

Training Adolescent Leaders in Sexual and Reproductive Health

Annual Report

Key to Abbreviations used in the document

CARA	Rural Center for Attention to Adolescents (Mexico)
IMSS	Mexican Institute for Social Security
RMU	Rural Medical Units
VMEIST	visits for monitoring, evaluation and in-service training
SISPA	Health Information System for the Unregistered Population (Mexico)

1. Executive Summary

The aim of the Project is to strengthen the leadership capacity of the CARA Youth Teams for promoting sexual and reproductive health services among the teenage population in rural communities, and their capacity to persuade these young people to take advantage of said services. To achieve this aim, the Project is running a training program in co-ordination with IMSS Opportunities.

This Report covers the period January to December 2005, during which visits were made to 44 Rural Medical Units (RMU) and Rural Hospitals, providing on-site in-service training for healthcare personnel and adolescent leaders, by observing their educational practice and suggesting improvements. During the same period, development of the Leadership Training Guide was completed, following trials in the field with a group of IMSS Opportunities healthcare personnel from the Puebla IMSS delegation. The Guide is currently being printed. The central task during 2005 was the carrying out of visits for monitoring, evaluation and in-service training (VMEIST) as the fundamental strategy for supporting healthcare personnel and CARA motivators, encouraging them to put into practice what they had learnt in training, and reinforcing improvements in their attitudes and skills for working with young people in the promotion of sexual health.

Undertaking these visits implied the development of instruments and evaluation strategies, to study progress being made in the Project.

The year's most relevant results are:

- The initial target regarding visits for monitoring, evaluation and in-service training (VMEIST) was met and surpassed by 83%. This has contributed greatly to the process of improving attitudes among healthcare personnel towards adolescence in general, towards working with young people, and towards the promotion of youth leadership. It has also led to a greater increase in the skills of adolescent leaders, helping them make better use of the tools and strategies provided for the promotion of sexual and reproductive health.
- The VMEIST provided opportunities to observe the educational activities involving CARA young people's groups. The visits were also a chance to give feedback on the educational practice of healthcare personnel and adolescent leaders, as regards their handling of the information and didactic resources supplied at the previous year's training workshops on aspects of empowerment, leadership, life skills, and sexual and reproductive health.
- The VMEIST also helped to improve attitudes among IMSS Opportunities healthcare personnel towards adolescence generally, to working with young people, and towards the promotion of youth leadership. The visits have also led to a greater increase in the skills of adolescent leaders, helping them make better use of the tools and strategies provided for the promotion of sexual and reproductive health. In the three provincial states where the Project is being operated, the young people are already perceiving an increase in their own participation in the activities organized by CARAs, and consider that their participation is worthwhile.
- An evaluation comparing the perception of teenagers in communities where the Project is being executed, with the perception of teenagers in communities not covered by the Project, demonstrated that the first group perceives a greater number of services related to sexual and reproductive health, or has more information about the services. There is also a notable difference in the perception of these groups of young people as to whether the healthcare personnel respond to all their questions

satisfactorily, with 12.8% more adolescents from communities covered by the Project expressing satisfaction.

- In San Luis Potosí, more of the activities assigned to each of the CARA are now being undertaken. San Luis Potosí is the state where training was given first, and where, as a consequence, the time lapse between training and data collection is greater. This suggests that the other two provincial states might register an increase in the future.
- No significant changes were reported in the SISPA¹ records that would suggest an increase in demand for the sexual and reproductive health services offered by IMSS Opportunities. However, on taking into account other institutional indicators, such as the basis for analysis of the supervisions, some positive progress was noted.

2. Original General Objective

To increase the demand for healthcare services and information regarding sexual and reproductive health, in highly marginalized regions, by means of strategies for training CARA Youth Team leaders in themes to do with sexual and reproductive rights.

3. Specific Objectives

Since writing the previous report, a decision has been taken to break down the objectives set out in the Project. It was felt that this would be clearer, allowing a more precise reporting of results aimed at during each stage of Project execution. Thus:

¹ Health Information System for the Unregistered Population, that records data from the whole of the Health Sector in Mexico.

