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E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

University Leadership for Change in Sexual and Reproductive Health in Niger

Project Report

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About E2A

The Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. E2A aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services.

Awarded in September 2011, this project will continue for eight years, until September 2019. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

The Evidence to Action (E2A) project has a mandate to focus on the reproductive health and family planning needs of women and girls. E2A takes a life cycle approach in order to support programming that addresses specific needs at all stages of the reproductive life cycle, in diverse settings and through the application of best practices. In 2014, USAID West Africa awarded field support to E2A to strengthen youth-focused family planning programming in Niger, complemented by E2A core funds from USAID Washington.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

Acronyms

AgirPF	Agir pour la planification familiale
AIDS	Acquired Immunodeficiency Syndrome
AMU	Abdou Moumouni University
ANBEF	Association Nigerienne pour le Bien Etre Familial
AYSRH	Adolescents and Youths' Sexual and Reproductive Health
CNOU	Centre National des Œuvres Universitaires
CROU	Centre Régional des œuvres universitaires
DAYH	Division for Adolescent and Youth Health
DHS	Demographic Health Survey
E2A	Evidence to Action Project
FP	Family Planning
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IEC	Information Education Communication
MHE/RI	Ministry of Higher Education, Research and Innovations
MPH	Ministry of Public Health
NGO	Non-Governmental Organization
NIPH	National Institute of Public Health
NHIS	National Health Information System
NTHC	National Technical Health Committee
PtC	Pathway to Change
REACH	Reflection and Action for Change
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
ULC	University Leadership for Change
UNDP	United Nations Development Program

Executive Summary

From March 2014–June 2016, E2A implemented the University Leadership for Change (ULC) project in Niger to promote youth leadership for driving social change and health systems strengthening with the aim of reducing unintended pregnancies and maternal mortality, and increasing gender equality. In Niger, public health issues and family planning and reproductive health, in particular, are among key priorities for development. Several health indicators call for the urgent attention, especially in the field of adolescent and youth sexual and reproductive health (AYSRH). With an average of 7.6 children per woman, Niger has the highest fertility rate in the world, as well as the highest rate of child marriage worldwide: 76.3 percent of women currently 20-24 years were married before age 18 and 28 percent before age 15.[1]

ULC was designed as an innovative response to young people's sexual and reproductive health (SRH) and family planning needs, and to prepare young women—with the support of young men and their communities—to make and act on informed decisions about delaying sexual debut and delaying the first pregnancy and spacing and limiting their pregnancies to ensure the healthiest outcomes.

To achieve this goal, the project focused on the five following objectives:

- Increase awareness and knowledge of AYSRH and behavior change among Abdou Moumouni University (AMU) peer leaders and increase awareness of AYSRH issues among university students;
- Increase utilization of SRH services among AMU students;
- Strengthen service delivery through capacity building of service providers and improving linkages to other health centers and Ministry of Public Health (MPH) programs;
- Generate, share, and apply information and evidence regarding access to SRH services in university settings (among AMU, MPH, and implementing partners); and
- Raise awareness about AYSRH at the community level.

The project aimed to primarily reach the student population of AMU in Niamey and community youth (10 – 24 years) in different regions across Niger. From its design phase, the ULC project made a deliberate choice to work with and through young people as leaders and vectors of change. University students were not only viewed as recipients of SRH information and services, but they were also involved as decision-makers and frontline implementers in the process. The 2012 Demographic Health Survey (DHS) for Niger shows a clear association between levels of education and people's understanding, attitudes, and behavior related to SRH and family planning. Because of their high educational attainment and their mobility, university students in Niger are well-positioned to not only improve their own SRH, but also to increase peer demand for and access to youth-friendly SRH services in Niger. As young people, they know their needs best and can easily identify with other students. Moreover, they are perceived both on campuses and in communities as knowledgeable peers and leaders and therefore best placed to engage fellow students and community youth on SRH topics.

At the heart of this project was a comprehensive approach to behavior change that sought to create an enabling environment to improve SRH among young people. The project was composed of three main technical components: (1) Youth leadership and demand generation; (2) Expanded access and improved quality of SRH services; and (3) Participatory stakeholder engagement for sustainability**.** These three pillars were used simultaneously to work towards the achievement of the ULC project's objectives.

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[1] Institut National de la Statistique (INS) et ICF International, 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012*. Calverton, Maryland, USA : INS et ICF International.

In terms of results, the project reached around 8,000 young people (3,899 university students out of a total 19,000 students and 4,000 community youth) through SRH behavior change and sensitization activities led by 202 trained peer leaders. These sensitization activities increased openness and dialogue about sexuality and SRH, as well as knowledge and awareness among students and other youth in communities. Moreover, the project improved the relationship between students and the AMU university health center staff, resulting in improved quality of SRH services for young women and young people in general. The project also introduced contraceptive services for the first time at the AMU health center and built the capacity of health providers to offer youth-friendly SRH and contraceptive services. This resulted in increased access to—and utilization of—SRH/family planning services among students. Around 80,000 condoms were distributed, 712 students received SRH/family planning counseling, and 61 students received contraceptive methods at the university health center. Students involved in the project created a youth-led NGO on their own initiative to continue the ULC approach beyond the lifespan of the project.

E2A also launched a new social and behavior change monitoring and decision-making tool, the "Pathways to Change Dashboard". The dashboard summarizes the barriers and facilitators to SRH identified by young people. It is easily searchable and provides evidence that can be used for monitoring behavior change activities, programmatic decision-making, and strengthening AYSRH interventions.

An important component of ULC was an emphasis on scalability, using ExpandNet's approach to systematic scale-up planning, *Beginning with the end in mind*. The promising results of the integrated approach to the three ULC components motivated the Ministry of Higher Education, Research and Innovation (MHE/RI), the MPH, USAID, and partners[2] to plan for scale-up of the ULC approach. The ExpandNet tools were first introduced to stakeholders in Niger in March 2015 and these tools guided the different phases of a scalability assessment and scale-up planning, which included the following activities:

- Scale-Up Orientation (March 2015)
- Beginning with the End in Mind Orientation Workshop (July 2015)
- CORRECT Analysis (August 2015)
- Process Documentation Data Collection (Phase 1 & 2: Sept-Oct 2015, Phase 3: April-May 2016)
- Scale-up Reflection Workshop (December 2015)
- Scale-up Feasibility Testing in Maradi, Tahoua, and Zinder (January-May 2016)
- Nine Steps Scale-up Planning Workshop, resulting in a clear consensus on the essential ULC package for scale-up, as well as draft plans to scale-up the ULC approach to additional sites throughout Niger and institutionalize the ULC approach through Niger's national AYSRH programs (October 2016)

At the time of writing this report, partners (MPH, MHE/RI, AgirPF, and Pathfinder International) were in the process of implementing the scale-up plans developed during the Nine Steps Scale-up Planning Workshop in October 2016. Regional partners were also exploring the possibility of scaling up the approach to other countries in West Africa.

At the same time as the scale-up planning took place, the MPH was conducting a final review of its new AYSRH strategic plan. This provided an opportunity to include ULC interventions in the national strategic plan to ensure their sustainability.

[2] Key partners include: Pathfinder International and the AgirPF/EngenderHealth Project

The following lessons were learned from both the pilot experience in Niamey and the scale-up planning process to campuses in Maradi, Tahoua, and Zinder:

- A multi-sectoral approach to AYSRH programming in university settings is critical for ownership and sustainability.
- Integration of university health centers into the public health system is necessary to increase access to quality youth-friendly SRH/family planning services.
- Addressing gender barriers is paramount to the success of AYSRH programs in Niger.
- Involving and supporting young people as leaders brings added value and contributes to sustainability.
- The use of narratives in behavior change interventions has the potential to address complex behavioral needs of diverse young people.
- The expansion of youth-led activities at community level increases their accountability and leadership.
- Establishing mechanisms to promote participatory and co-shared coordination of the project among the different stakeholders, including young leaders, is key for accountability and sustainability.
- It is important to clarify the concept of "process documentation" in relation to the experience of implementation and "scaling up" since many stakeholders do not understand and are not familiar with data collection for evaluation purposes.
- Systematic process documentation plays a useful role in quality improvement.
- Testing health innovations, and adapting them in different contexts and under routine operating conditions, can considerably increase the likelihood of success for scale-up efforts

In conclusion, the project achieved its objectives and showed, through the process documentation, how to plan and roll out scale-up strategies. Although the ULC project has drawn to a close, several opportunities exist to build on the project's achievements and support scale-up of the ULC approach, with the ultimate aim of further improving AYSRH in Niger and in other West African countries.

CONTEXT AND RATIONALE

Introduction

From March 2014-June 2016, E2A launched the University Leadership for Change (ULC) in Sexual and Reproductive Health Project, aiming to strengthen young people's access to sustainable sexual and reproductive health (SRH) and family planning (FP) information and services at the Abdou Moumouni University (AMU) in Niamey. E2A implemented the project in partnership with the Ministry of Public Health (MPH), the Ministry of Higher Education, Research and Innovation (MHE/RI), Pathfinder International, and Agir pour le Planification Familiale (AgirPF). The project also collaborated with young people as hands-on stakeholders, frontline implementers, and vectors for change. The change model built into the project's design makes the project relevant, sustainable, and scalable.

This report presents the project outcomes and documents the strategies and approaches that led to the results achieved. The report also highlights considerations for scaling up the ULC approach in different contexts. The success stories and lessons learned within this report are relevant for a global health audience seeking to improve AYSRH outcomes through effective strategies for behavior change that are coupled with the delivery of youth-friendly SRH services.

Project background and rationale

Adolescent and Youth Sexual and Reproductive Health in Niger

With a total population estimated at slightly over 17 million[3] people, one-third of them now live in the capital city of Niamey. Niger's population is predominantly young, with youth aged 10-24 years representing 32 percent of the total population.[4]

AYSRH Context in Niger

Youth Population: 32% of total population

Total Fertility Rate: 7.6

Contraceptive Prevalence Rate: 15-19 yrs: 6%

20-24 yrs: 13%

Child Marriage: 75% before 18 yrs

Niger ranks among the lowest of countries included in the UNDP Human Development Index.[5] In Niger, public health issues, and family planning and reproductive health (FP/RH), in particular, are among key development priorities. Several health indicators call for the urgent attention, especially in the field of adolescent and youth sexual and reproductive health (AYSRH). With an average of 7.6 children per woman, Niger has the highest fertility rate in the world and the highest rate of child marriage worldwide: 76.3 percent of women currently 20-24 years were married before age 18 and 28 percent before age 15.[6] In several communities, young girls are married in their early adolescence due to cultural beliefs or for socio-economic reasons, and subsequently enter into motherhood while they are still children. As a result, maternal mortality rates are alarming; 52% of young mothers, that is, more than half of adolescent mothers, die as a consequence of early pregnancy while giving birth or in the aftermath of delivery.[7]

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[3] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[4] Population Reference Bureau, The World's Youth 2015 Data Sheet and 2015 World Population Data Sheet.
[5] http://hdr.undp.org/en/countries/profiles/NER
[6] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[7] Institut National de la Statistique (INS) et ICF International, 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012*. Calverton, Maryland, USA : INS et ICF International.

Only 13 percent of married women aged 20-24 and 6 percent of married girls 15-19 years use a modern contraceptive method,[8] and very few (less than 20 percent) know about a woman's period of fertility,[9] which results in 40 percent of adolescents (15-19 years) having already started their reproductive lives.[10] In 35% of cases, birth spacing intervals are less than two years among 15-19 year old adolescent girls,[11] which affects their health and limits their potential to provide adequate care to their families, or to further their education and participate in the economy. This situation has serious consequences on communities' livelihoods and well-being and presents formidable challenges for the government and other actors to reduce poverty.

Niger's 2012 Demographic Health Survey (DHS) statistics on HIV and AIDS show low national prevalence (0.4 percent). Yet, this national estimate hides disparities between specific groups, including sex workers, prisoners, and migrants. Knowledge on HIV and AIDS among young people in Niger is low; only 14 percent of young girls and 25 percent of young men aged 15-24 have a good knowledge[12] of HIV and AIDS. According to the 2012 DHS on Niger, although a high proportion of young people know where to take HIV tests, only 1.5 percent of boys and 4.1 percent of girls aged 15-19 have taken HIV test within the last 12 months and know their HIV status. Condom use is still very low whereas multi-partnership is a current practice among men as they grow older, due to the high prevalence of polygamy. According to Niger's 2012 DHS, less than half of 18-49 year olds in Niger are supportive of education on how to use condoms for 12-14 year old adolescents.[13]

These health and demographic statistics are exacerbated by an under-resourced health system, a conservative cultural context underpinned by gender inequality, and major barriers to access SRH information and services in particular.

