular focus on information and services provision, concept operationalization of 'meaningful youth participation.'	**Focus** Continued MCSA refinement, with a particular focus on fostering sustainable youth-centered approaches, and establishing sustainable ASRHR alliances by 2020
Implementation parameters	**Implementation parameters**	**Implementation parameters**
Implemented by the SRHR Alliance [Rutgers, AMREF-Netherlands, CHOICE for Youth and Sexuality, dance4life, Simavi]	Implemented by the Youth Empowerment Alliance [Rutgers, AMREF-Netherlands, CHOICE for Youth and Sexuality, dance4life, Simavi, STOP AIDS NOW!, IPPF]	Implemented by the Get Up Speak Out Consortium [Rutgers, CHOICE for Youth and Sexuality, dance4Life, IPPF, Simavi, Aidsfonds]
Working with 50 partner organizations at country level	Working with 60 partner organizations at country level	Working with over 50 partners organizations at country level
9 Countries • AFRICA - Ethiopia, Kenya, Malawi, Tanzania, Uganda • ASIA - Bangladesh, India, Indonesia, Pakistan	**7 Countries** • AFRICA - Ethiopia, Ghana, Kenya, Senegal, Uganda • ASIA - Indonesia, Pakistan	**7 Countries** • AFRICA - Ethiopia, Ghana, Kenya, Malawi, Uganda • ASIA - Indonesia, Pakistan
Budget **€50 mln**	Budget **€29 mln**	Budget **€39 mln**
Research/learning agenda	**Research/learning agenda**	**Research/learning agenda**
Rutgers-led Research (10 studies) **1** Working with a multi-component approach and an alliance structure **2** Operationalizing the approach to reflect a commitment to sexual diversity **3** Strategies to effectively address sexual and gender-based violence	**Rutgers-led Operations Research - (30 studies)** **1** Strategies to increase the use of SRH services/ contraception for the diversity of young people **2** Effects of Meaningful Youth Participation on young people, partner orgs, the ASK program **3** Formative research for content development and effectiveness of e & mHealth interventions	**Rutgers-led Operations Research - (Studies ongoing)** **1** Intersectionality and synergies of working with the MCSA **2** Strategies to effectively operationalize the multi-dimensional • Youth-Centered Approach • Gender transformative Approach; • Social accountability • Mitigation/management of social opposition • Whole School Approach

Unite for body rights (UBFR) 2011-2015	Access, services, and knowledge (ASK) 2013-2015	Get up speak out (GUSO) 2016-2020
Research/learning agenda	**Research/learning agenda**	**Research/learning agenda**
External End-of-Program Evaluation Mixed method, realist evaluation design to: **1** Assess results of UBFR achievement in Increasing youth access to quality SRHR information; improving access to quality SRH services; strengthening civil society for social mobilization and advocacy) **2** Understand processes and enabling/hampering factors leading to results, including the use of an Alliance strategy	**External End-of-Program Evaluation** Mixed-method, realist evaluation design to: **1** Assess results of ASK achievement in increased access of SRHR info for diverse categories of young people; increased youth access to SRH commodities and quality services; Improved enabling environment/ respect for SRHR of young people **2** Understand processes and enabling/hampering factors leading to results, including the use of an Alliance strategy	**Rutgers-led Process Evaluation** Mixed method process-effects design to better understand: **1** Alliance building **2** Youth-centered approach **External Program Evaluation** Mixed-method pre-intervention, midpoint, and endline design to: **1** Assess results of GUSO achievement in access to SRHR info and education; access to youth-friendly SRH services; improved enabling environment for SRHR **2** Assess changes in young peoples' gender attitudes, empowerment, self-esteem vis-à-vis above results areas
For details, see: https://www.rutgers.international/sites/rutgersorg/files/PDF/UFBR-Synthesis-report_final-2016-05-13.pdf	For details, see: https://www.rutgers.international/how-we-work/research/operational-research-ask	For details, see: https://www.rutgers.international/programmes/get-speak-out-youth-rights/get-speak-out-resources

The Multi-Component Systems Approach to ASRHR programming

What is it?
The MCSA consists of four interlinked components - strengthening sexuality information and education; strengthening youth-friendly services, amplifying community and societal support for ASRHR, and amplifying government support for ASRHR – and a conviction that these four 'cornerstones' must be concurrently activated to achieve and sustain ASRHR. As shown in Figure 2, the MCSA is centered on young people and their right to healthy SRH lives, while recognizing that work at multiple levels of the social ecology and family, community, education and health system support is needed to achieve the central goal.

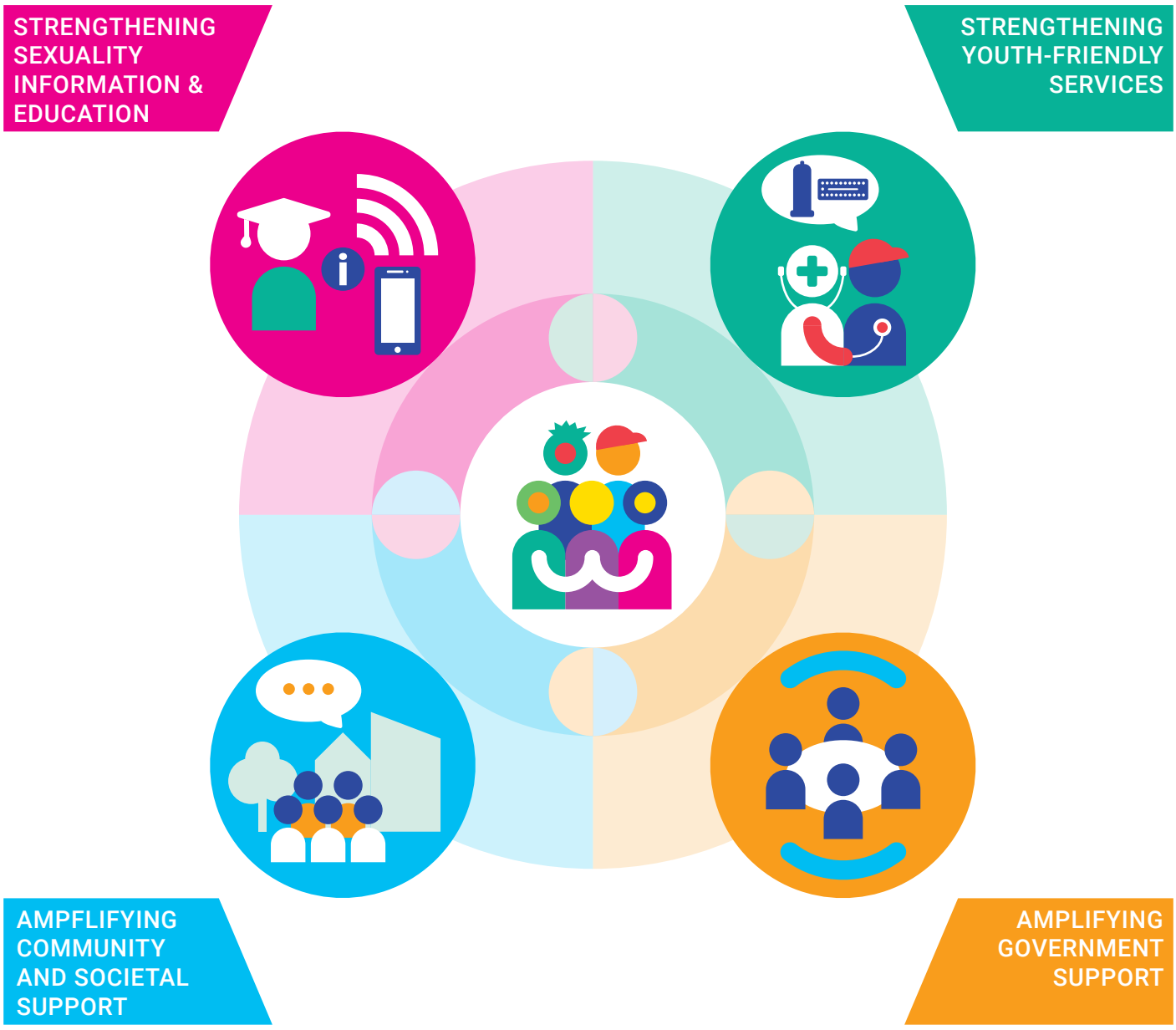
Depending on each country context, these components are planned and implemented by the different organizations that comprise the country ASRHR Alliance. Based on their organizational expertise – whether skilled in comprehensive sexuality education[6], strengthening local health services to become more youth-friendly, reinforcing capacities of community-based NGOs and CBOs to offer ASRHR-focused community outreach and social mobilization, or supporting government authorities to improve health services, policy advocacy and implementation – Alliance members work in concert to move forward a results-oriented ASRHR agenda.