Objectives included in the original proposal	Objectives broken down
<p>1. To strengthen the leadership capacity of CARA Youth Teams for the promotion of self-care in sexual and reproductive health, among adolescents from the highly marginalized regions in rural areas</p>	<p>1.1.To increase the knowledge of IMSS Opportunities healthcare personnel regarding:</p> <ul style="list-style-type: none"> ○ Empowerment ○ Leadership ○ Life skills ○ Sexual and reproductive health <p>1.2. To improve the attitudes of IMSS Opportunities healthcare personnel towards adolescence, to working with young people, and to the promotion of youth leadership</p> <p>1.3.To increase the knowledge of the youth motivators regarding:</p> <ul style="list-style-type: none"> ○ Empowerment ○ Leadership ○ Life skills ○ Sexual and reproductive health <p>1.4.To increase the skills of adolescent leaders in the use of tools and strategies for the promotion of sexual and reproductive health</p>
<p>2. To increase the participation of young people in promotion activities among the teenage population in rural areas, encouraging them to use the sexual and reproductive health services</p>	<p>2.1.To increase the participation of adolescent leaders in CARA promotion activities</p> <p>2.2.To improve CARA promotion activities</p> <p>2.3.To increase compliance with the activities assigned to each CARA (in terms of number)</p> <p>2.4.To increase the demand for sexual and reproductive health services provided by IMSS Opportunities:</p> <ul style="list-style-type: none"> - Family planning - Attention during pregnancy and childbirth

4. Context

At the end of 2005, some IMSS directors changed. That, together with other institutional priorities, delayed the beginning of the Project's replication phase, during which IMSS Opportunities had originally planned to extend the training strategy validated by the Project, to 100% of the IMSS units in the three regional states participating in the Project. The delay within IMSS has inevitably affected the achievement of Project objectives.

Moreover, the disasters caused by hurricanes Stan and Wilma, put IMSS Opportunities on red alert. This inevitably meant concentrating their efforts on victim-relief and reconstructing RMUs and Hospitals affected, requiring the postponement of other all activities previously planned, among which was the Project's replication phase due to begin in October-November 2005.

5. Report on the Specific Objectives addressed in 2005

5.1. Analysis of results by objective

Many Projects in sexual and reproductive health concentrate basically on organizing training workshops as the prime means of changing attitudes and practices. However, as these transformations are never immediate, it is always necessary to provide on-going support to the learning process over time, using additional educational strategies.

From previous experience, Thais has proved that training events designed to strengthen attitudes and skills for working with young people and for the promotion of sexual health, require subsequent reinforcement in the form of monitoring, supervision, evaluation and in-service training. The aim is to provide on-going feedback, which offers participants the chance to evolve towards the construction of healthier lifestyles and styles of work that favor sexual well-being.

Hence the central task set for 2005 was the programming of said visits for monitoring, evaluation and in-service training (VMEIST). The objectives

reported refer to reinforcement of the leadership capacity of the Youth Teams, an increase in the participation of young people in the promotion activities, and persuading more of the rural teenage population to use sexual and reproductive health services.

It should also be mentioned that the data in this Report comes from questionnaires applied to healthcare personnel and members of the Youth Teams during the VMEIST. Data was also taken from questionnaires applied to focal groups of adolescents.

A brief outline of the process entailed is given here, to help ensure a better understanding of the results obtained during the visits phase.

a. After the training workshops, and due to the benefits gained from careful public relations contacts made previously with local IMSS officials, three meetings with the multi-disciplinary teams from the IMSS delegations were programmed for the month of March, one per state. The meetings were designed to inform participants of results generated during the previous stage, to plan the visits phase jointly, and to discuss the methodology to be applied during these follow-up visits.

b. Initial Project planning set a target of 24 quarterly visits for in-service training; 12 in Oaxaca, 6 in San Luis Potosí and 6 in Michoacán. These visits were to cover both RMUs and Rural Hospitals.

Given the limitations in terms of time and resources, the idea of quarterly visits was replaced by a sample of communities. Local teams helped in selecting which communities should be visited, and decided on a sample of 44 out of the total 74 communities taking part in the Project. This, in the end, actually meant that more RMUs and Rural Hospitals than the original target number were visited (see Table 1). The selection made, covered 59% of the communities that had participated in the training workshops.

c. During the visits, the Thais team observed how the healthcare personnel and Youth Teams handle the information and didactic resources supplied during

training, both in educational activities with groups of adolescents, and in activities to do with training and promotion of sexual and reproductive health services at the CARAs.

This observation formed the basis on which useful feedback could be offered, and personnel could make commitments to improve practices applied in the attention being provided for young people.

The observation methodology followed the one set out in the Observation and Feedback Guides designed especially for the purpose. The Guides are made up of two broad sections: A) Operating guidelines for managing the visit session, including general aspects and facilitation techniques taken from IMSS Opportunities' own operating manuals; and B) Facilitation that covered general aspects of group management, promotion of life skills, empowerment and leadership (see Addendum 1).