The ULC project was designed within a favorable political environment guided by national FP/RH policies that guarantee access to information and services for young people. In addition, the MPH)had recently set an ambitious FP/RH objective at the 2012 London Summit on Family Planning to increase contraceptive prevalence rates from 12 percent in 2011 to 25 percent in 2015 and 50 percent in 2020. Niger's Family Planning 2020 commitments also include a focus on youth and male engagement.

Rationale for working with university students in Niger

Within this context, the ULC project was designed as an innovative response to young people's SRH needs. From its design phase, the ULC project made a deliberate choice to work with and through young people as leaders and vectors of change. University students were not only viewed as beneficiaries of SRH information and services, but they are also involved as decision-makers and frontline implementers in the process. This approach was essential for ensuring adherence by target communities. Youth

[8] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[9] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[10] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[11] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[12] Include men and women who know that regular use of condoms and limiting sexual partners to one non-infected partner help reduce the risks of HIV transmission ; people who know that a healthy person may however have the virus and those who reject the two myths and most widely spread ideas concerning HIV transmission or prevention. Institut National de la Statistique (INS) et ICF International, 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012*. Calverton, Maryland, USA : INS et ICF International.
[13] Institut National de la Statistique (INS) et ICF International, 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012*. Calverton, Maryland, USA : INS et ICF International.

participation in BEHAVIOR CHANGE programs has the potential to increase young people's openness and ownership, especially when addressing sensitive issues such as sexuality.

The 2012 DHS for Niger shows a clear association between levels of education and people's understanding, attitudes, and behavior related to SRH/FP. Because of their high educational attainment and their mobility, university students in Niger are well-positioned to not only improve their own SRH, but also to increase peers' (both inside and outside of university) demand and access to youth-friendly SRH services in Niger. As young people, they know their needs best and can easily identify with other students. Moreover, they are perceived both on campuses and in communities as knowledgeable peers and leaders, and therefore are best placed to engage fellow students and community youth on SRH topics. With this in mind, E2A decided to work with university students in Niger, building on their unique position to advance SRH as current-day leaders amongst their peers and high-level leaders of tomorrow. The ULC project was the first initiative of its kind to be implemented at a University in Niger.

Abdou Moumouni University context

The pilot phase of the ULC project was implemented at AMU in Niamey. This university has been a public institution for higher education since 1971. In 2014, the student population was 19,000, including 14,500 males and 4,500 females.

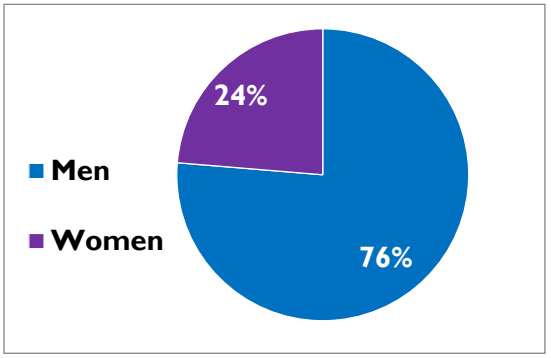


Figure 1. AMU Student Population breakdown by sex (2014)

AMU facilities are managed by the *Centre National des Oeuvres Universitaires* (CNOU), a university structure that reports to the contact. There is one main residence with 12 buildings for students' accommodation. Some buildings offer separate accommodation for males and females. The campus was initially planned for 2,000 students (2 per room), but the student population has continuously increased each year, leading to overcrowding. In 2015, the population living in the residence was estimated to be 6,000-8,000 students. In addition to the main residence, there are three other residences in different parts of Niamey. Also, some students are housed in what are called "embassies," residences for students from each region of Niger available at a subsidized cost.

The AMU health center offers curative consultations, primary care, hospitalization for some conditions, and referral services to Lamordé district hospital. The health center is staffed by 11 personnel, including: a doctor, six nurses (including one volunteer), a laboratory officer, a custodian, and two paramedics. Since its creation, the AMU health center operated in parallel to the national public health system, greatly limiting relations with local public health structures. This situation has largely been due to the fact that the university, as well as its health center, is under the supervision of the MHE/RI and some health providers are hired directly by the central level of the MHE/RI, while the others are contracted by the CNOU.

ULC PROJECT OVERVIEW

Project goal and objectives

The ULC Project's goal was to reduce unmet need for FP and unintended pregnancies and to prepare young women—with the support of young men and their communities—to make and act on informed decisions about delaying sexual debut, delaying the first pregnancy and spacing and limiting their pregnancies to ensure the healthiest outcomes. The project primarily aimed to reach the student population of AMU Niamey and community youth (10–24 years) in regions across Niger.

To achieve this goal, the project focused on the following five objectives:

1) Increase awareness and knowledge of AYSRH and SBC among university peer leaders, through building capacity of peer leaders and increasing awareness of AYSRH issues among university students;
2) Increase utilization of SRH services among university students;
3) Strengthen service delivery through capacity building of service providers and improving linkages to other health centers and MPH programs;
4) Generate, share, and apply information and evidence regarding access to SRH services in university settings (among AMU, MPH, and implementing partners); and
5) Raise awareness about AYSRH at the community level.

The original project duration was from March 2014-December 2015. The USAID West Africa Mission then awarded a costed extension of the project for the period of January to June 2016. This extension period was dedicated to consolidating and expanding project achievements, laying the foundation for potential scale-up of the intervention to other university campuses in Niger, and producing documentation that can be used for technical and advocacy purposes.

ULC intervention approach

The project was driven by an approach grounded in the following principles:

Youth Leadership

The ULC project promoted youth leadership as a strategy for driving social change and delivering positive SRH outcomes among young people. As stated above, the ULC approach to working with university students as leaders was based on the fact that, like other young people, they have unmet SRH/FP needs and thus constitute a target group by themselves. Moreover, they form the vanguard of the country's future leadership. Their high mobility (coming from all over the country) and educational level are of strategic importance for reaching out to their peers and creating demand for SHR/FP services throughout Niger. Thus, the ULC project made deliberate efforts to involve and support students as leaders for advancing SRH, rather than working with them solely as beneficiaries.

A comprehensive approach to behavior change

At the heart of ULC was a comprehensive approach to behavior change. Given the low level of demand for SRH and FP services in Niger, especially among adolescents and youth, E2A made a strategic decision to anchor the ULC project in a comprehensive approach to behavior change, rather than simple Information Education and Communication (IEC) approaches. Experiences in other countries have shown that while traditional approaches to IEC may increase young people's knowledge about AYSRH, they are

insufficient on their own to engender behavior change.[14] This is why E2A chose to use more in-depth, reflexive methods, which facilitate the transition from reflection to action. These kinds of approaches are more effective when working with small groups of participants. To this end, the ULC project did not aim to reach the entire university student population, but rather to reach a select group of students (as peer leaders) with in-depth approaches to behavior change.

Multi-component approach to address supply and demand

Integrated, multi-component approaches that address all levels of the ecological model (individual, relationships, community, and society) are recognized as a good practice for AYSRH.[15] This is why the ULC approach included interventions to strengthen supply and demand for SRH information and services on all levels of the ecological model (see the technical strategy section for more details). Coordination of the supply and demand sides of the SRH equation was also prioritized to ensure sustainability and scalability.

Systematic planning for future scale-up

An important aspect of the ULC project was an emphasis on systematic planning for potential scale-up, using ExpandNet's approach, *Beginning with the end in mind*.[16] This approach is based on the premise that if future scale-up is a possibility, interventions should "begin with the end in mind" and a pilot projects should be designed in ways that enhance potential for future large-scale impact. The ULC pilot project was implemented at AMU in Niamey, and the approach was also tested in three other university campuses in Niger, in Tahoua, Maradi, and Zinder, to determine feasibility for future scale-up.

ULC technical strategy

The ULC project's technical strategy was based on a change model with three key pillars (Figure 2):

Figure 2. ULC Technical Strategy Components

(1) Youth leadership and demand generation: This component included two parts:

a. *Demand creation among students:* The project trained student leaders on SRH and comprehensive behavior-change methodologies, providing supportive supervision to the student leaders to run peer-based behavior-change activities on campus.

b. *Demand creation in communities:* The trained student leaders facilitated community-based activities with adolescents and young people in communities across Niger which addressed social norms and positively influenced SRH outcomes.

(2) Expanded access to quality SRH services: This pillar focused on working with the AMU health center to make contraceptives accessible to students. In partnership with AgirPF, the ULC project trained university health center providers on behavior change, contraceptive service delivery, and youth-friendly approaches; provided supportive supervision with the MPH; and facilitated linkages between the university

[14] Chandra-Mouli, Venkatraman, Catherine Lane, and Sylvia Wong. "What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices." *Global Health: Science and Practice* 3.3 (2015): 333-340.
[15] Svanemyr et al. 2015. "Creating an enabling environment for ASRH: a framework for promising approaches". Denno et al. 2015. "Effective strategies to provide ASRH services and to increase demand and community support".
[16] WHO/ExpandNet. 2013. *Beginning with the End in Mind: Planning pilot projects and other programmatic research for successful scaling up*". *Geneva :WHO*

and district health centers, which enabled the university to procure contraceptive commodities through the public health system.

(3) Participatory stakeholder engagement for sustainability: An important component of the ULC was the establishment of a "co-management committee" that routinely brought together students, university health providers, MPH and MHE/RI representatives to work together and ensure that the project evolved in the right direction, adjusting to context as necessary.

These three pillars worked simultaneously in the ULC's technical strategy (Figure 3). The technical strategy was also designed to align with the priorities set out in Niger's National 2012-2020 Family Planning Action Plan[17] (Figure 4).

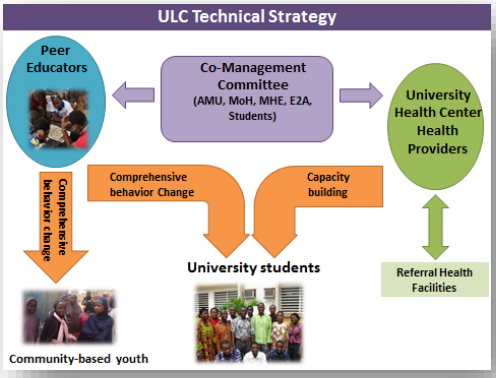


Figure 3. ULC Technical Strategy and Change Model

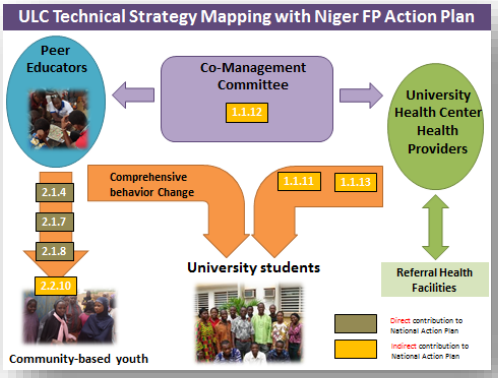


Figure 4. ULC Technical Strategy Mapping against Niger National FP Action Plan (See footnote for corresponding actions from the National Action Plan)[18]

Summary of main activities implemented to achieve the project objectives

The ULC project defined a series of activities under each of the five objectives, as described below:

Objective 1: Increase knowledge of AYSRH and behavior change among university peer leaders and increase awareness of AYSRH issues among university students

a) Capacity building of AMU youth leaders for SRH behavior change and demand generation

The ULC peer education approach consisted of training and supporting students as change agents. It was therefore crucial to first strengthen their knowledge and skills related to AYSRH/FP.

[17] Ministry of Public Health, Directorate of Reproductive Health and Directorate of Maternal and Child Health. 2012. "Planification Familiale au Niger : Plan d'Action 2012- 2020".

[18] 1.1.11 Make available FP-IEC materials in all public and private health facilities
1.1.12 Make available FP educational materials in all training centers including the FP Division
1.1.13 Make available data collection tools in all public and private health facilities
2.1.4 Conduct awareness sessions about the benefits of FP at health areas
2.1.7 Using modern means of communication to educate young people about FP (toll-free line; Quiz)
2.1.8 Promote annually the education of adolescents and youth by peer educators on SRH/FP in schools
2.2.10 Conduct awareness sessions on FP for men in public places (markets, mosques, public places, etc.)