Note that some Alliance members also work at the international level to advocate within the global SRH, gender and human rights, and adolescent health communities for similar actions.

6 For more information on Rutgers' approaches, steps and content for CSE see: https://www.rutgers.international/facts-figures/knowledge-file-comprehensive-sexuality-education

FIGURE 2

The Multi-Component Systems Approach



How does the MCSA work in practice?

Activities in the four component areas are defined by 1) the country context in which the MCSA operates (sociocultural, structural/ services, environmental and community readiness to engage); 2) the existing resource base to support ASRHR actions; and 3) alliance members' skills sets, motivations, and in-country presence/infrastructure. After a situation analysis, each country Alliance sets program goals and builds a multi-year work plan that includes all four components.

Several critical strategies exemplify what makes the approach unique:

- *Building an inter-organizational foundation of shared values and technical expertise.*
  Alliance members take time to build personal awareness and understanding of values around ASRHR issues; this creates a common and mutually-reinforcing agreement and vision among Alliance members of ASRH, gender, and rights regardless of the component in which implementation occurs.[7] Within each component area, there is often significant work to build technical foundations of partner organizations and deepen capacity to act. The combination of commonly-held values and technical foundation prepares members to address sensitive issues holistically, and if and when pushback occurs, to refer to organizational positions and understanding as a basis for action.

  See Case Study 1 - Indonesia
  Navigating an ASRHR Agenda in a changing political environment in Indonesia: MCSA in action. Annex A provides examples of typical foundation-setting activities in the four component areas.

- *Interlinking components to create synergy and common purpose.*
  Many activities are systematically planned to develop bridges across components to create synergies across the social and institutional ecology. For example, a strategic activity linking education, services, and community support components might involve an Alliance member supporting a cadre of community-based workers/peer educators who provide both educational outreach and services and also help raise community awareness of ASRHR. Another example: Alliance members working in tandem across components might focus on expanding access to service referrals or vouchers to young people. Referrals are typically the responsibility of community health workers. Yet teachers and youth peer educators might also be asked to make service referrals to young people, creating more moments for referral, reducing missed opportunities by young people to use services as needed, and increasing policy and other commitment to ASRHR across sectors.

  See Case Study 2 - Tanzania
  The added value of the MCSA: Experience and evidence from Kilindi District, Tanzania Annex A also provides examples of how components are linked via activities with a common aim.

- *Employing social accountability mechanisms to engage young people/civil society in systems change.*
  Through the use of social accountability approaches, alliance partners empower young people and supportive adults and organizations to interact directly with services, schools, and government to become more accountable to ensuring access to ASRHR information and services. By extension, local partners are better equipped to mitigate opposition that may arise within communities, institutions, and government as ASRHR awareness raising and other activities begin. Understanding realities of initial community concerns about ASRHR, sometimes expressed as social opposition, advocacy and community discussions are also planned. Young people are often involved as educators in both school and community settings, also serving to create new youth role models as community change agents.

  See Case Study 3 - Ghana
  Using Social Accountability to address issues of young people's access to and use of health services: Mid-Program experiences of the Get Up Speak Out Program in Ghana

7 Rutgers and Alliance partners have developed an approach to build common understanding to which all alliances adhere. This is embodied in a suite of field-tested tools in its Essential Packages Manual to support reflection and planning with partners in all components.
See: https://www.rutgers.international/our-products/tools/essential-packages-manual

Alliances themselves require technical support to work strategically and efficiently. Based on its implementation experience and informed by published literature, Rutgers has developed clear guidance on effective partnership processes that are used by alliance partners (Rutgers, 2016, Corbin et al., 2018). Key elements include having a common mission; clarifying values relating to young people and ASRHR; capacity-building; south-to-south sharing and learning including building evidence from implementation insights, having joint monitoring and evaluation indicators and data reviews to adjust strategies; and coordinating youth as partners efforts. Building trust and a shared vision also allow joint monitoring of changing environments, whether political, economic, cultural, social, or organizational. Alliance members and partners can be better informed to either mitigate opposition or maximize new opportunities to advance a positive ASRHR agenda.

Thus, an ASRHR suite of activities works within and across levels to build solidarity and capacity of Alliance members and partners and young people themselves. Over several years, as diverse activities are implemented within each component, and across components, new interactions and network connections are created. This expanding web of connections leads to communities more supportive of adolescent rights, ASRH, and more equal adolescent relationships with partners and between generations; and to changes in government accountability and service systems. Over time, the initial effects of implementing the MCSA also deepen.

MCSA Program Change Theory

Based on Rutgers' growing body of research and experience and the peer-reviewed literature, the MCSA change theory has emerged (Figure 3). The MCSA components (shown at left in the figure) operate at different levels of the socio-ecology – strengthening sexuality information and education and youth-friendly health services, amplifying community and government support for ASRHR – and ultimately lead to individual and structural shifts and ASRHR-supportive environments. The long-term results (shown at right) are all young people, especially girls and young women and others who are socially-marginalized, are empowered to realize their SRH and rights in societies that are supportive of young peoples' sexuality. Between these beginning and ending points are a series of change pathways whose arrows show how program implementation leads to a series of intermediate, sometimes interlinked effects, that eventually lead to the expected results.

It is important to note that both the pathways and results of the MCSA align with and enhance the SDG aspirations by improving the SRH and rights of young people, reaching a broader, more diversified generation of citizens better prepared to contribute to society. By holistically addressing the complex contexts in which people live, the MCSA can equip and support adolescents to grow into adulthood better-positioned take on the new challenges embodied by the SDGs.