A first pool of leaders was selected from the Students' Union and trained by the MPH's Adolescent and Youth Health Division and implementing partners[19] as student supervisors in the first quarter of 2014. Subsequently and based on clearly defined criteria including gender, the student supervisors helped to identify and train peer leaders who were in charge of planning and leading comprehensive behavior change activities with other students.

Training sessions were held over a six-day period. The first phase was based on the MPH's AYSRH training curricula and covered topics related to HIV and AIDS, Sexually Transmitted Infections (STIs), youth-friendly services, and substance use/abuse. The second phase of the training focused on behavior change methodologies, notably Pathfinder International's *Pathways to Change* (PtC) game and *REACH* (Reflection and Action for Change) methodology, which help young people reflect on personal, social, and environmental variables that influence SRH behaviors. This phase included skills-building for peer education (e.g., small group facilitation, interpersonal communication skills, monitoring and supervision, etc.).

After the first year of implementation, a number of peer leaders and student supervisors had graduated. Building on lessons learned from the first training phase of peer leaders and student supervisors, a new cadre of "peer leaders" were trained by E2A, "senior" peer trainers and student supervisors, MPH, and University health center staff in February 2016. This second recruitment and training allowed the project to fill gaps and take into account possible drop offs. A coaching system was established between existing peer leaders and new peer leaders. Refresher training for existing PLs and student supervisors was provided, while exploring options for improving the structure of PEs and students supervisors based on feedback received from the initial implementation phase. This eventually led the project team to create a single cadre of "peer leaders" rather than having distinct responsibility for student supervisors and peer leaders.

The two main behavior change methodologies used by the ULC project were designed by Pathfinder International to stimulate reflection and to develop realistic action plans to contribute to behavior change. It is worth mentioning that these methodologies are complementary to the IEC approach in the sense that beyond improving knowledge, they allow for deeper engagement with AYSRH/FP issues and lead to actions for change. With PtC and REACH, the emphasis is on quality more than quantity; they are not intended to reach masses, but rather focus on a reflexive process, leading to lasting changes.

Figure 5. Pathways to Change Board Game

PtC is a simple board game with two objectives: 1) to introduce small groups of community members and target populations to simple ideas about behavior change that can help them discuss change among themselves and with family and friends, and 2) as a means of helping projects learn what communities and target populations associate with specific kinds of behavior change—what they think can be a barrier to change and what they think might facilitate change.

During the ULC project, the PtC participatory methodology helped students elicit perceptions of barriers and facilitators of change (see text box on following page for examples) in their own SRH-related behavior. This serves the purpose of both sensitizing student participants in basic concepts of behavior change as they relate to young people as well as helping peer leaders understand the perceptions of their peers and thus improving their ability to

[19] Pathfinder International's Technical Advisors for the E2A project, LAFIA MATASSA and AGIR/PF.

address their psycho-social needs. Outputs from the PtC methodology are also used to move students from reflection to action using the REACH methodology.

Barriers and facilitators to change in behaviors related to SRH during *Pathways to Change* games included:

Barriers:

- Lack of access to transport
- Lack of Education
- Lack of trained youth-friendly health providers
- Fear of parents' judgmental attitudes
- Underestimation of risk of pregnancy/STIs
- Disagreements with partner/husband
- Moral/religious beliefs
- Traditions and social norms
- Opposition from friends
- Lack of self-confidence

Facilitators:

- Supportive peers
- Youth-friendly and well-trained health providers
- Quality of services
- Confidence in partners/parents
- Access to services
- Availability of food
- Knowledge of services available
- Favorable Islamic beliefs

REACH is a group exercise which takes the PtC reflection process a step further through action. Working with the REACH tool, a small group is guided in prioritizing behavioral issues found in trigger videos that are relevant to their situation, at individual or at community level. Subsequently, the small group members select one of the high priority issues identified and transform it into a concrete action and a work plan that they can undertake as a group.

b) Development of three behavior change video tools

The ULC project produced three behavior change films as part of the REACH methodology. The scenarios and scripts of the films were based on the data collected through PtC games with students, and health providers and young people in communities across Niger. The data from PtC provides insights about the barriers and facilitators that affect young people's access and utilization of SRH services. E2A worked with two local film production companies, Maggia and B@K Techno, in collaboration with the MPH and the MHE/RI, to produce the three films.

The first film, "**Binta's Dilemma**," was released in February 2015. The video addresses the facilitators and barriers faced by Nigerien university students when accessing FP/SRH services. Issues raised in the video include contraception, unwanted pregnancy, and peer pressure on young girls to bear children soon after marriage. This film was well-received by national and international stakeholders.

The second film, "**Whose Norms?**," released in December 2015, examines facilitators and barriers that affect service providers' ability to deliver youth-friendly FP/SRH services. It examines personal, social, and structural challenges that service providers face when offering young people contraceptive services. This tool sought to help improve the quality of youth-friendly services.

During the extension period, a third REACH film, "**Hadjo's Dreams**," was released. This film highlights the issue of child marriage and examines the facilitators and barriers that members of rural communities face to prevent child marriage and improve SRH outcomes for adolescent girls. This film helped the project extend its reach beyond the university campus.

All three films are short videos designed to trigger reflection and dialogue; they do not show ideal situations, but rather present the dilemmas with which young people, health providers, and communities at large, are confronted, in relation to decision-making about AYSRH. The films were used as part the ULC's REACH activities on campus and in community settings. Students' reactions to the films varied; for example, after a screening of *Binta's Dilemma*, some students expressed aversion to the idea of a young married woman delaying childbearing to continue her studies while others expressed support for joint decision-making about family planning between a couple and with mothers-in-law, who often have a great influence on young wives' decisions about childbearing.

c) University-based behavior change and demand creation activities at AMU led by student peer leaders

Once trained, peer leaders conducted on-campus behavior change activities, particularly *Pathways to Change* and *REACH* sessions. Peer leaders conducted PtC and REACH sessions with students in different locations within the university. Many sessions were held in the youth space renovated by the ULC project (next to university health center). Other sessions took place in the university residence buildings or at the regional student "embassies." The peer leaders chose the venue based on participants' availability. PtC and REACH sessions were led by pairs of peer leaders. One peer leader facilitated, while the other took notes as rapporteur. For the PtC sessions, groups consisted of three to eight participants. For REACH sessions, groups were generally between eight and ten participants. In total, 425 PtC sessions and 83 REACH sessions were held.

The peer leaders encountered some difficulties conducting REACH sessions, mainly due to the time it takes to complete the full methodology. Students found it difficult to find time to lead sessions lasting several hours. As a result, the ULC project simplified the methodology to reduce the duration of the sessions while still allowing enough time for in-depth reflection.

In order to facilitate the work of the peer leaders, the ULC project renovated and equipped a youth space, adjoined to the AMU health center, which was offered set up by the *Centre National des Oeuvres Universitaires* (CNOU) for students' activities. The space was equipped to enable peer leaders to plan and conduct activities (including tables and chairs for meetings, TV and DVD player for REACH sessions, and an air conditioner).

Objective 2: Increase utilization of SRH services among university students

a) Procurement of SRH/FP commodities for the university health center

Prior to the ULC project, the university health center did not provide contraceptive services and was not looped into the standard procurement system for acquiring contraceptive commodities. The ULC project facilitated the procurement of contraceptive commodities, as a follow-up to the training on contraceptive technologies for university health center providers, led by AgirPF and the MPH (see Objective 3). The ULC project held several meetings with the local health district and the regional health directorate to integrate the AMU health center into the SRH/FP supplies procurement system. As a result, the university health center was able to procure a full range of modern contraceptive methods (male condoms, oral contraceptive pills, injectables, and IUDs) in order to provide contraceptive services to students.

b) Dialogue session between students and health providers

The PtC sessions with students highlighted that one of the main barriers that prevent students from accessing SRH/FP services at university health center was fear of judgmental treatment by health providers, as well as fear of lack of privacy and confidentiality. To address this barrier, dialogue sessions were organized to bring providers and students together to discuss issues related to SRH/FP service quality. These dialogue sessions were the first time since the creation of university health center that students and providers met to discuss such issues. Following these discussions, providers and students agreed on a set of actions to help address the barriers, including posting the schedule for the different service providers, including availability of the midwife, in a visible location and taking measures to ensure privacy and confidentiality.

c) The organization of an HIV counseling and testing (HCT) event

A three-day HCT event was held at university health center in April 2016. HCT services were offered by the university health center nurses with technical supervision from the MPH's Division of Adolescent and Youth Health, the MHE/RI's School Health Bureau, and Health District of Gawèye. All university health center providers were trained in HIV counseling techniques and acquired practical experience offering HCT services. As a result, HCT services were integrated into the university health center package of

services (see Table 2 on page 24 for number of students who accessed HCT services during intervention period). In addition, 20 ULC peer leaders/student supervisors distributed leaflets with information about services offered at the university health center.

Objective 3: Strengthen service delivery

a) Youth friendly services study visit

At the beginning of the project, E2A organized a study visit for representatives from the MPH's Division of Adolescent and Youth Health to a more mature university-based AYSRH program in Ethiopia, led by Pathfinder International. This study tour helped to inform program planning in Niger.

b) Secondment of a part-time midwife to the AMU health venter

Prior to the ULC project, the AMU health center had no previous experience offering contraceptive services. The initial planning discussions with the MPH led to an agreement for the ULC project to support the part-time secondment of an MPH midwife to the health center. The midwife worked two days per week at the university health center, offering FP/SRH services to young clients, as well as providing coaching for the other university health center providers who were trained by E2A and AgirPF to ensure sustainability. In addition, E2A ensured that all university health center providers completed their annual US Government FP compliance training.

c) Training AMU health providers on FP and youth-friendly services

To increase utilization of SRH services by young people (Objective 2), biases and other barriers that prevent health providers from offering quality youth-friendly SRH services must be reduced. E2A collaborated with the MPH and AgirPF to ensure that 10 AMU health providers were trained on contraceptive technology (including counseling techniques and how to deliver the full range of modern contraceptive methods), youth-friendly services, and behavior change techniques. Since the project was funded by USAID, the AMU health providers also completed training on the US government's legislative and policy requirements for family planning.[20]

d) Supervision and monitoring of university health center

SRH/FP service delivery at the university health center was supervised through joint supervision visits by the MPH's Division of Adolescent and Youth Health, the Gaweye Health District, AgirPF, and E2A. In addition, the ULC project facilitated the integration of university health center into the health district's standard supervision system. The peer leaders also used PtC and REACH to create a database for learning purposes and in view of scale-up. Peer leaders recorded the barriers and facilitators identified by the small groups while playing the game, student Supervisors collected this information, and through the use of a coding system, synthesized and submitted the data to the Project Manager. This data were used to create the "Pathways to Change Dashboard" (see Objective 4).

Objective 4: Generate, share and apply information and evidence regarding university access to SRH services in university settings

a) Pathways to Change Dashboard

Framing behavior change in ways that target populations can easily assimilate is central to E2A's approach. Reviewing commonly cited barriers and facilitators of change as they relate to specific behavioral

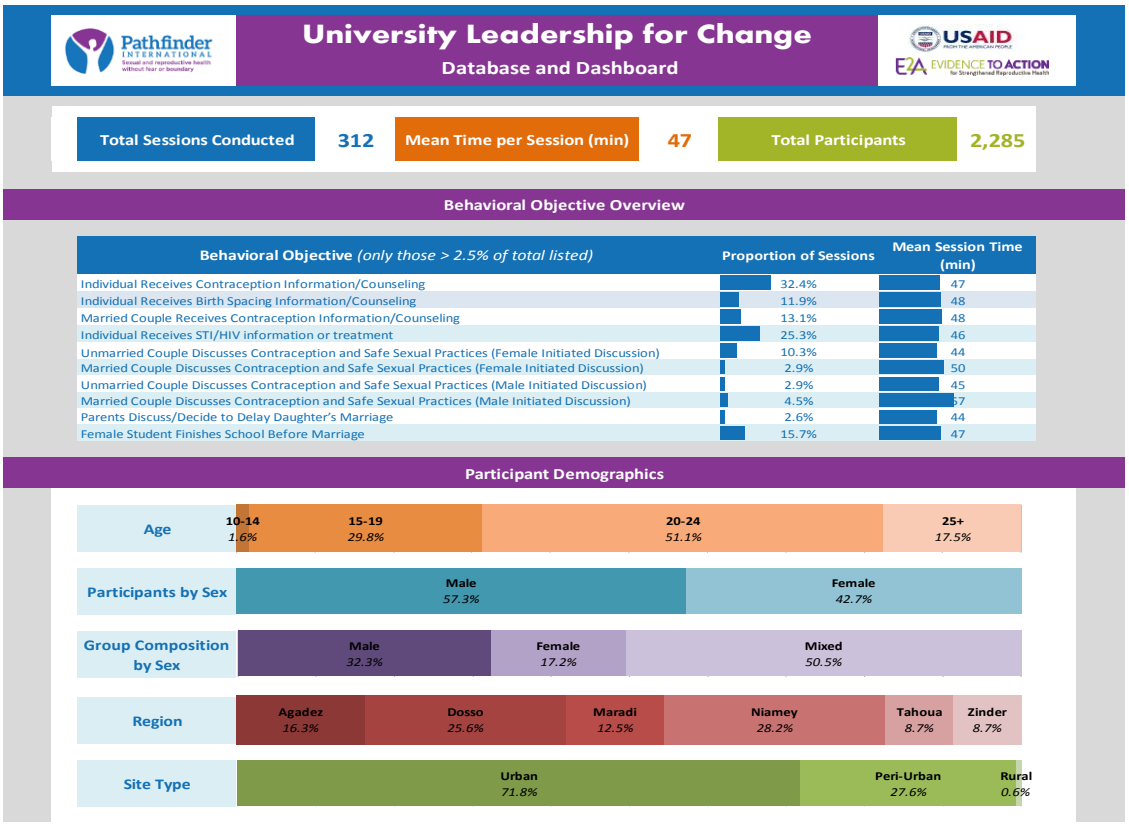
[20] This training is mandatory as part of compliance procedures for USAID awards. The training covers relevant US policy documents that relate to voluntarism and informed choice for FP clients, method mix, voluntary sterilization and abortion.

objectives allows programming to build on current understanding, redress gaps in understanding, and promote ownership and sustainability of activities.

PtC and REACH are not only important programmatic activities in their own right, but they also produce information on barriers and facilitators to accessing SRH previously unavailable in the AMU context. The routine collection of PtC and REACH outputs provided an ample corpus of data to create a database with information about the challenges faced by AMU students, university health center staff, and community members in relation to youth-friendly SRH/FP services.

This database was used to produce the "Pathways to Change Dashboard" (Figure 6), which was designed to support AYSRH programming in Niger by providing an easily searchable means of differentiating key barriers and facilitators (coded according to their basis in personal, social, or structural levels of the behavioral ecology) most frequently associated with specific AYSRH behavioral objectives along a number of independent variables. The dashboard allows users to review commonly cited barriers and facilitators of change as they relate to specific behavioral objectives and specific sub-groups of project beneficiaries. This, in turn, allows users to build on current understanding, redress gaps in understanding and promote ownership and sustainability of activities.

Figure 6. PtC Dashboard



It is worth noting that the PtC game was not designed as a formal research tool; however, in the absence of such research, the PtC Dashboard provides an evidence base on which to ground and guide AYSRH activities in Niger. A partial list of the ways in which information contained in the PtC Dashboard can be used include:

- Development of scripts and other narratives that can be broadcast over radio or using videos;
- Identification of areas of IEC materials that need to be developed to fill gaps;
- Assessment of the behavioral "climate" that will be encountered when doing AYSRH work in different parts of Niger in anticipation of intervention adaptations.
- Use, alongside segmentation of the target population and surveillance research, to develop better targeted activities.

b) Sharing and disseminating lessons learned

Learnings from the ULC project were shared at both national and international fora. At the national level, the ULC Project Manager was invited to present the project and its results to the Technical Committee responsible for overseeing and revising Niger's National Family Planning Action Plan. In addition, results and learnings from ULC were shared at a mid-term reflection meeting in December 2015 and a final dissemination meeting in October 2016.

At the international level, E2A was invited to present the ULC project at several international conferences, including:

- The first and second WAHO Good Practices Fora
  - July 2015 in Ouagadougou, Burkina Faso
  - October 2016 in Grand Bassam, Côte d'Ivoire
- The International Conference on Family Planning, January 2016 in Nusa Dua, Indonesia
- The International SBCC Summit, February 2016 in Addis Ababa, Ethiopia

Objective 5: Raise awareness about AYSRH at the community level

a) Community Health Caravans

Peer leaders/student supervisors conducted several activities, including information caravans on university campuses located in other regions of Niger. In collaboration with the other co-management committee members, they organized two community-based health caravans that sought to increase young people's knowledge and understanding of SRH/FP issues. This was made possible thanks to close collaboration with the MPH, the West Africa Network of Medical Students (WAMS WEB) and the MHE/RI, and CNOU. In March 2015, communities of Birnin Gaoure, Dosso, Madoua, Maradi and Tahoua were visited; Peer leaders facilitated PtC and REACH sessions through showings and discussions of the film *Binta's Dilemma*. The second caravan visited university students at the campuses in Niamey, Maradi, Tahoua and Zinder, to improve students' knowledge of contraceptive methods.

b) Community-based activities led by student peer leaders

AMU has a longstanding history of community engagement, including a committee, as part of the CNOU, which assists students with organizing activities during their vacation time to work with secondary school students and other community groups. The ULC peer leaders used this mechanism to bring their training in AYSRH, provision of AYSRH information techniques, and behavior change to the communities where they spend their holidays, using PtC and REACH methodologies, and trigger videos (REACH films). Such activities were carried out in the regions of Agadez, Dosso, Maradi, Tahoua and Tillabéry while student peer leaders were on Christmas holidays in their respective hometowns.

In addition, peer leaders and student supervisors conducted PtC "Training of Trainers" with community workers from the Nigerien Association for Family Planning (ANBEF)[21] and four integrated health centers, implementing partners located in Pathfinder's area of intervention for a Hewlett Foundation-funded project for young married women. Community trainers started cascading sessions at the grassroots level under the supportive supervision of their trainers and ANBEF, thus increasing the ULC reach at community level.

[21] The IPPF Member Association in Niger (Association Nigérienne pour le Bien Etre Familial)

Quantitative results

The activities described in the previous sections made it possible to achieve the following results:

- 202 students were trained as peer leaders and Student supervisors, acquiring skills and competencies in behavior change techniques (Tale 1). Of the 202 students, 135 were trained at AMU in Niamey and 67 were trained as part of the feasibility testing phase in universities in Maradi (21), Tahoua (26), and Zinder (20).

Table 1. Number of peer leaders and student supervisors trained

Number of students trained on AYSRH and behavior change (Oct. 2013 - June 2016)		
	Student Supervisors	Peer Leaders
Male	10	129
Female	9	73
Total	19	202

- 425 PtC sessions were organized with young people.
- 3 REACH videos for behavior change locally produced — "Binta's Dilemma," "Whose Norms?" and "Hadjo's Dreams."
- 83 REACH sessions held with young people using the three REACH films.
- 45 community workers from ANBEF trained as trainers on behavior change to be able to lead activities with young married women in Niamey.
- 3,899 students and 4,000 community youth reached with information about SRH, including contraception, by trained peer leaders. A higher proportion of young women were reached in community settings (40%) compared to university settings (32%) (Figure 7). Considering that young women only represent 24% of the overall student population in Niamey, the fact that just over one-third of all students reached were women demonstrates that the project's gender-sensitive approaches were successful at engaging young women in the university environment. A higher proportion of adolescents were reached in community settings compared to university settings (Figure 8). This is to be expected given that most university students are young people older than 19 years.

Figure 7. Number of young people reached by peer leaders, by sex

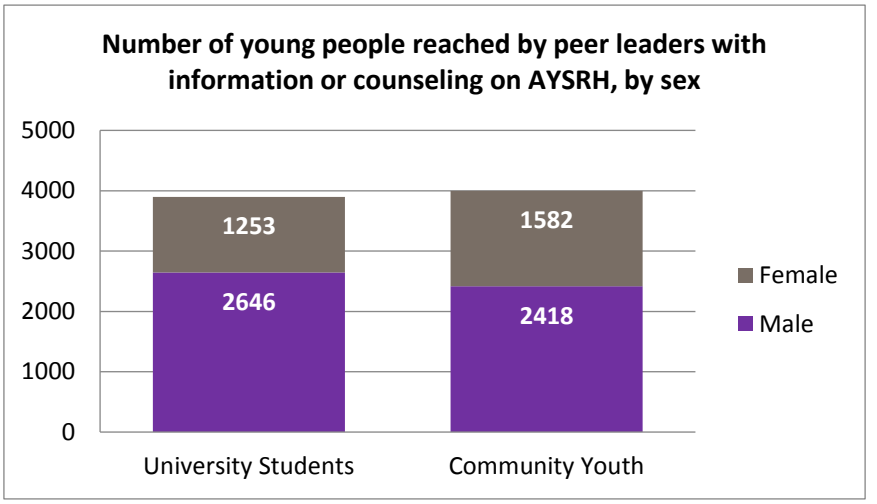
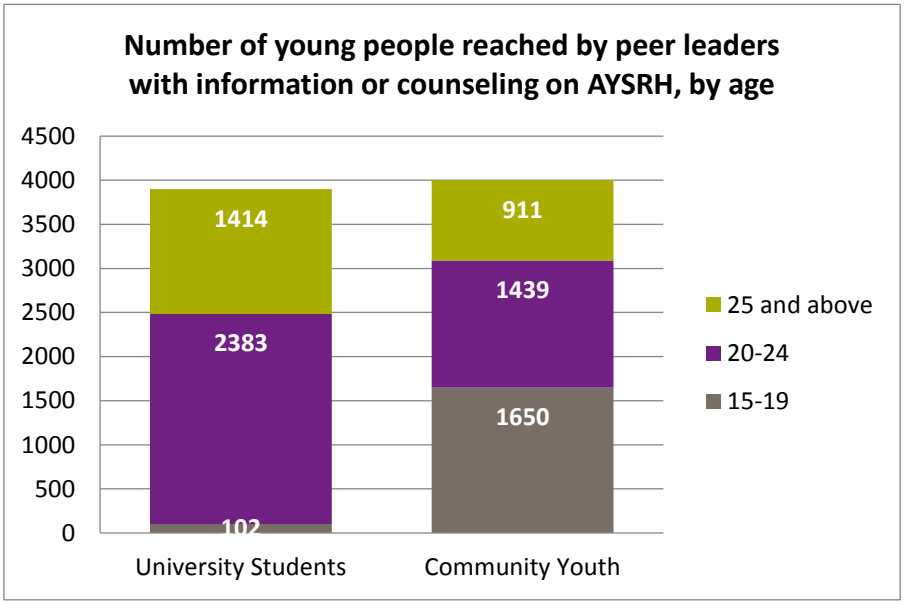


Figure 8. Number of young people reached by peer leaders, by age



- 407 university students referred by peer leaders to the university health center for contraceptive services or HCT (Table 2).
- 754 university students received SRH/FP counseling services at the university health center (Table 2). Just over half, 56%, were young women.

Table 2. Number of students who accessed SRH/FP counseling and HCT services

Total number of students who accessed SRH counseling and HIV services		
	SRH/FP counseling	HCT Services
Male	334	160
Female	420	86
Total	754	246*
15-19	5	16
20-24	379	131
25 and above	370	99
Sub-total: 15 -24	384	147
Total	754	246*

** Total HCT services for Oct 2014- June 2015 are 407. Results above represent data available disaggregated by age and sex. Disaggregates were not available for all HCT services.*

- 79,976 condoms were distributed on campus.
- 61 female students accessed modern contraceptive methods (other than condoms) at the university health center (Table 3).[22] It is important to analyze the contraceptive service uptake data in light of the AYSRH context in Niger. Demand for modern contraception among young women is very low. Only 12% of all sexually active women aged 20-24 years use a modern method of contraception and among them, 4% use the lactational amenorrhea method in the postpartum period.[23] Furthermore, most young women students are unmarried and the general contraceptive preference among unmarried sexually active young people in Niger is to use condoms. [24]

[22] The national HMIS in Niger does not disaggregate data by marital status or parity.

[23] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.

[24] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.