The intermediate effects resulting from the implementation of the MCSA have been observed to varying degrees in Rutgers' led alliance studies, which helped inform the change theory pathways. These documented effects lead to three critical observations that argue the added value of the MCSA approach. First, if the MCSA was uni-component in focus, for example, focused only on services improvement, the many observed intermediate effects would likely NOT have occurred; likewise, the expected outcomes would not have happened or would have yielded less change. Second, the MCSA pathways clearly show the inter-relatedness and reinforcement of effects from activities in different component areas; this argues that the MCSA results will lead to normalization of ASRHR and be more sustainable. See the Kilindi, Tanzania case study 2 for insights. Finally, while the MCSA focus is on adolescent health, these intermediate effects are likely to transcend to other sectoral areas. Young people being more open to new gender-equitable ways of being, changing public perceptions of ASRHR and sexuality education, more government and community leaders and teachers and health providers publicly speaking & acting on ASRHR and sexuality education are critical to achieving short term goals.
These intermediate effects – many which are intangible and represent life skills development of adolescents, adults, and organizations - also represent more broadly-acting results.
For example, having more youth-friendly services and young people having positive experiences with services may result in more young people seeking other preventative and curative services. Communities that have successfully mobilized for ASRHR may extend their adolescent health efforts to address non-health issues confronted by young people and their parents. Adolescents' experiencing greater gender equality and more equal relationships and respect and greater freedom of movement will develop a range of attitudes, beliefs, and skills – educational, economic, political participation - that will better equip them for adulthood and challenges ahead. Assuming that the MCSA increases social capital (resulting in more effectively functioning communities vis-à-vis ASRHR that include such factors as more shared understanding and shared values, more trust, cooperation, and reciprocity), then one can argue that the MCSA approach can make a stronger contribution to SDG achievement.

FIGURE 3

Multi-Component Systems Approach - Program Change Theory

MCSA Package

STRENGTHENING SEXUALITY INFORMATION & EDUCATION

ACTIVITIES - **SE curriculum strengthening | teacher and school board training | Peer educator network training**

STRENGTHENING YOUTH-FRIENDLY SERVICES

ACTIVITIES - **Training providers & peer providers | Support to establish YFS points in existing facilities and new SDPs at community level | Targeted community outreach to vulnerable youth**

AMPLIFYING COMMUNITY AND SOCIETAL SUPPORT

ACTIVITIES - **Mass media, social media, Community sensitization and debate | SRHR weeks | Engaging with media | Journalist training | Placing news article | youth-led social media**

AMPLIFYING GOVERNMENT SUPPORT

ACTIVITIES - **Policy revision | Policy implementation | Bylaw formation | NGO participation in government | Technical Working Groups**

Mediating / Enabling Factors or Effects

Teachers & providers with confidence & willingness to support ASRH/SE

YP with increased ASRHR Knowledge, Attitudes and Skills & competencies

More numerous and more diverse channels allowing YP easy access to services &info education

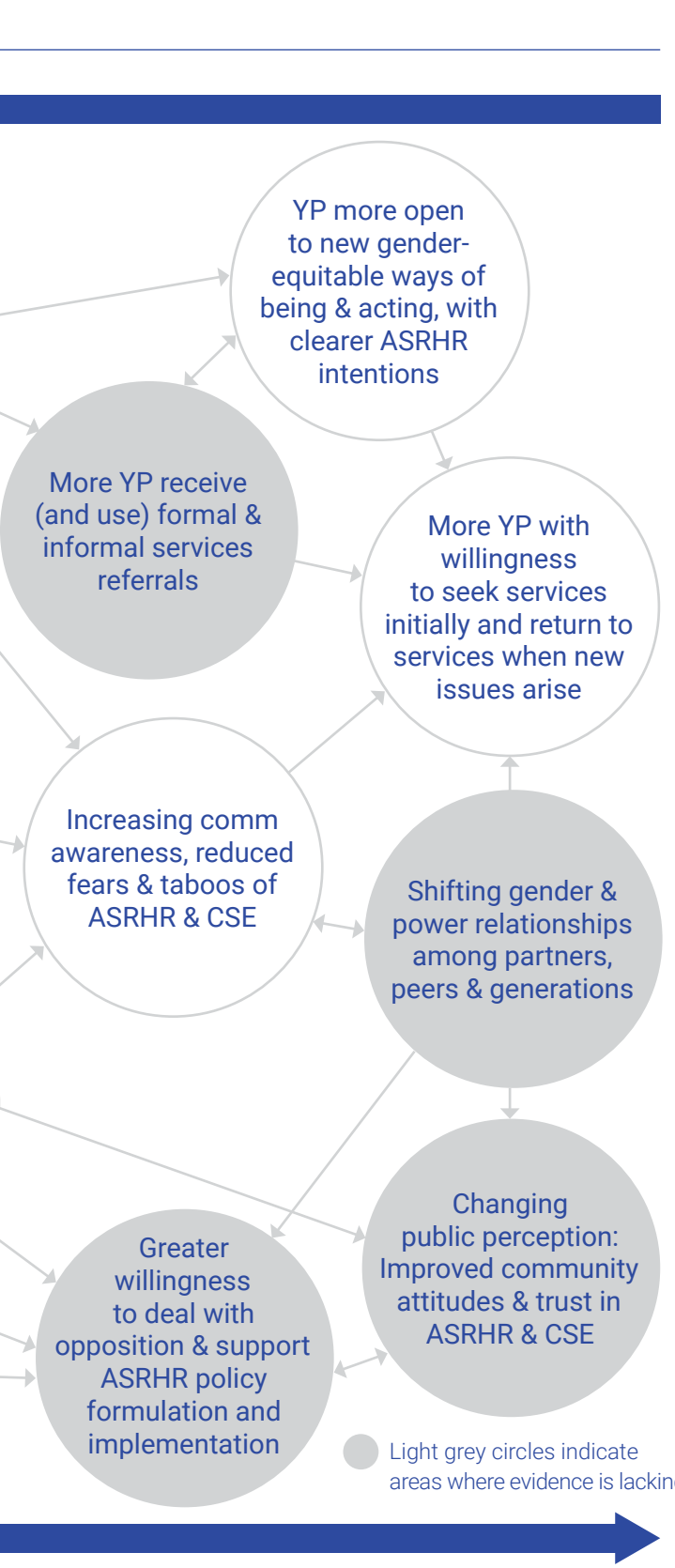
Raising permission & space for public and private dialogues

Increased solidarity of civil society actors (eg, youth, community leaders, journalists

More shared norms, values, and understanding among stakeholder groups

More government & community leaders publicly speaking & acting on ASRHR/ SE

Iteration, Synergies, and New/Deepening Effects Over Time



Short-term - - - Long-term Results

INDIVIDUAL

Young people including marginalized youth, better able to navigate conflicting norms, messages, and expectations

STRUCTURAL

Adolescent-responsive health services, adjusted to young people's social & geographical access realities, that reward youth service-seeking and use of services

School-based SE/CSE, with proactive educators, fully realizing intent of SE & youth rights and voice

Explicit, pro-ASRHR/SE/youth education, health policies, bylaws & budgets.

ASRHR-ENABLING SOCIAL ENVIRONMENT

Social capital – community members, leaders and institutional actors - that is aligned with ASRHR and gender equity, Inclusive of all young people and adults. Supported by youth-positive socio-cultural norms

LONG TERM

All young people, especially girls and young women, empowered to realise their SRHR in societies that are positive towards young people's sexuality.

SDGs 2030: Improved SRH and R of young people; a new generation of citizens better prepared to contribute to society

Key arguments to expand the MCSA to address ASRHR in the SDG era

1

The MCSA is effective when working at scale

> The MCSA is designed to operate at scale, and evidence from three program evaluations demonstrates its effectiveness at scale across components and by participating country sites.

Evidence is seen across programs and countries that the MSCA reached and surpassed many of its performance targets in the four component areas, attesting to their wide-scale reach. It is important to note that outcomes varied by country, although the direction of change was generally positive across countries.
The snapshot summary of end-of-program evaluation results of the UBFR program on the next page reflects similar results from the ASK program evaluation and the current GUSO program.

2 The MCSA can move forward sensitive ASRHR agendas in differing country contexts

> The incremental strategy used by the ASRHR Alliance members - to initiate and continue dialogue on sensitive issues such as sexuality education and ASRHR - is acceptable to a broad range of individual and institutional stakeholders operating in vastly different sociocultural contexts.

Regardless of vastly different contexts in which it was implemented – 11 LMIC countries in Asia and Africa - the MCSA led to greater acceptance of ASRH by many stakeholders in government, civil society, and communities. Cultural competence and sensitivity are a hallmark of the approach, made possible by local alliance members who are part of the social context.

The MCSA begins ASRHR discussions at the level of dialogue prevalent in different country settings. For example, LGBT is an essential area for responsive ASRHR programs, but how to discuss gender identity will differ in different country contexts; sensitive issues do not always have to be addressed directly. An incremental approach is seen by MCSA members as a better way to create dialogue, understanding, and build the enabling environment.

The MCSA thus avoids typical reactions of SRH themes being judged inappropriate for adolescents, and instead leads to notable shifts in valuing the importance of such information and services for young people by their parents, providers (education and health services), government officials, and informal opinion leaders (Kaleidos Research & International Centre for Reproductive Health, 2016; ASK and UBFR Evaluation Reports).

> The ASRHR Alliance members have demonstrated the MCSA's flexibility to adapt program approaches to different country contexts.

The MCSA has been or is currently being successfully applied by Alliance members and their partners in 11 different countries. Because Alliance members act locally, initial MCSA planning is adapted in each context, building on sociocultural context, capacities of social service structures, and realities faced by young people and leading to joint and country-specific M&E indicators. Country Alliance coordination meetings are regularly scheduled to ensure a shared vision and values, map coverage by components, and reduce duplication of actions. Regularly-scheduled learning and reflection meetings allow time for deepening the common vision as well as reviews of data and implementation trouble-shooting and solution-sharing (Kaleidos Research & International Centre for Reproductive Health, 2016; ASK and UBFR End-of-Program Evaluation Reports).

3 The MCSA appears to sustain effects in the four component areas once a program ends

> Ideally, a post-intervention study would be conducted five or more years post-program to ascertain the level of sustainability of activities and socio-structural shifts. Still, end-of-program evaluations and targeted qualitative studies during program implementation indicate that many of the structural changes will likely remain as well as normative shifts (see figure 4).

Improvements in health and education services and their system supports (such as training of teachers and providers) indicate that youth-friendly enhancements will likely be sustained once program funding ends.

End-of-program evaluation studies in multiple countries (Kaleidos Research & International Centre for Reproductive Health, 2016; ASK and UBFR End-of-Program Evaluation Reports) showed that services improvement and capacity building efforts resulted in trained providers and improved health services. Respondents in the Tanzania study indicated that increased use of health services by young people, bolstered and reinforced by friendly providers creates its demand-supply-motivation dynamic that will encourage continuation (Sambaiga, R. 2015).

These same studies also indicate that MCSA support of education system adjustments have moved life skills education curriculum to become more comprehensive (along with the lines of comprehensive sexuality education) in areas where the Alliances have operated. Alterations in in-service training curricula for life skills education teachers have not only led to more teachers trained in CSE/gender equality. Now institutionalized in in-service training, new cadres of teachers will continue to be reached, eventually creating a large force of teachers more comfortable with and seeing higher value in teaching CSE subjects. Using this logic, more students will receive quality CSE, producing an equivalent cadre of better-informed young people with a set of life skills that will prepare them for adolescent and later adult relationships.

Of course, systems are dynamic and always changing, which influences the sustainability of results. A sustainability study of the Youth Encouragement Project in Uganda showed that health services results were minimally sustained due to the continuous and significant amount of staff turnover in the health sector as well as within the NGOs that drove the collaboration with government facilities.

> In sites where information on government change due to Alliance action has been collected, budget, resource lines, and ASRHR bylaws have been created.

The MCSA works with local government administrative authorities to implement the MCSA, effectively working to mainstream ASRHR acceptability, creating a foundation for sustainability. Because officials and their constituent communities see and value results such as reduced rates of teen pregnancy and increased use of services by young people, it appears that human and financial resources will continue to support ASRHR efforts in district health plans, where budget allocations occur. The qualitative end-of-program intervention research in Tanzania (Sambaiga, R. 2015), for example, showed that the MCSA resulted in the passage of community bylaws that favor ASRHR and that sanction early marriage.

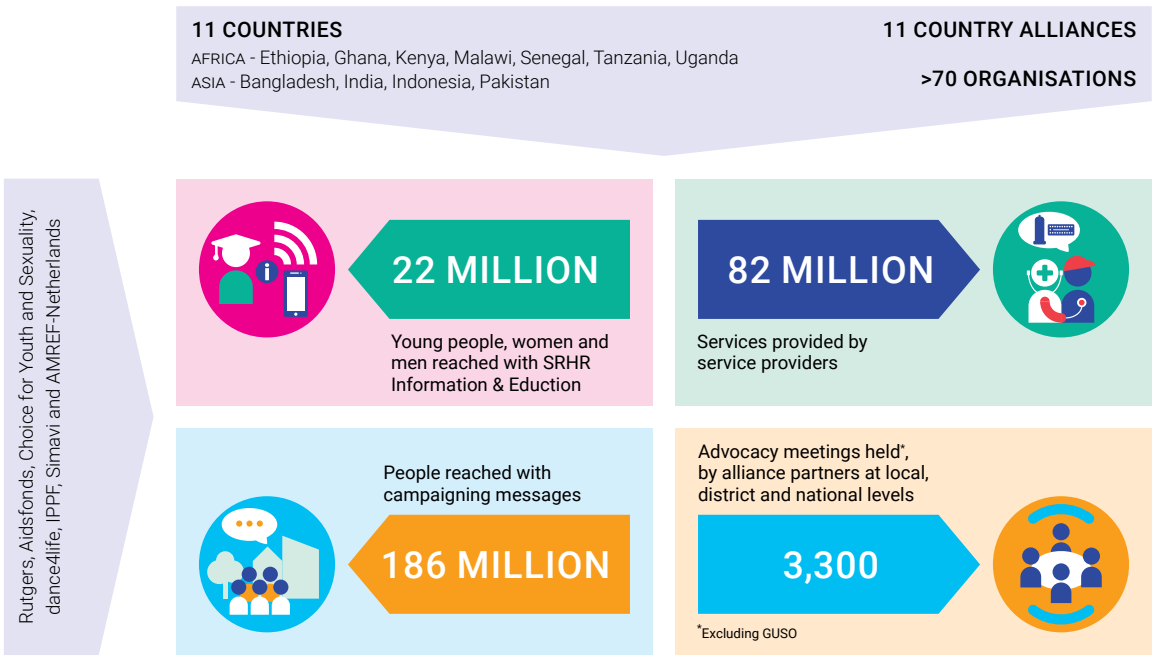
> In sites where information on normative community change has been collected, a more-enabling ASRHR environment has been created and should continue.