Table 3. Uptake of contraceptive services by students at the university health center

Number of students who obtained FP methods	
By Age	
20-24	46
25 and above	15
Total	61
By Method	
Female Condoms	0
Oral Pills	51
Injectables	7
Implants	3
IUD	0
Total	61
Number of male condoms distributed	79,976

These quantitative results enabled the ULC project to achieve or surpass most of the targets set in the project's Performance Management Plan (see Annex 1). Some targets were not achieved for the following reasons:

- The number of student supervisors (indicators 1 and 5) was not fully achieved, because of the decision to revise the peer leader/supervisor structure during the project's second year. Rather than having student supervisors as a separate cadre from peer leaders, the project team agreed to have a single cadre of peer leaders. This decision was based on the fact that the peer leaders and student supervisors ended up playing virtually similar roles, so it was not necessary to have two different groups. This decision also partly explains why the number of peer leaders (indicator 3) surpassed the project targets.
- The target for the number of students referred by peer leaders for FP and HCT services was not fully achieved (indicator 12). This is partly because the project encountered difficulties with the documentation system for referrals during the first year of implementation.
- The target for the number of university students who obtained FP methods (other than condoms) was not fully achieved (indicator 13a and 13b). This is partly due to the preference among unmarried sexually active young people in Niamey to use condoms rather than other contraceptive methods. In addition, behavior change and demand creation are long-term processes, especially in conservative contexts like Niger. As such, results in terms of uptake of services may not be immediately observable.

The coordination of activities, especially through the inclusive co-management committee, and the data collection and management system were important factors for the project success and visibility.

Qualitative results

In addition to the quantitative results above, several qualitative results were achieved.

Increased openness and dialogue about sexuality and SRH

The ULC project activities were successful in promoting open dialogue about sexuality and SRH issues. The methods and techniques used in the project activities were designed to foster dialogue. For example, PtC sessions created a safe space for discussion and reflection among young people about barriers and facilitators related to SRH. The dialogue sessions between students and service providers also created an opportunity for open dialogue about youth-friendly services. Such activities allowed students and other actors to interact and discuss SRH-related issues, sometimes for the first time.

Peer leaders are now perceived by their fellow students as trusted reference persons for SRH issues. The ULC project not only helped these student leaders to increase their knowledge about SRH/FP, but also facilitated new connections with a broader range of students. Having a cadre of trained peer leaders who are accessible to students and available to orient others contributed to increased dialogue on campus about SRH-related matters.

> *"The project is a great initiative; it has been helpful in meeting a number of challenges in relation to sexuality. Previously, students wouldn't talk about sexuality, but the project activities have facilitated discussions on AYSRH."*
>
> ***Peer leader in Niamey***

Improved quality of sexual and reproductive health services for young women

Based on students' appreciation of the quality of health services, the Student's Union demanded that a gynecologist be recruited and permanently based at the university health center. A part-time midwife was seconded to university health center from MPH to provide youth-friendly SRH services. The university health center staff positively welcomed the addition of a skilled health professional, as it alleviated their workload and strengthened the team. In addition, the fact that she was a female health provider helped to address the reticence that female students had about seeing a male doctor. The midwife was well positioned to offer SRH services to young women who often felt uncomfortable sharing their SRH concerns with male health providers.

> *"We have learned a lot with the project and we have changed our attitudes towards our service users, i.e. students. The training sessions made it possible to break the barriers between students and ourselves. In the past, I used to consider girls who came to ask for condoms as insolent and spoilt. But with the trainings and awareness sessions, we have learnt to accept such situations; moreover, we have added counseling and awareness sessions in our activities."*
>
> ***University Health Center, Provider***

Improved relationships between students and university health center staff

The introduction of youth-friendly SRH/FP services and capacity building for university health center providers contributed to improved relationships between health providers and students. The opportunities for collaboration, including joint supervisions and participation in the Co-Management Committee, also strengthened relationships between students and health providers. Furthermore, the dialogue sessions between health providers and students on the quality of services offered an opportunity for both groups to share and exchange their perceptions about the major difficulties related to seeking and offering YFS. Prior to the ULC project, these types of discussions had not taken place. Health providers who had previously held negative opinions of young girls using SRH services became more open-minded.

Improved coordination between the university health center and the public health system

The ULC project played a pivotal role in reviving and strengthening linkages between university health center and the public health system at national and local levels. As mentioned earlier, prior to the ULC project, the university health center was fairly detached from the public health system. The project helped to strengthen the relationship by formalizing the procurement process for contraceptive supplies, involving the district and regional health authorities in supervision visits to the university health center, and inviting the local health authorities to join the Co-Management Committee.

Since the introduction of the ULC project, university health center staff members are more involved in activities and trainings organized by the MPH. As a result, they have increased access to continuous capacity-building opportunities.

> *"From last year on, things have improved a lot. This is the result of new policy changes put in place with partners' support. We felt the need to go to them [the Health District] and build new working relations; our data are now integrated in the Lamordé health information system." (University Health Center, Provider).*
>
> *"The UHS (university health center) was a quasi-private unit under the Ministry of Higher Education. But with the integration of FP, we strengthened relations with the Ministry of Public Health. Previously, the only relations we had with them concerned immunization programs."*
>
> ***University Health Center, Provider***

Increased knowledge and awareness of SRH among students

Knowledge and awareness about SRH increased among peer leaders as well as other students. Peer leaders noted that the trainings and tools offered by the ULC project not only improved their understanding of SRH issues, but also equipped them with skills to help share this knowledge and understanding with other students and young people in community settings. Many peer leaders acknowledged that their previous exposure to SRH was limited to the very basic exchanges with parents, health professionals, teachers, and in IEC sessions. One of the most important factors that motivated peer leaders to be part of the project was the strong desire to learn new knowledge about SRH, in order to help fellow students and young people in communities to lead health and fulfilling lives.

Participating in the project intervention helped peer leaders to develop a new and more positive understanding of sexuality. They were able to reduce shame surrounding discussions about SRH.

"Before the intervention, many students were not informed or ill- informed about SRH. PEs sensitized a large number of fellow students. For example, many girls shared that our activities have helped them understand what the emergency pill is all about." (Peer Leader, Niamey)

"What motivated me to become a PE was learning that HIV prevalence is higher among young people than the general population in Niger. Knowing that other young people are at risk and I have information that can help them protect themselves – this is what motivates me. It's a fight for social justice and for public health." (Peer Leader, Niamey)

"Before the ULC project, I thought that contraception was not allowed by Islam. But, now I have developed new knowledge and learnt that contraception is permitted by Islam, even in the Qur'an…Honestly, I had a negative view about contraception before, but now I see it as something positive."

Peer Leader, Niamey

Strengthened youth leadership for SRH/FP and the establishment of a youth-led ULC Association to sustain project achievements

Through their participation in the ULC project, peer leaders gained transferable leadership skills that can be applied to broader SRH and development efforts. For example, many of the peer leaders stated that their involvement in the ULC project allowed them to improve their public speaking skills and increased their understanding of how SRH/FP contributes to broader development efforts.

"Now, we can speak in front of large groups without shaking and without taboo. It's not easy to speak in front of a crowd, but because of the project and the activities we led, we can now speak easily in front of a crowd."

Peer Leader, Niamey

ULC peer leaders have been recognized for their strong youth leadership on SRH and FP issues by partners beyond the project. For example, one peer leader was nominated national president of Niger's Young Ambassadors for Family Planning Network, supported by the Ouagadougou Partnership. A peer leader was also selected to as an emerging leader to participate in the OASIS Initiative's Sahel Leadership Program, which aims to prepare emerging leaders to deliver integrated, scalable solutions for the Sahel and catalyze innovative thinking and collaboration across different sectors and disciplines.

Inspired by the ULC intervention, peer leaders took the initiative of setting up an independent student-led association for the sustainability of the ULC approach, entitled *Association LUC*. As they felt empowered, peer leaders agreed to set up a formal structure to continue with SRH behavior change activities and formed a registered NGO with the mandate of running SRH behavior change activities in university and community settings with other young people.

The objectives of Association LUC are to:

- Promote sustainable AYSRH Leadership activities and provide AYSRH trainings to young people in school and in communities;
- Carry out AYSRH awareness activities among young people to run health caravans for communities' education, organize conferences, and PtC and REACH sessions;
- Set up regional branches of the association in additional universities;
- Look for SRH/FP funding opportunities; and
- Reach out to youth in schools and community structures with SRH activities.

The creation of this student-led NGO was an unexpected result. The idea and the initiative came entirely from the students themselves. This is a sign that the ULC approach was aligned with students' needs and interests.

Group of young women playing Pathways to Change Game

SCALE-UP PLANNING

Rationale: Beginning with the end in mind

The ULC project was designed as a model with the potential for scale-up to other universities in Niger, as well as other universities across West Africa. E2A promotes systematic approaches to scale-up with the aim of increasing the scalability of innovations for SRH and FP (Figure 9). Often, pilot projects or health interventions that have been successfully tested on a small scale become less effective when they are scaled up. One of the reasons for these difficulties is requirements for larger scale implementation are not sufficiently taken into consideration during the pilot phase. For the ULC project, E2A made deliberate efforts to plan for scale-up in a systematic way using ExpandNet tools, so as to increase the ULC approach's scalability.

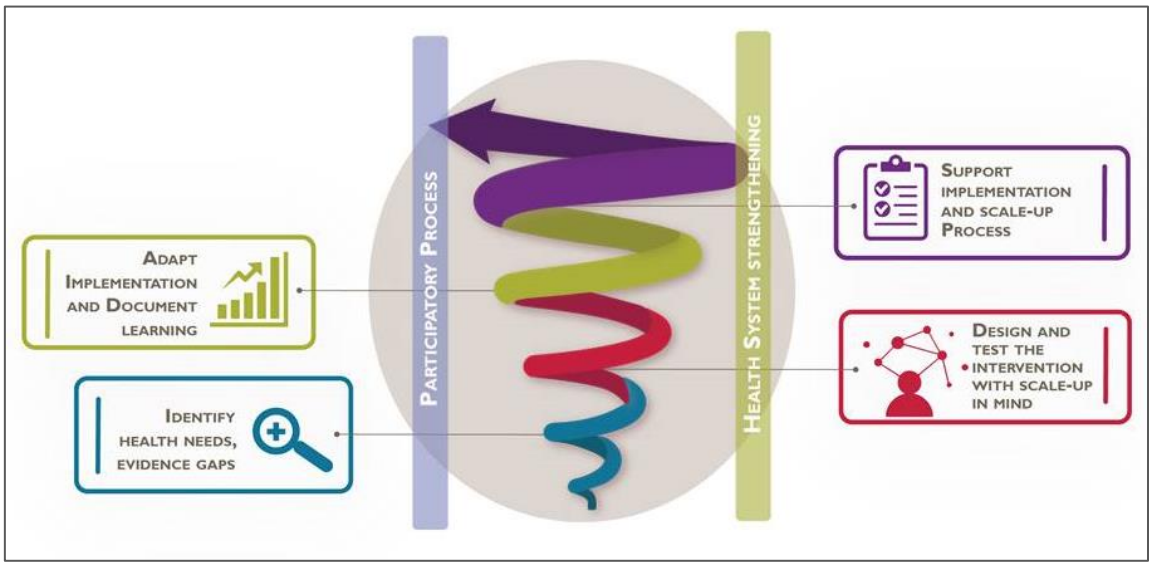


Figure 9. E2A Evidence to Action Cycle

ULC scale-up planning process

Using recommendations from ExpandNet's *Beginning with the end in mind* tool, E2A took steps during the early stages of project design and implementation to plan for potential future scale-up. For example, the establishment of the Co-Management Committee, composed of MPH, MOE/RI, students, and university health providers, was a first step toward planning a participatory process with diverse stakeholders to assess the ULC approach's scalability. The ExpandNet tools were first introduced to stakeholders in Niger in March 2015 and these tools guided the different phases of scalability assessment and scale-up planning (Figure 10).