The Kilindi post-program evaluation indicated that community volunteer networks would likely continue, and through such efforts, a more-enabling ASRHR environment will be sustained. Similarly, by working with local civil society leaders, the MCSA helped to normalize ASRHR acceptability. Equally important, new gender roles models have emerged and will likely remain, such as men accompanying their wives to ANC clinics, helping communities to internalize gender role and other normative shifts (Sambaiga, R. 2015).

Under such conditions, today's and tomorrow's youth will continue to have more choices than before, be more confident to seek information and services, be more gender-equal in their interactions with peers, and be better positioned to assume adult roles that will lead to SRHR outcomes.

FIGURE 4

Results snapshot - Selected findings from the programmes UFBR (2011 - 2015), ASK (2013 - 2015) and GUSO (2016 - June 2019)



What remains to be learned about the MCSA? A proposed research agenda

Over eight years, Rutgers and partners have been systematically exploring different aspects of the MCSA through operations and evaluation research, program studies, and partner implementation experiences. Evaluations have demonstrated results in a range of domains but not enough time has passed to determine how sustainable is the MCSA regarding systems changes, social changes, and to identify unexpected results that might emerge with time. Some change pathways are not as well-understood as others. Evidence continues to be built under the on-going GUSO program, including studies on power and gender dynamics between young people and their partners, on gender transformative approaches among health workers, and on the impact of the MCSA on youth empowerment. If the change mechanisms implicit in the pathways below are better understood through research, Rutgers and partners will be better-informed about how to adapt the approach in new country settings without losing the values and principles underpinning the pathways activities that have made the MCSA so successful.

Below are questions that Rutgers believes, if answered, will provide crucial still-missing evidence on how the MCSA processes lead to the observed program results.

1. To what extent does the MCSA approach lead to sustained changes?

The results of the MCSA show staying power based on anecdotal evidence. Some degree of sustainability is assumed in the MCSA change theory (see diagram). Given the relative newness of the approach, it would be important to conduct post-program evaluations in former program areas to assess sustainability, as this would provide a more profound argument for investment by others. Do individual, structural, and enabling environment changes remain intact after 5+ years? Do key activities that hold critical change mechanisms continue to be implemented with different resources or with no additional resources? What systems and environmental changes in the post-program years have supported or inhibited sustained effect?

2. How can MCSA activities engage private and traditional sector providers to amplify access to and use of SRH services by young people ?

To date, the MCSA has focused on public sector health services and systems. In many countries, youth are accessing services from private clinics and traditional providers more than from government providers. Working with more providers should amplify access and services used by young people. How do current MSCA strategies need to be adapted for the engagement of non-public sector providers? To understand the inclusion of private and traditional services in the services change pathway requires a better understanding of the private/traditional provider-user interface and strategy testing.

3. Do MCSA activities lead to pro-ASRHR shifts in community norms or collective community attitudes?

Many community-level shifts have been captured in qualitative studies. But systematic efforts to assess quantitatively or qualitatively whether MCSA activities lead to alterations in community norms or collective community attitudes have not yet been made. Whether to evaluate the intermediary effect via a population-based survey to assess normative shifts or to hone in on specific changes within families and neighborhoods remains a question.

4. Do MCSA activities lead to a greater willingness by Alliance partners to deal with opposition and support ASRHR policy formulation and implementation?

The MCSA approach assumes but has never systematically studied whether building social capital and solidarity of partners will result in their greater willingness to take controversial positions than push community normative boundaries and to manage pushback when it occurs.

Conclusions

The SDGs adopted by 193 nations are built on the understanding that we need systemic approaches that aim to align structural and social systems that can be implemented at scale to address root causes hampering human development on a global scale. The SDGs recognize that government, civil society, and other actors' intentions to invest in adolescent health and wellbeing represent a pivotal avenue to prepare the next generation for the challenges they will encounter as adults in a world that is rapidly evolving socially, technologically, and environmentally. To assure scale, sustainability, and relevance in a changing world, new program approaches are needed that can work in complex environments, balancing different levels and facets represented by the socioecological model, maximizing inter-organizational partnerships that also include meaningful engagement by the diversity and age group of young people.

The Multi-Component Systems Approach by Rutgers and partners, which has been evolving and tested over the past eight years in 11 countries, offers one proven and forward-looking solution that represents the next iteration of socioecological programming approaches. It is designed to work effectively in a range of contexts and with a variety of actors at local, regional and national levels. Grounded in values such as equal rights to information and services, gender equity, and meaningful youth engagement, the MCSA's flexibility in operating different contexts, respecting cultural and system starting points, sets a new course in programming that can be amplified by other ASRHR actors.

Rutgers' approach is to use research and evaluation to assess program outcomes and also understand the change mechanisms inherent in the MCSA. A substantial body of evidence now exists to argue that the MCSA design allows wide-scale reach and that it is useful, leading to significant improvements in the adolescent achievement of sexual and reproductive health and fulfillment of SRH rights. The effect of the MCSA is also observed in the enabling environment, with increased social capital at the community level and amplification of pro-ASRHR actions at different government levels. Systemic changes are occurring in health and education services and community support that portend sustained impact over time in services availability and a pro-ASRHR environment.

While many change pathways in the program change theory are understood, some would benefit from additional exploration to know how the change mechanisms operate in different contexts. Currently under investigation in the GUSO program, how and to what extent does the MCSA (versus a uni-sectoral approach) shift gender and power relationships between young people and their partners? For very young adolescents, how does investment in this period before developing sexual relationships lead to stronger assets and resilience for the later adolescent years? Related but at the community level, how and to what extent and with which stakeholders does the MCSA shift community norms and attitudes towards ASRHR?

At a cross-country level, how do such change pathways play out in different country contexts, and how does country adaptation influence the range of outcomes? At an alliance level, how does the partnership composition amplify results or not? Does greater solidarity mean alliances will more likely take on controversial issues inherent in ASHRH?

These unanswered questions will serve not only to consolidate understanding of the MCSA but also build evidence that the holistic approach offers a new paradigm for ASRHR programming. We invite interested governments, NGOs, and donors to join Rutgers in contributing at scale to the SDGs by moving forward the MCSA in new contexts.

Key takeaways

Takeaway 1 - Working in Partnerships
Programs focused on adolescent sexual and reproductive health and rights build a foundation for the SDGs. Current efforts to improve adolescent sexual and reproductive health and wellbeing, though, are not well aligned with SDG aims to conceptualize and act more broadly within complex social social systems and structures. Inter-organizational partnerships with a range of expertise and mandates offers a viable approach for comprehensive adolescent sexual and reproductive health programs, underpinned by values of equity, gender equality, reproductive rights and meaningful youth engagement, to achieve large-scale impact while recognizing local context.

Takeaway 2 - Eight years of experience in the Multi-Component Systems Approach
Based on eight years of program learning from research, monitoring and evaluation in 11 country contexts, Rutgers and its partners have developed an evidence-based approach - the Multi-Component Systems Approach - that leads to large-scale impact, while designed to address the complexity of systems and societal issues noted above that confront adolescent health programs.

Takeaway 3 - MCSA Research
The research indicates that the Multi-Component Systems approach is 1) effective when working at scale; 2) can move forward sensitive ASRHR agendas in a variety of contexts; 3) is adaptable in different cultural contexts; and 4) appears to sustain systemic and social changes by building community social capital, creating mutually-supporting sexuality education and services efforts supported by government.

Takeaway 4 - New program paradigm
The MCSA approach offers a new program paradigm for ASRHR that is better aligned with and builds an SDG foundation. An excellent evaluation and research base has demonstrated the MCSA's impact and explored many of the change pathways that lead to impact to build understanding of how the approach leads to the observed effects.

Takeaway 5 - Remaining questions
Answering remaining questions will deepen understanding of process and MCSA's impact: (1) What strategies allow engagement of private and traditional sector providers to amplify access to and use of SRH services by young people? (2) How and to what extent does the MCSA shift community norms and attitudes towards ASRHR? (3) How does Alliance composition lead to differing levels of solidarity and willingness to take on controversial issues inherent in ASHRH agendas? (4) As a new program approach, a post-program sustainability assessment would allow better understand of what pathways and impacts remain and how changing evnironemnt influenced sustainability.

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Bangladesh
SRHR Alliance (4 organisations): Family Planning Association Bangladesh (FPAB), Christian Hospital Chandraghona (CHC), Dustha Shasthya Kendra (DSK), Population Services Training Center (PSTC), Reproductive Health Services Training and Education Programme (RHStep)

Ethiopia
SRHR Alliance (4 organisations): Development Expertise Centre (DEC), Family Guidance Association of Ethiopia (FGAE), Talent Youth Association (TAYA), Youth Network for Sustainable Development (YNSD)

Ghana
Ghana Sexual and Reproductive Health and Rights Alliance for Young People, (6 organisations): Planned Parenthood Association of Ghana, NORSAAC, Hope or Future Generations, Savana Signatures, Presbyterian Health Services – North and Curious Minds

India
SRHR Alliance (6 organisations): Voluntary Health Association of India (VHAI), Bihar Voluntary Health Association (BVHA), Students Partnership Worldwide (SPW), NEEDS, SEWA BARAT, Integrated Development Foundation (IDF)

Indonesia
Aliansi Satu Visi, ASRHR Alliance Indonesia (20 organisations), GUSO partners (10 organisations): IPPA Lampung, IPPA Jakarta, IPPA Central Java, IPPA Bali, Rutgers WPF, ARI, IHAP, YPI, Red Cross East Jakarta, Ardhanary Institute

Kenya
Kenya SRHR Alliance (17 organisations), GUSO partners (9 organisations): ADS-Nyanza, Centre for the Study of Adolescence (CSA), Family Health Options Kenya (FHOK), Great Lakes University of Kisumu (GLUK), Kisumu Medical and Education Trust (KMET), Nairobits Trust, NAYA Kenya (Network for Adolescent and Youth of Africa, Ambassador for Youth and Adolescent Reproductive Health Programme (AYARHEP) Women Fighting AIDS in Kenya (WOFAK)

Malawi
SRHR Alliance Malawi (6 organisations): Centre for Alternatives for Victimized Women and Children (CAVWOC), Centre for Human Rights and Rehabilitation (CHRR), Centre for Youth Empowerment and Civic Education (CYECE), Family Planning Association of Malawi (FPAM), Youth Net and Counselling (YONECO), Coalition of Women Living with HIV and AIDS (COLWHA)

Senegal

SRHR Alliance (3 organisations): Association sénégalaise pour le bien-être familial (ASBEF), Amref Health Africa, Centre Ginddi

Tanzania

The Tanzania Sexual and Reproductive Health and Rights (SRHR) Alliance (5 organisations): (Pamoja Tunaweza), African Medical and Research Foundation (AMREF), Restless Development, Health Actions Promotions Association (HAPA), National Institute for Medical Research (NIMR) Mwanza Centre, and Medico Del Mundo

Uganda

SRHR Alliance Uganda (8 organisations): Straight Talk Foundation, Restless Development, Reach A Hand Uganda (RAHU), Reproductive Health Uganda (RHU), Family Life Education Program (FLEP), UNYPA, NAFOPHANU, Centre for Health, Human Rights and Development (CEHURD)

Pakistan

Parwan Alliance (until 2018), (6 GUSO partner organisations): Rutgers Pakistan, Family Planning Association of Pakistan (FPAP), Idara-e-Taleem-o-Agahi (ITA), Blessings Welfare Association (BWA), Participatory Integrated Development Society (PIDS), Visionary Foundation Pakistan (VFP). As of 2019 Utho Bolo: Family Planning Association of Pakistan (Rahnuma FPAP), Idara-e-Taleem-o-Agahi (ITA), Blessings Welfare Association (BWA)

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Annex A

How does the MCSA work

Illustrative activities by component

Activities in the four component areas are defined by 1) the country context in which the MCSA operates (sociocultural, structural/services, environmental/community readiness to engage); 2) the existing resource base to support ASRHR actions; and 3) alliance members' skills sets and motivations. Of note in each table are activities that serve to work across components, as strength of the MCSA.

While the responses in the tables below represent actual MCSA activities, issues, and responses in any country will vary.
The tables, on the next pages, are thus illustrative.

STRENGTHENING SEXUALITY INFORMATION & EDUCATION

MCSA Component - **Illustrative Activities**	
Improve the foundation of sexuality education in and out-of-school.	Alliance members develop and revise with central/district education authorities curricula that are • Effective, Evidence-based, contextualized, and include comprehensive SRHR information • Employ participatory and experiential educational methods and materials • Tailor curricula to the (gender) specific needs of target- and age groups
Facilitate successful implementation of SRHR information and education in schools	Alliance members work with government authorities and education- and health-focused NGOs to • Train teachers and peer educators • Create headmaster-teacher ownership of sexuality education in schools • Strengthen the education link with health services through exchange visits and referrals • Create a safe and enabling school environment through whole-school approaches • Engage with parents to increase parental understanding and support for positive and healthy sexuality development
Advocate for pro-ASRHR policies and procedures	Alliance members support civil society and government/NGO technical staff efforts to: • Advocate at local, district and national levels to increase support for providing accurate, comprehensive information for young people; • Influence relevant policies (e.g., back-to-school policies for girl-parents; • Provide input for national guidelines on CSE.
Extend access to quality information	Alliance members support NGO projects and government efforts to: • Develop innovative e & mHealth education and information applications, e.g., websites, social media, and helplines, enabling young people to access SRHR directly • Support development of peer-education models and networks to reach in and out-of-school youth as well as parents and the broader community to build community and parental support for sexuality education and ASRHR

STRENGTHENING YOUTH-FRIENDLY SERVICES

MCSA Component – **Illustrative Activities**	
Improve providers' capacities to offer youth-friendly services (YFS)	Alliance members engage government and NGO technical advisors and providers to • Deepen awareness of youth participation in adolescent-friendly services • Assess the partners' technical and organizational capacities to organize YFS • Train existing and future trainers (Training-of-Trainers approach) recruited from local partners on medical and non-medical aspects of YFS.
Address service-site barriers to young people using SRH services	Alliance members work with government and NGOs to • Deepen self-awareness of clinic staff and service providers of negative attitudes to young people's SRHR they may have, especially for young unmarried people • Seek the voice of young people, e.g., using community scorecards that ask young people to assess how well services address their needs and wishes, using this information to develop and test services adjustments • Make monitoring and reporting mechanisms easier to use, such as introducing mobile monitoring applications
Expand young people's access to and utilization of SRH services	Alliance members work with government and NGOs to: • Bring services to young people, e.g., health workers visit schools or engage in outreach activities such as youth health camps, mobile clinics; peer providers, and community health workers providing information and condoms. • Include educational activities and community dialogues as part of the delivery of contraception and SRH health services. • Bring young people to services by expanding referral mechanisms, e.g., health and non-health agents provide vouchers to young people desiring and needing services.