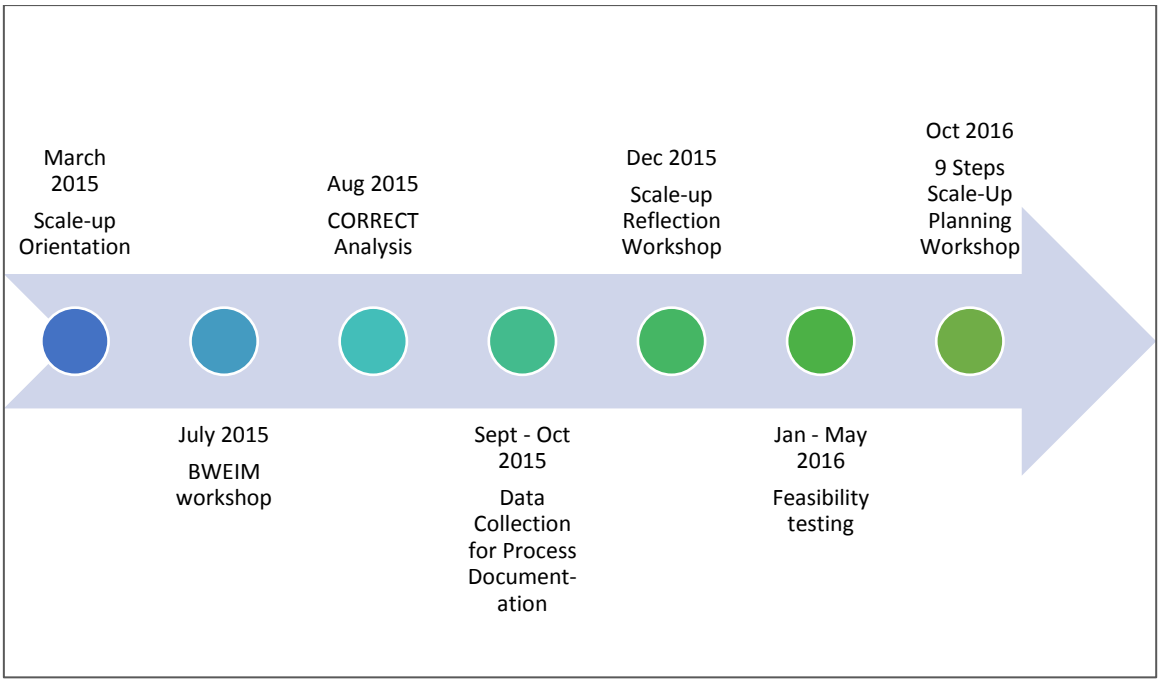


Figure 10. ULC Scale-Up Planning Chronology

Scale-Up Orientation (March 2015)

In March 2015, E2A invited a scale-up expert, Modibo Dicko, to give an orientation on ExpandNet's systematic scale-up approaches to stakeholders, including representatives from the Ministry of Public Health, during a national workshop on AYSRH. Mr. Dicko also led an orientation session on ExpandNet's approaches with the Niamey-based Project Manager.

Beginning with the End in Mind Orientation Workshop (July 2015)

In July 2015, a more in-depth workshop was organized in Niamey on ExpandNet's *Beginning with the end in mind* tool for ULC project staff, the Co-Management Committee members, and peer leaders. The objective of the workshop was to introduce the ExpandNet approach to scale-up and to orient participants on the role of process documentation for scale-up planning. Qualitative data on project implementation is important to assess the scalability of the innovation, as well as identify opportunities to increase the likelihood for success of future scale-up. This qualitative process data is complementary to the routine data collection for project monitoring and allows for a more comprehensive information base from which to plan future scale-up efforts. The workshop also introduced participants to the "CORRECT" framework[25] for assessing scalability (see section below).

CORRECT Analysis (August 2015)

ExpandNet's CORRECT framework articulates seven attributes that help to increase the success of scale-up efforts for health interventions:

- **C**redible in that they are based on sound evidence and/or advocated by respected persons or institutions
- **O**bservable to ensure that potential users can see the results in practice
- **R**elevant for addressing persistent or sharply felt problems

[25] WHO/ExpandNet, 2010. "Nine Steps for Developing a Scaling-up Strategy". Geneva: WHO.

- **R**elative advantage over existing practices so that potential users are convinced the costs of implementation are warranted by the benefits
- **E**asy to install and understand rather than complex and complicated
- **C**ompatible with the potential users' established values, norms and facilities; fit well into the practices of the national program
- **T**estable so that potential users can see the intervention on a small scale prior to large-scale adoption.

Following the Beginning with the end in Mind Orientation Workshop, the ULC Project Management team (in Niger and in Washington, DC) carried out an initial CORRECT analysis. This analysis demonstrated that the ULC project incorporated most of the seven attributes listed above. However, the analysis also highlighted several actions that could improve the ULC's scalability, most notably: the need to test the ULC approach in different contexts, the need to test the approach under routine operating conditions of the health and university system, and the need for continued advocacy to secure resources for implementation at larger scale.

Process Documentation Data Collection (Phase 1 & 2: Sept-Oct 2015, Phase 3: April-May 2016)

E2A hired a consultant to develop and lead a qualitative data collection strategy to produce process documentation for scale-up planning purposes. The data collection strategy sought to analyze how the ULC project had evolved in ways that could either facilitate or inhibit scale-up to other universities in Niger. The data collection instruments were grounded in a socio-anthological approach and also incorporated components of ExpandNet's tools. Focus group discussions and key informant interviews were conducted with students, university authorities, health providers, and representatives from the MPH (at central and local levels) and MHE/RI.[26]

Data were collected in three phases. The first phase (September 2015) involved data collection at the AMU Niamey campus to gather insights from project implementers (students, health providers, Co-Management Committee Members, etc.) about the project's implementation experience. The main findings and recommendations included: the need to strengthen communication and coordination between Co-Management Committee members, the importance of involving all university health center personnel in project activities for greater ownership and buy-in, the proposal to include regional and district health staff in the Co-Management Committee to facilitate supervision of project activities (rather than relying solely on the central level MPH), and the importance of recruiting and training a new cadre of peer leaders to ensure sustainability of activities.

During the second phase (October 2015), the consultant traveled to three university campuses in other regions (Maradi, Tahoua, and Zinder[27]) to collect formative data on the contexts in each university and the implications for potential scale-up. The formative data collection revealed a high need for SRH information and services among students at the three universities. While knowledge about contraceptive methods was high among students, myths and misconceptions about possible side effects were commonplace. Also, few students demonstrated good knowledge about HIV and AIDS and other STIs. The focus groups and interviews also revealed that students' fear judgement from health providers at the university infirmaries; they believe that health providers consider any female student consulting for sexual health matters as someone who has had sex. This, in turn, has a negative effect on the students' reputation, especially for unmarried young women. As a result, they prefer not to consult and avoid mockery. The formative research showed that students in Maradi, Tahoua, and Zinder consider peer-to-peer activities and caravans as useful channels for awareness-raising about health issues.

[26] An in-depth Process Documentation Report is available upon request.
[27] These three campuses were selected by the Co-Management Committee, because the universities have functional health centers and large student populations.

All three universities have infirmaries, but the capacity of each health center varied considerably. The Maradi campus had recently renovated its health facility with five health providers (four nurses and one doctor). In Zinder, the health center was staffed by five personnel (three nurses and two doctors) and offered only basic curative health services. A new health center was built in Tahoua, where the infirmary previous consisted of a single room shared by two nurses and a part-time contracted doctor. In all three infirmaries, the staff had limited competencies in SRH/FP and none offered youth-friendly FP services. The university health centers are autonomous structures funded by the Regional Centers for Universities Social Affairs (CROU), under the institutional leadership of the MHE/RI. There was limited collaboration between the university health centers and the local health districts and regions.

The third phase of data collection was conducted in April-May 2016 in order to collect data on the implementation experience of the feasibility testing phase, during which the approach was introduced in Maradi, Tahoua, and Zinder.

Scale-up Reflection Workshop (December 2015)

In December 2015, E2A organized a scale-up reflection workshop, which gathered 25 participants including: ULC Co-Management Committee, AMU peer leaders, MPH relevant divisions and regional authorities, representatives of regional universities and their respective health services, and project implementing partners and USAID.[28] This workshop's objectives were to:

- Ensure participants have a clear understanding of the systematic scale-up approaches;
- Introduce the E2A and ExpandNet approach to process documentation for a sustainable scale-up of the ULC innovation;
- Present the preliminary results of the ULC project process documentation; and
- Reach a consensus on expectations from the ULC scale up and on the next steps to assess the applicability of the ULC in different contexts.

In five groups, participants conducted a thorough analysis of key elements of the scale-up process, reflecting on the following:

1. The « CORRECT » analysis of the ULC interventions in Niamey to assess relevant attributes for the three other regions.
2. Defining the ULC innovation package and making recommendations to keep the package as simple as possible.
3. Determining the context of the feasibility testing project sites and implications for the introduction of the ULC approach.
4. Defining technical support and supervision needs.
5. Monitoring and evaluation, and process documentation of the ULC feasibility testing phase.

The workshop resulted in recommendations to strengthen implementation of the ULC approach in Niamey and to introduce the approach in Maradi, Tahoua and Zinder for the feasibility testing phase. The main recommendations included:

- Strengthen the peer leadership approach in Niamey.
- Strengthen youth-friendly SRH service delivery at the AMU university health center.
- Revitalize the Co-Management Committee and include district and regional health structures in the committee.
- Simplify the ULC intervention package to facilitate scale-up into new sites.
- Adapt the service delivery strengthening strategies to the contexts in the Maradi, Tahoua, and Zinder universities.

[28] Full workshop report available at:
http://www.e2aproject.org/publications-tools/report-on-reflection-workshop-ulc-niger.html

- Establish regional Co-Management Committees.

Scale-up Feasibility Testing in New Regions (January-May 2016)

According to the *Beginning with the end in mind* framework, testing an intervention in diverse settings and under routine conditions of the health system is important to optimize scalability. Therefore, a five-month feasibility testing phase was carried out at university campuses in Tahoua, Maradi, and Zinder. The regional feasibility testing projects were launched in January 2016 with the aim of testing the ULC approach in different sociocultural contexts, in order to draw lessons for a broader project scale-up.

The regional project plans were designed based on the Niamey pilot model and the recommendations made during the December 2015 scale-up reflection workshop. An initial visit was made by the Niamey project team to meet different stakeholders in the three regions and share information about the ULC approach. University and health authorities in all three regions agreed to test the approach. Regional coordinators were hired to manage the introduction of the ULC approach.

Student leadership for behavior change and demand creation

One of the first steps taken in all three regions was the recruitment and training of students as peer leaders. Based on learnings from Niamey, deliberate efforts were made to recruit young students in earlier years of study, as well as to respect gender parity (Table 4).

Table 4. Number of peer leaders recruited in regional projects

Region	Female	Male	Total
Tahoua	13	13	26
Maradi	9	12	21
Zinder	8	12	20
Total	30	37	67

Peer leaders were trained on AYSRH, peer education techniques, and behavior change methodologies (namely, PtC) by the senior AMU peer leaders and the MPH's Division of Adolescent and Youth Health. Following their training, the peer leaders led regular behavior change and sensitization activities with fellow students, including the use of PtC.

Strengthening SRH/FP service delivery

The ULC feasibility testing phase introduced several initiatives to strengthen SRH/FP service delivery at the three universities.

In **Maradi**, the regional project team, in collaboration with the Regional Health Directorate, initiated a procurement system for SRH/FP commodities (notably condoms and pills) to the university health center. The commodities are sent from the Regional Health Directorate via the health district. A referral system was also set up to link peer leaders with the university infirmary, as well as the infirmary with the health district.

In **Tahoua,** the ULC approach initiated the process to link the university infirmary with the MPH's procurement system for contraceptive supplies, including condoms. The regional ULC Coordinator contacted the Regional Intersectoral Committee against HIV and AIDS to facilitate the procurement of male condoms. A simple procedure following national guidelines was developed for future supply needs.

As for students' supply, peer leaders set up a system by which seven peer leaders collected condoms from the infirmary for distribution to students. The peer leaders used a tracking form to document distribution levels.

In addition, through several meetings with the infirmary and the district health center, a mechanism was established to make it easier for students to seek STI, HIV, and contraceptive services. The university infirmary does not have sufficiently trained personnel or equipment to offer a full range of contraceptive methods. Nurses are only able to provide condoms and pills. Thus, the new system involved coaching the infirmary personnel on contraceptive counseling for all methods (including the use of a demonstration kit of all modern methods) and strengthening the referral system to refer clients to the District Health Center methods other than pills or condoms.

A referral and counter-referral system was established to monitor students who were referred by peer leaders. However, a month into the implementation period, it appeared that students were not obtaining contraceptive services at the university infirmary. The peer leaders spoke with their peers and learned that students did not feel comfortable to seek contraceptive services at the university health center, because there were often several nurses in the consultation room at same time. This environment did not protect clients' privacy and confidentiality. As a result, the Co-Management Committee explored options for improving privacy and confidentiality at the university infirmary.