AMPLIFYING COMMUNITY AND SOCIETAL SUPPORT

MCSA Component – **Illustrative Activities**	
Create understanding and support at an interpersonal level	Alliance partners support interpersonal communication activities that allow more individualized reflection on ASRHR issues, such as • Specialized training and value clarification for CBOs) and NGOs • In turn, the CBO and NGOs host meetings with opinion leaders on SRHR topics such as youth sexuality, abortion, and youth-friendly services. Individuals and groups often include religious leaders, community leaders, parents and extended family members including young people • CBOs and NGOs also organize awareness-raising events for the general public, such as theatre performances, rallies, quizzes and debate competitions
Use media to amplify ASRHR understanding and support	To amplify support for SRHR among a broader audience, Alliance members • Organize and conduct mass media awareness campaigns on local, district and national levels (radio and television) • Employ social media channels (such as Facebook, Instagram) to extend reach within young people's networks
Strengthen collaboration & forge partnerships between core Alliance members and local organizations	By working together as an extended alliance, local partners can develop capacities and extend MCSA reach: • Engage in joint awareness-raising activities, which gives them a stronger voice than they would have individually. • Deepen learning, e.g., creating opportunities to exchange experiences, good practices, and learn from one another. • Create solidarity with other like-minded organizations and by extension, willingness to take on sensitive issues in community forums

AMPLIFYING GOVERNMENT SUPPORT

MCSA Component – **Illustrative Activities**	
Foster positive policy environments at national levels	Alliance members with national and local partners can: • Implement targeted advocacy activities aimed at influencing policymaking at local (bylaw creation), national and international levels (policy creation or revision and international agreements), as well as holding governments accountable for policy implementation: • Ensure the voice of young people is part of the policy dialogue, including vulnerable groups within the larger group of young people. • Building capacities to ensure meaningful youth participation has been central to this strategy.
Build advocacy capacity	Often a skill that is lacking within in-country alliances, the program can: • Support placement of a dedicated advocacy advisor in each country. • Apart from training and providing advice, the advocacy expert supports the development of country-level advocacy strategies
Strengthen collaboration & forge partnerships between core Alliance members and local organizations	By working together as an extended alliance, local partners can: • Engage in joint advocacy activities, which gives them a stronger voice than they would have individually. • Deepen learning, e.g., creating opportunities to exchange experiences, good practices, and learn from one another. • Create solidarity with other like-minded organizations and by extension, willingness to take on sensitive issues at more structural/services levels

Case Study 1
Indonesia

Navigating an ASRHR agenda in a changing political environment in Indonesia MCSA in action

The year 2018 was named the 'year of politics' in Indonesia given its run-up to the 2019 elections for president, regional government heads, as well as national and local legislative. Just how political was evidenced by the sitting president who announced a conservative religious cleric as his running mate. Throughout 2018, the Parliament was cautious making policies and programs. It was also a sensitive time for the Alliansi Satu Visi, the GUSO-supported ASRHR Alliance, that since 2016 had been working at the central level to create a more comprehensive ASRHR policy environment and in five cities (estimated population of 9.1 million) to demonstrate the practice and benefits of a more comprehensive ASRHR approach. The experience shows that even during touchy political moments, the MCSA, alliance members draw from a foundation of shared values that facilitates forward movement of sensitive work in policy-making, service delivery systems, and community and political environments, carefully tailoring possibilities to advance an ASRHR agenda.

At the national level. Three ministries - Health, Education, and Religious Affairs - worked with Alliance member over three years to complete guidelines that established teacher proficiencies to teach sexuality education in elementary, middle, and high school. This strategy created consensus and trust across ministries that could advance or block a sexuality education agenda. In 2018, a new policy on curriculum diversification gave local government authorities the final says on which educational materials to include in their curriculum. The Alliance immediately began to advocate for a strong commitment from local government to adopt the entire reproductive health education guidelines and mobilize resources for implementation, aided by the logos of three central ministries which assuaged local fears of implementing reproductive health education. Another winning strategy has been to work with the central Ministry of Health (MoH) to find provinces where the Ministry of Education could conduct module piloting in 2019, allowing new ASRHR activities to continue in a politically-expedient way, while building evidence for later expansion.

To better implement youth-friendly service policies, the MoH developed YFS quality assessment tools in 2017/2018 with the help of Rutgers-Indonesia, and also issued technical guideline on integrated ASRH services to extend services reach. The new tool and guidelines created a new opportunity for Alliance members to support integration of comprehensive youth-friendly services not only into government primary care facilities but also more community health posts, diversifying channels for young people to access ASRHR services.

At the local level. The relatively unfavourable national political situation did not disrupt too much the political situation in the five intervention areas. As proof:
In four of five intervention cities - Jakarta, Semarang, Bali, and Kupang – six NGOs received formal support in 2018 in the form of MoUs and recommendation letters from the city government to implement the ASRHR programme promoted by GUSO.

In Bali and Semarang governments have committed to the sustainability of the program post-2020 with their funding.

National politics were more at play in education, where teachers were more reluctant to discuss issues such as LGBT, abortion, and access to contraception for unmarried young people. In mid-2018, the District Education Office in Lampung ordered a stop to comprehensive sexuality education provision. But Alliance and local partner advocacy efforts to local governments, complemented and strengthened by central-level advocacy to the MOE, convinced that the District Education Office to reverse the ruling, and comprehensive sexuality education program was reinstated.

By creating and reinforcing not only technical linkages but also interpersonal relationships and understanding of context, the MCSA leads to greater trust within and between education, health services, and the enabling civil society and government allies. During politically-sensitive times, Alliance members learn quickly about new developments, and assess options to either exploit opportunities with its partners that might emerge or mitigate pushback.

> Aliansi Satu Visi, ASRHR Alliance Indonesia, comprised of 20 organisations of which 10 implementing GUSO organisations: IPPA Lampung, IPPA Jakarta, IPPA Central Java, IPPA Bali, Rutgers WPF, ARI, IHAP, YPI, Red Cross East Jakarta, Ardhanary Institute

Case Study 2
Tanzania

The Added Value of the MCSA: Experience and Evidence from Kilindi District, Tanzania

Four years of MCSA implementation under the Unite For Body Rights Program in Kilindi District in northern Tanzania (reaching an estimated population of 240,000) led to startlingly good results in the end-of-program evaluation: 80% increase over the program baseline in adolescent SRH knowledge, 45% increase in young people's self-efficacy to make safe and informed SRHR decisions, and a 27% increase in young people's use of family planning services over the 2011 baseline. When asked why the results were so good, local Alliance partners and AMREF, the Alliance member lead in Kilindi, pointed to the MCSA approach. Rutgers conducted qualitative research in 2015 to explore why; the study findings below help to understand better the power of the MCSA.