> *"With this project, all eight contraceptive methods are presented to students during the counseling session, and once they have opted for one method, we refer them to the district, using a HMIS standard form. One month later, we monitor the use of the service."*
>
> ***Tahoua University Health Provider***

In **Zinder**, the project facilitated the procurement of Depo-Provera, and male and female condoms and pills to the university infirmary by the health district. In addition, the health district provided a new algorithm for STI treatment to the university health providers to improve the quality of their STI services. Health providers were also coached on contraceptive counseling by the MPH's Division of Adolescent and Youth Health. Despite these changes, uptake of contraceptive services remained low due to students' concerns about privacy and confidentiality. As a result, the ULC project helped the university infirmary to develop a new scheduling system that ensured only one consultation would take place at a time.

Regional Co-Management Committees

The regional Co-Management Committees were comprised of all project stakeholders who met once a month to oversee project progress and guide adaptations as needed. Monthly meetings were held regularly with all project stakeholders, which demonstrated the high level of commitment to, and interest of regional actors in the ULC.

Results of the regional feasibility testing phase

The five-month feasibility testing phase resulted in the following quantitative results:

Maradi	Tahoua	Zinder
• 36 PtC sessions held • 1 sensitization event and • 1 SRH conference held • 300 students reached through peer leaders	• 40 PtC sessions held • 321 students reached through peer leaders • 15 students referred by the peer leaders for SRH/FP services • 1632 condoms distributed • 150 students received HCT services	• 41 PtC sessions held • 9 sensitization events held • 854 students reached through peer leaders • 286 students received HCT • 1860 condoms and 38 cycles if pills distributed • 26 cases of STIs diagnosed

In addition to these quantitative results, the project's process documentation confirmed that the ULC approach was relevant, appropriate, and adaptable to the different university contexts. Stakeholders at the three universities also agreed that the approach could be implemented under routine operating conditions and has the potential to make important contributions to improving the health and well-being of students. These findings, in addition to the previous results of the CORRECT analysis, confirmed that the ULC approach has the necessary attributes for successful scale-up.

Nine Steps Scale-up Planning Workshop (October 2016)

A culminating dissemination and scale-up planning workshop was organized at the end of the ULC's project period, in October 2016.[29] This workshop was planned using ExpandNet's guide *Nine steps for developing a scaling-up strategy*.[30] The objectives of the workshop were fourfold:

1. Disseminate the results of the ULC in Niamey and the pilot projects in Maradi, Tahoua, and Zinder;
2. Agree on the package of activities to scale-up;
3. Identify the steps for the ULC scale-up strategy; and
4. Agree on the next steps of the scale-up process, including roles and responsibilities of different stakeholders.

The 60 participants included representatives from the MPH (central and regional levels), regional universities and their health services, the Niamey-based ULC student-led NGO, the MHE/RI, and implementing partners (AgirPF, Pathfinder International, Lafia Matassa, ANBEF, etc.). The workshop was jointly facilitated by ExpandNet and E2A, starting with presentations on (1) systematic approaches for scale-up; (2) the ULC project strategy, activities, and results; (3) the results of the feasibility testing phase in Maradi, Tahoua, and Zinder.

Following the presentations, participants worked in regional groups to discuss the nine steps for developing a scale-up strategy, as recommended by ExpandNet. Each region discussed and agreed on the priority activities to scale up based on the three pillars if the ULC technical strategy (youth leadership and demand creation; improving access and quality of SRH/FP services; co-management committees). Each region then filled in the nine-step matrix detailing actions to be undertaken as part of the scale-up strategy. The workshop resulted in a clear consensus on the essential ULC package for scale-up, as well as draft plans to scale up the ULC approach in additional sites throughout Niger. These plans will be used by the MPH, MHE/RI, AgirPF, Pathfinder International, and other partners to guide efforts for scaling-up the ULC approach.

At the end of the workshop, a meeting was held with the Naimey-based Co-Management Committee to debrief and agree on next steps. As a conclusion, the MHE/RI and the MPH reaffirmed their commitment and collaboration for the scale-up process and for the institutionalization of the ULC innovation.

Scale-up in practice: transition of the ULC approach to other user organizations

As the ULC's project period drew to an end, E2A held discussions with key partners in Niger to agree on a strategy for managing future scale-up of the ULC approach. The main partners were the MPH and MHE/RI (for vertical scale-up and continued institutional leadership), the AgirPF Project (for operational management, as a user organization in Maradi and Niamey), and Pathfinder International (for operational management, as a user organization in Zinder). The section briefly summarizes the agreements made with these actors for scaling up the ULC approach in Niger.

[29] Workshop report available upon request.
[30] WHO/ExpandNet, 2011. "Nine Steps for Developing a Scaling Up Strategy". Geneva: WHO.

MPH and MHE/RI

Both the MPH and MHE/RI agreed to seek opportunities to incorporate the ULC approach in policy and program instruments. For example, in October 2016, E2A's Niger Project Manager was invited to present the ULC package at a workshop to define the MPH's national guidelines for the minimum package of AYSRH activities in health service delivery points. Peer education, including the use of PtC, was included as a central component of the minimum package. In addition, E2A's Niger Project Manager was invited by the MPH as a technical expert to support the development Niger's new National Adolescent Health Strategy (Oct-Nov 2016). The ULC intervention package was included in the draft version of the strategy, which was under revision at the time of writing this report. Such efforts demonstrate the MPH's commitment to institutionalize the ULC approach, which will facilitate wider scale-up. Both the MPH and the MHE/RI are also committed to continuing their participation in future ULC Co-Management Committees at the central and local levels.

AgirPF

As described earlier, AgirPF was one of E2A's main partners for the ULC project, specifically around service delivery strengthening. AgirPF is present in Niamey and Maradi and will continue operations until September 2018. Therefore, AgirPF has an important role to play in scaling up the ULC approach in these regions. In June 2016, E2A developed a transition plan to hand over operational management of the ULC approach to AgirPF. The plan was further enhanced during the October 2016 Nine Steps Scale-up Planning Workshop, where stakeholders from Niamey and Maradi (as well as Tahoua and Zinder) developed a draft scale-up strategy and clearly identified leadership and support by the AgirPF project.

Pathfinder International

Pathfinder International established an office in Niger in 2015. Since then, Pathfinder has initiated SRH/FP programs in Niamey, Dosso, and Zinder with funding from the Bill & Melinda Gates Foundation and the Cargill Foundation. Several of Pathfinder's ongoing programs include a focus on increasing access and uptake of SRH/FP services among young women. E2A was recently awarded funds from the USAID Sahel Regional Office to expand FP services in Zinder as part of a wider resilience program (RISE), with Pathfinder International as the implementing partner. This new award, as well as Pathfinder's ongoing programs, will enable Pathfinder International to contribute to scale-up efforts of the ULC approach, specifically in Zinder. During the October 2016 Nine Steps Scale-up Planning Workshop, stakeholders from Zinder worked with Pathfinder International to develop a regional scale-up strategy. In addition, certain aspects of the ULC approach were included in the approved work plan for the new RISE FP activities in Zinder (notably, community-based sensitization and behavior change activities led by university PEs).

LESSONS LEARNED

This chapter outlines some of the main lessons learned from the ULC pilot experience in Niamey, as well as the application of a systematic approach to planning for scale-up in Maradi, Tahoua, and Zinder.

Lessons learned from the pilot experience in Niamey

A multi-sectoral approach to AYSRH programming in university settings is critical.

The university health center at AMU is technically under the institutional leadership of the MHE/RI; however AYSRH service delivery is part of the mandate of the MPH. It was important to involve both ministries multi-sectoral program design and management, as well as to ensure mechanisms were in place for inter-ministerial coordination and collaboration (e.g., the Co-Management Committee)

Integration of university health centers into the public health system is necessary to increase access to quality youth-friendly SRH/FP services.

The ULC project made important contributions to strengthening the linkages between the university health center (in Niamey and the other regions) and the district and regional health centers. Prior to the ULC project, the university health center operated fairly autonomously, which had negative ramifications on SRH/FP commodity procurement, supervision, data collection and utilization, and capacity building of health providers. Integrating the university health center into the public health system is critical for ensuring quality youth-friendly services in university settings, as well as for the sustainability of AYSRH programming on campus.

Addressing gender barriers is paramount to the success of AYSRH programs in Niger.

Given the small proportion of women in university settings in Niger, it was important to emphasize gender parity and address gender-related barriers for young women's participation in the ULC project activities. In addition to making efforts to achieve gender parity in peer education activities, the ULC behavior change methodologies allowed students and service providers to discuss and reflect on gender-related barriers and facilitators that affect young people's access to SRH/FP information and services. These reflections led to identifying actions to address gender-related barriers. The ULC experience also highlights the importance of promoting male involvement in AYSRH programming with young people in Niger.

The expansion of youth-led activities at community level increases their accountability and leadership.

The ULC experience supports previously published evidence[31] about the benefits of meaningfully involving young people in SRH programs. Involving and supporting young people as leaders ensured that the ULC project approach was relevant and attractive to students, while also leading to improved sustainability of the project activities. This is evidenced by the creation of the youth-led ULC NGO, which will continue to apply the ULC approach beyond the life span of the project. Involving young people in decision-making helped the project to integrate important considerations into project planning, for example:

- Students are not available during the exam and Ramadan periods and fewer students are available on campus during holiday periods. It was important to adapt activity planning around students' availability.

[31] Attawell, K., Going to scale in Ethiopia: mobilizing youth participation in a national HIV/AIDS program. 2004.
Esu-Williams, E., et al., Involving young people in the care and support of people living with HIV and AIDS in Zambia. 2004: Population Council Washington, DC.
Swartz, S., et al., 'Think for yourself-Think for tomorrow': Exploring the impact of peer-led HIV intervention and psychosocial support groups for vulnerable youth in South Africa. 2010, Cape Town: Human Sciences Research Council.

- In order to make the peer leaders more credible with their peers and in the communities, it was important to provide them with badges and certificates as identity cards.
- In order to maintain students' and young people's interest to attend sensitization activities at all time, it was important for peer leaders to have a sensitization plan with different topics on various aspects of young people's sexual and reproductive health issues.

The use of narratives in behavior change interventions has the potential to address complex behavioral needs of diverse young people.

The use of narratives in behavior change interventions,[32] particularly those that weave behavior-related cognition, affect, values, contextual cues, and social arrangements into characters, chronologies, and causality, carry the potential to address the complex SRH behavioral needs of youth. The ULC experience demonstrated that:

- Participatory discussions with youth should be a central component of the narrative-development process in order for the youth to own and identify with the story and for the story to be a true vehicle for change.
- Formative research and pretesting should be done when developing narratives to ensure the audience finds them emotionally engaging, realistic, credible, and culturally appropriate. Because each youth population is inherently unique, to elicit behavior change or productive conversations that can lead to behavior change, it is essential to know the population you are working within and to develop stories that can reveal their sociocultural norms, power dynamics, and wishes and desires. During the pretesting phase, any gaps in the plotline or character development that are not well understood by the audience should be addressed.
- Facilitators should be trained and supported to keep dialogic space open, create opportunities for the audience to share stories, and establish trust with the audience. The facilitators responsible for presenting the story should inevitably play a prominent part in how the story is received. Facilitators should be both trusted and skilled, with the ability to evoke emotions and invite reflection, rather than being bossy or demanding. Young people themselves should be considered for facilitation roles, as many young people may be more open to discussing sensitive topics with their peers.
- The routine and systematic collection and analysis of how young people interpret and respond to narratives is a useful way to collect data relevant for program decision-making. Tools that can synthesize such data, including the PtC Dashboard, are useful for program planning, management and monitoring.

Lessons learned from applying a systematic approach to scale up

Participatory stakeholder involvement is essential for successful scale-up.

Involving stakeholders in a participatory process was crucial to developing consensus around scale-up and designing an inclusive scale-up strategy. Stakeholders held different understandings of the concept of scale-up, so it was necessary to invest time to continuously engage them in dialogue and reflection to develop a common understanding and vision of systematic approaches scale-up.

It is important to clarify the concept of "process documentation" in relation to the experience of implementation and scaling-up.

The concept of "process documentation" was not initially well understood by project stakeholders, many of whom were more familiar with data collection for evaluation purposes. It was important to clarify with stakeholders that the purpose of process documentation is to learn from the experience. The data collected and shared are as important as the narratives produced during the implementation of the

[32] Including through films or games such as *Pathways to Change*

intervention. The aim of leading participatory reflection and analysis with stakeholders are to identify recommendations to improve quality, access, and results of the intervention with scale-up in mind.

Process documentation plays a useful role in quality improvement.