In Kilindi, the MCSA 'glue' was the CORPS (Community-Owned Resource Persons, similar to Community Health Workers), a network of trusted youth volunteers selected by and living in target communities and trained by AMREF as ASRHR change agents to foster actions across and within the four components of the MCSA. The CORPS activities led to multiple inter-component links between health, education, civil society, and local government. For example, CORPS members coordinated ASRHR information diffusion to reach a larger and more diverse audience that would not have been reached by one channel alone. Youth peer educators operated in and out of schools, alongside health providers and CORPS, to pass similar ASRHR messages to their respective clientele. Peer educators provided condoms to young people, creating new service delivery channels for those who might be afraid or ashamed of asking for contraception from CORPS or clinic or pharmacy staff. Conversely, CORPS and health providers worked to expand referral vouchers by youth peer educators and teachers (non-health actors), creating new referral channels, and 'permission' and opportunities for young people in- and out-of-school to act on intentions to use services.

The broad-based actions to improve knowledge and dispel myths while increasing young people's access to contraception was complimented by AMREF's awareness-raising and capacity-building activities with district health and education officials and community leaders. District officials revised SRHR policies, and community leaders acted, in one case establishing a bylaw to penalize child marriage. These actions legitimized ASRHR as a community issue. The visibility and voices of these opinion-leaders normalized ASRHR in the communities, creating community and leadership trust and support for other ASRHR activities more generally.

To state it another way, study respondents pointed to how the MCSA led to increased community social capital, something that is not possible to achieve with more traditional ASRHR programs that focuses on one sector. Taken together – having better linked ASRHR-supportive structures; more universal understanding and appreciation of ASRHR across education and health services staff and between young people and adults in the community; more coherent and like-minded civil society and local government support; and young people themselves engaged in roles beyond passive program beneficiaries – these factors led to a confluence of changes, which in turn, contributed significantly to the knowledge, self-efficacy, and services improvements that were seen in the program endline evaluation.

> The Tanzania Sexual and Reproductive Health and Rights (SRHR) Alliance (Pamoja Tunaweza) is a collaboration between five civil society organizations: African Medical and Research Foundation (AMREF), Restless Development, Health Actions Promotions Association (HAPA), National Institute for Medical Research (NIMR) Mwanza Centre, and Medico Del Mundo.

Case Study 3
Ghana

Using social accountability to address issues of young people's access to and use of health services: Mid-program experiences of the Get up Speak out Program in Ghana

Ghana is often considered a health innovation leader in Africa, including its progressive SRHR policies and programs. For GUSO and its mandate to engage young people as actors in ASRHR programs, there is a growing safe and flexible space for prioritizing and promoting young people's SRHR issues such as accessing and utilizing Comprehensive Sexuality Education/Information; using family planning, STI/HIV, safe abortion and SGBV services. Policies exist or are being revised to support ASRHR including: the National Comprehensive Sexuality Education Guidelines for In-and-Out of School delivery, which are being rolled out through a multi-organizational effort: an ongoing review of the operational guidelines and standards for youth-friendly health services that aim to improve young people's access to quality, rights-based SRHR services; and the inclusion of FP services in the National Health Insurance Scheme which addresses financial access constraints experienced by young people. Civil society spaces continue to improve with growing recognition and activism for the rights of young people to non-discriminatory SRH services, evidenced by the second National Adolescent Reproductive Health Summit in 2018 and the Africa Youth SDG's Summit, both which seek to sustain attention to and actions for young people's SRHR. To support these efforts, the Ghana ASRHR Alliance has taken the challenge and is working in three northern regions of Ghana to improve ASRHR in an area that is characterized as more traditional than the southern regions.

In this context, GUSO began several social accountability innovations that are yielding promising results not only leading to more responsive and inclusive services but also creating new roles for young people and new avenues to be engaged in respectful, rights-oriented dialogues with adult providers and the broader community. One strategy has been the use of Youth Friendly Scorecards implemented in six health facilities and their catchment areas. The Scorecard involves the participation of all categories of young people who visit the health facilities, regardless of age, whether married or not married, or seeking curative or preventive services. The analyzed feedback from young people provides systematically-collected information to use in face-to-face discussions and action planning between young people and service providers. Topics often covered in these face-to-face talks include negative attitudes of service providers, and for some health facilities, privacy and confidentiality issues during service provision, long waiting times, non-availability of IEC take-home materials for clients, and unaffordable charges for services rendered to young people.

The use of youth-friendly scorecards and meaningful youth-led engagement in client-provider discussions in all six health facility catchment areas has increased accountability by local health authorities evidenced by services adjustments, including:

- More client-centered planning of health services to suit young people.
- More client-friendly services. Even by those already trained in YFS, the opportunity to listen to feedback on services can be an eye-opener.
- Structured follow-up for young people who are socially-marginalized or with complex needs. This includes young people requiring post-abortion care services, or who are family planning defaulters and at risk for unwanted pregnancy, with recurring sexually-transmitted infections, or are HIV-positive and not being treated.

Given this success, other opportunities to foster social accountability across MCSA components are being explored, for example, to amplify community roles on behalf of young people. GUSO partners are starting to work with existing community-level structures such as Health Management Committees, offices of Assemblymen and women, Pastors and Imams, and chiefs and elders, to capacitate such structures to expand their community representation/ accountability roles to ensure broader support for improving young people's SRH services access.

> Ghana Sexual and Reproductive Health and Rights Alliance for Young People, comprised of six organisations implementing the GUSO programme: Planned Parenthood Association of Ghana, NORSAAC, Hope or Future Generations, Savana Signatures, Presbyterian Health Services – North and Curious Minds

Annex B
List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASK	Access, Services and Knowledge (SRHR Alliance Programme 2013-2015, SRHR Fund)
AYSRH	Adolescent Youth Sexual and Reproductive Health
AYSRHR	Adolescent Youth Sexual and Reproductive Health and Rights
CBO	Community-Based Organisation
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
FP	Family Planning
GUSO	Get Up Speak Out (SRHR Consortium Programme)
HIV	Human Immunodeficiency Virus
IEC	Information and Education Communication
IPPF	International Planned Parenthood Federation
KAS	Knowledge, Attitudes and Skills
LGBT	Lesbian, Gay, Bisexual, Transgender
LMIC	Lower and Middle-Income Countries
MCSA	Multi-Component Systems Approach
M&E	Monitoring and Evaluation
MoE(C)	Ministry of Education (and Culture)
MoH	Ministry of Health
MYP	Meaningful Youth Participation
NGO	Non-Governmental Organisation
NL/UK	Netherlands/United Kingdom
OR	Operational Research
RBA	Rights Based Approach
SDG	Sustainable Development Goal
SE	Sexuality Education
SDPs	Service Delivery Points
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TWG	Technical Working Group
UFBR	Unite for Body Rights (SRHR Alliance Programme 2011-2015, MFS II)
UN	United Nations
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
WSWM	World Starts With Me (CSE curriculum)
YAP	Youth/Adult Partnership
YF	Youth friendly
YFS	Youth-friendly services
(Y)PLHIV	(Young) People Living with HIV