Applying a systematic approach to scale-up, including qualitative data collection for process documentation, allowed the project team to identify opportunities for continuous quality improvement of the intervention. The process documentation served as an action-research tool, as it helped stakeholders to review and reframe the project activities in order to improve the quality of project activities during implementation. It was important for the Co-Management Committee to be open to introducing modifications to the implementation approach based on routine monitoring data and the process documentation results. It was also important to ensure sufficient monitoring of any modifications introduced, so as to ascertain their potential effect on the scalability of the intervention.

Testing health innovations in different contexts and under routine operating conditions can considerably increase the likelihood of success for scale-up efforts.

The ULC experience confirmed the importance of ExpandNet's recommendations to test health innovations in different socio-cultural and institutional contexts, as well as to test the innovation under routine operating conditions, in order to improve scalability. The feasibility testing phase in Maradi, Tahoua, and Zinder generated important recommendations to simply the ULC approach and to build the necessary capacity (among user organizations[33] and the resource team[34]) to manage future scale-up of the intervention.

[33] The term "User Organization" is defined by ExpandNet as "the institution(s) or organization(s) that seek to or are expected to adopt and implement the innovation on a large scale." (WHO/ExpandNet, 2010, "Nine Steps for Developing a Scaling-up Strategy", Geneva: WHO).

[34] The "Resource Team" is defined by ExpandNet as "the individuals and organizations that seek to promote and facilitate wider use of the innovation. A resource team may be formally charged with promoting the innovation or may act informally in this role." (WHO/ExpandNet, 2010, "Nine Steps for Developing a Scaling-up Strategy," Geneva: WHO).

CONCLUSION AND LOOKING AHEAD

The ULC project demonstrated that, when young people are given opportunities to lead as change agents, important gains can be made to advance AYSRH. Students in Niamey have increased their knowledge and skills in SRH/FP and have been at the heart of efforts to spread SRH/FP information among their fellow students and peers in their respective communities. Beyond spreading SRH/FP information and generating a demand for SRH/FP youth-friendly services, they have been able to sow seeds of new knowledge and a lasting commitment to improve AYSRH in Niger, thereby playing a remarkable leadership role. The project emphasis on youth leadership development contributed to the creation of a new youth-led NGO, the ULC Association, which will continue to carryout AYSRH behavior change and sensitization activities beyond the duration of the project. In addition, ULC Peer Leaders have been recognized for the AYSRH leadership and offered opportunities to apply their leadership in regional SRH/FP initiatives, including as FP Young Ambassadors for the Ouagadougou Partnership.

The project's comprehensive behavior change methodologies, PtC and REACH activities, not only opened up dialogue and reflection about how to improve AYSRH, but also collected data on barriers and facilitators to accessing SRH information and services with relevance for ongoing and future AYSRH programs in Niger.

On the supply side, students can now, for the first time, receive contraceptive counseling and a broad range of contraceptive methods as a part of the ongoing SRH services offered by university health centers. The collaborative approach to service delivery strengthening, carried out in partnership with the MPH, the MHE/RI, and AgirPF, resulted in sustainable quality improvement for youth-friendly services at the university health centers in Niamey, Maradi, Tahoua, and Zinder. The project not only confirmed the need to increase access to youth-friendly SRH services for university students, but also successfully tested models for strengthening service delivery for this population of young people.

The ULC project is a concrete example of successful multi-sectoral collaboration between the various stakeholders. Continued collaboration and leveraging of each stakeholder's comparative strengths, resources, and influence will be important for future scale-up efforts. The ULC project was also a learning experience in that it successfully applied tools and methodologies developed by Pathfinder International (i.e. PtC, REACH) and ExpandNet in various resource-constrained and conservative settings in Niger.

The application of the *Beginning with the end in mind* principles early in the project shaped the project trajectory in such a way to facilitate future scale-up. The flexible management of the project allowed for constant consultations, analysis, and adaptations which offered opportunities to regularly review strategies and adopt appropriate changes informed by the context at the moment, and to document them. In this sense, documenting the various project steps and milestones was instrumental in informing and forming the scale up strategy.

The ULC pilot experience in Niamey and the regional feasibility projects in Maradi, Tahoua and Zinder demonstrate that the ULC approach has the potential to improve AYSRH and has the necessary attributes for successful scale-up across Niger and in other countries in West Africa. Moreover, the ULC experience built the capacity of local actors, who are now in a strong position to scale-up the ULC approach throughout Niger, thus ensuring a certain level of sustainability of the project outcomes. Going forward, the established co-management committees, commodity provision through the public sector, and the inclusion of ULC interventions in the national AYSRH strategic plan increase the likelihood of sustainability.

While the ULC project concluded in September 2016, several opportunities remain to build on achievements and expand the reach of the ULC approach, which will require additional support.

***Technical assistance for scale-up*:** Niger's MPH and MHE/RI are interested in scaling up the ULC approach to other universities across Niger, and regional partners are exploring the possibility of scaling up the approach to other countries in West Africa. Given E2A's expertise in systematic approaches to

scale-up, we intend to offer technical leadership for the participatory design of strategies for systematic scale-up, as well as technical assistance to in-country stakeholders to monitor and document the scale-up experience.

Application of the PtC Dashboard: The PtC Dashboard summarizes the barriers and facilitators to SRH identified by young people. It is easily searchable and provides evidence that can be used to strengthen several types of interventions, including: development of scripts for radio, video or community theater; identification of gaps to be addressed through new IEC materials; assessment of the behavioral "climate" that will be encountered when conducting AYSRH work in Niger; segmentation and surveillance research; and stimulation of conversations led by peer leaders. E2A intends to support Pathfinder to disseminate the PtC Dashboard to support other programs in Niger, as well as to explore opportunities for adapting the tool to other country/program contexts.

***Support for the student-led ULC Association*:** The student-initiated and -led ULC association is a registered NGO and students introduced a membership fee to create a start-up fund. It has the potential to play an important role in future SRH efforts, especially in bringing youth perspectives and leadership to SRH interventions in Niger. E2A plans to involve the ULC Association in the new RISE FP project in Zinder.

***Application of the ULC REACH films and other resources*:** E2A is developing a toolkit of the resources developed and used during ULC project, which will include the three REACH films, guides on how to run comprehensive behavior change activities, monitoring tools, and peer education materials. E2A can offer technical assistance to help partners apply the ULC tools to strengthen SRH programs for youth in Niger and other countries across West Africa.

ANNEXES

ANNEX 1: ULC Indicators, Targets and Achievements

	INDICATORS	DISSAGREGATION 1	DISSAGREGATION 2	PROJECT TARGET	TOTAL PROJECT	PERCENT ACHIEVED TO DATE
1	Number of university student leaders trained as trainers in AYSRH, by sex	Male		20	10	50%
		Female		16	9	56%
		Total		36	19	53%
2	Percentage of student leaders who demonstrated an increased knowledge of AYSRH by sex	Male		90%	100%	111%
		Female		90%	100%	111%
		Average		90%	100%	111%
3	Number of university peer educators trained in AYSRH and SBCC issues, by sex	Male		60	129	215%
		Female		60	73	122%
		Total		120	202	168%
4	Percentage of university peer educators who demonstrated an increased knowledge of AYSRH and SBCC issues, by sex	Male		75%	92%	123%
		Female		75%	87%	116%
		Average		75%	90%	119%

5	Number of students leaders trained as trainers in: (a) Pathways to Change, and (b) REACH methodologies, by methodology and sex	Pathways to Change Methodology	Male	20	10	50%
			Female	16	9	56%
			Total	36	19	53%
		REACH Methodology	Male	20	10	50%
			Female	16	9	56%
			Total	36	19	53%
8	Number of Pathways to Change games organized by peer educators to discuss ideas and norms around SRH			150	425	283%
9	Number of REACH video sessions conducted by peer educators (to identify and prioritize behavioral issues with a view to transforming them into concrete actions)			40	83	208%
11	Number of university students reached by PE with information or counseling on SRH by age and sex	15-19	Male	n/a	49	n/a
			Female	n/a	53	n/a
		20-24	Male	1200	1607	134%
			Female	800	776	97%
		25 and above	Male	400	990	248%
			Female	200	424	212%
		Sub-total: 15 - 24		2000	2485	124%
		Total		2600	3899	150%

12	Number of university students referred by peer educators to the university health center for family planning methods and HCT by age and sex	15-19	Male	n/a	9	n/a
			Female	n/a	7	n/a
		20-24	Male	250	77	31%
			Female	100	54	54%
		25 and above	Male	60	74	123%
			Female	40	25	63%
		Sub-total: 15 - 24		350	147	42%
		Total		450	407	90%
13 a.	Number of university students who obtained FP methods at the university health center, by age and sex	15-19	Male	n/a	0	n/a
			Female	n/a	0	n/a
		20-24	Male	n/a	0	n/a
			Female	60	46	77%
		25 and above	Male	n/a	0	n/a
			Female	60	15	25%
		Sub-total: 15 - 24		60	46	77%
		Total		120	61	51%
13b.	Number of university students who obtained FP methods at the university health center, by FP method type	Female Condoms		0	0	#DIV/0!
		Oral Pills		70	51	73%
		Injectables		40	7	18%
		Implants		10	3	30%

		IUD		0	0	#DIV/0!
		Total		120	61	51%
13c	Number of male condoms distributed			65000	79976	123%
13d	Number of students who received FP/SRH counseling at the UHS, by sex and age	15-19	Male	0	0	n/a
			Female	0	5	n/a
		20-24	Male	150	114	76%
			Female	250	265	106%
		25 and above	Male	250	220	88%
			Female	100	150	150%
		Sub-total: 15 - 24		400	368	92%
		Total		750	754	101%
14	Number of university students who obtained HCT services at the university health center, by age and sex	15-19	Male	0	9	n/a
			Female	0	7	n/a
		20-24	Male	180	77	43%
			Female	150	54	36%
		25 and above	Male	80	74	93%
			Female	40	25	63%
		Sub-total: 15 - 24		330	147	45%
		Total		450	407	90%
15		Male Condoms		541.7	666.5	123%

	Couple Years Protection (CYP), by methods (Report number of condoms and oral pills cycles distributed)	Female Condoms		0.0	0	#DIV/0!
		Oral Pills		4.7	5.6	120%
		Injectables		10.0	1.8	18%
		Implants		25.0	7.5	30%
		IUD		0.0	0	#DIV/0!
		Total		581.3	645.3	111%
16	Number of University Health Center service providers trained in AYSRH, by service provider category and sex	Doctor	Male	1	2	200%
			Female	n/a	0	n/a
		Nurse	Male	2	3	150%
			Female	1	2	200%
		Auxiliary Nurse	Male	n/a	0	n/a
			Female	3	3	100%
		Total Providers		7	10	143%
17	Percentage of University Health Center service providers who demonstrated an increased knowledge of AYSRH, by sex		Male	80%	80%	100%
			Female	80%	75%	94%
			Average	80%	77.5%	97%
18	Number of AYSRH-MOH trainers trained In Pathways to Change, and REACH methodologies, by service provider category and sex	Doctor	Male	n/a	0	n/a
			Female	1	1	100%
		Nurse	Male	n/a	0	n/a
			Female	4	4	100%

		Total		5	5	100%
19	Number of IP staff trained as trainers in: (a) Pathways to Change, and (b) REACH methodologies, by methodology and sex	Pathways to Change Methodology	Male	4	4	100%
			Female	1	1	100%
			Total	5	5	100%
		REACH Methodology	Male	4	4	100%
			Female	1	1	100%
			Total	5	5	100%
20	Number of supervision visits conducted by MPH officials to monitor quality of service provided by the university health center service providers			7	3	43%
21	Number of meetings of the Co-Management Committee			10	10	100%
22	Number of policies or guidelines developed or changed with USG assistance to improve access to and use of family planning and reproductive health services			1	0	0%
23	Number of barriers to, and facilitators of, access to AYSRH services in AMU, identified through the Pathways to change activities and REACH Action sessions	Barriers		1000	1520	152%
		Facilitators		800	1335	167%
		Total		1800	2855	159%

24	Number of local/indigenous organizations trained with USG assistance that are providing services in FP/RH			2	3	150%
25	Number of community youth who received AYSRH information from trained university peer educators, by age and sex	15-19	Male	200	773	387%
			Female	150	877	585%
		20-24	Male	500	1120	224%
			Female	350	319	91%
		25 and above	Male	200	525	263%
			Female	100	386	386%
		Sub-total: 15 - 24		1200	3089	257%
		Total		1500	4000	267%
26	Number of people trained in family planning and reproductive health with USG funds	Male		90	93	103%
		Female		35	55	157%
		Total		125	147	118%

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