In addition, questionnaires were applied to healthcare personnel to enquire into general aspects of the population attended, as well as into the usefulness of the training workshop. Questionnaires were also applied to Youth Team motivators, to find out what they actually know about CARA activities, their degree of involvement in said activities, and their perception regarding some self-care behaviors related to sexual and reproductive health (see Addendum 2).

d. During the visits, two focal groups were organized. The groups comprised adolescents attending the local CARAs, one in Oaxaca and the other in Michoacán. These focal groups served to study the perception the young people had about the skills of the healthcare personnel and youth leaders, about belonging to the CARAs, and about the quality of sexual and reproductive health services they were receiving.

e. Lastly, in December, a study was made of whether or not the perception regarding quality of services, differs between communities receiving the workshop and communities not receiving the workshop. A questionnaire on service quality was applied to a sample of young people from Oaxaca, selected according to statistically reliable criteria (see Addendum 3). The results from the

questionnaires were then evaluated within the framework of a national meeting on indigenous adolescents organized by IMSS Opportunities. The results are given elsewhere in this report.

Objective 1.2. *To improve the attitudes of IMSS Opportunities healthcare personnel towards adolescence, to working with young people, and to the promotion of youth leadership*

Visits for monitoring, evaluation and in-service training (VMEIST) were made between April and July, basically studying 3 aims regarding people trained under the Project:

- That they should receive feedback on their work, in order to potentiate their skills at handling educational sessions with adolescents
- That they should acquire elements which would allow them to establish more effective personal and work relationships with the adolescents
- That they should develop skills to promote youth leadership

A total of 59% of the RMUs and Hospitals were visited in the 3 IMSS delegations where the Project is being executed. The distribution of the Rural Medical Units (RMU) and Rural Hospitals visited was as follows:

Table 1. Number of RMUs and Hospitals visited during the VMEIST stage

IMSS DELEGATION	Month	RMUs	Rural Hospitals
San Luís Potosí	April	10	2
Michoacán	May	8	1
Oaxaca	June and July	17	5
TOTAL		35	9

During the visits a total of 37 observations were made, and 36 questionnaires were applied to healthcare personnel. The following table sets out the distribution by state:

Table 2. Distribution of the Application of Instruments

State	Observation Guide Healthcare Personnel	Questionnaire Healthcare Personnel
SLP	11	11
Michoacán	8	6
Oaxaca	18	19
TOTAL	37	36

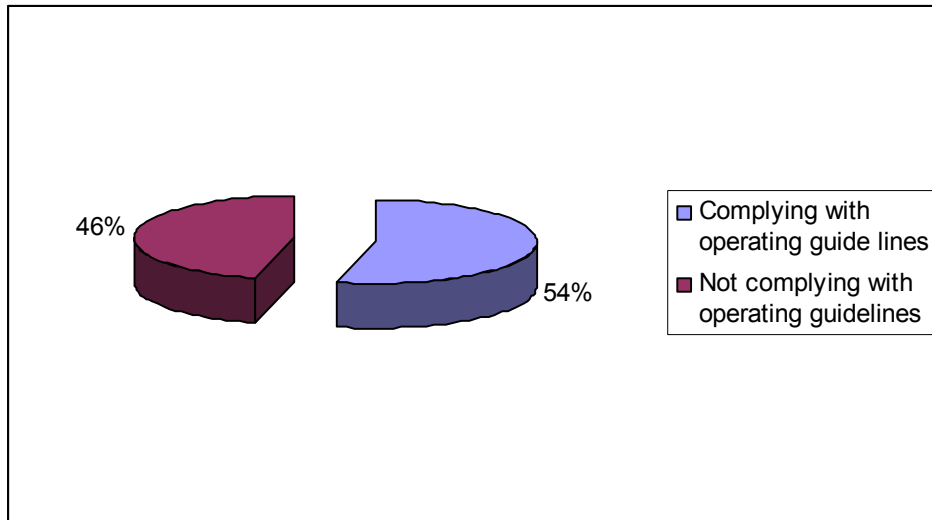
Healthcare personnel working in several different posts were observed. However, it should also be noted that there are several RMU doctors and medical auxiliaries who are the main healthcare providers for the whole population in a given rural community. (Medical auxiliaries are members of the local community, who have some basic training in nursing. Their usefulness is enhanced by the fact that they speak the local language and are familiar with local customs.)

Table 3. Post of Healthcare Personnel observed

Post	Number observed	%
Medical Auxiliaries	14	38
Doctors covering vacations	18	49
Promoters of Community Action	1	3
Rural Hospital Social Workers	4	10
Total	37	100

Results noted in the Observation Guides show that 54% of those observed are complying with the CARA **operating guidelines** as regards general aspects such as: group composition by sex and age; content percentage theoretical vs. life experience; and the material utilized. The other 46% of personnel observed, were found not to be complying.

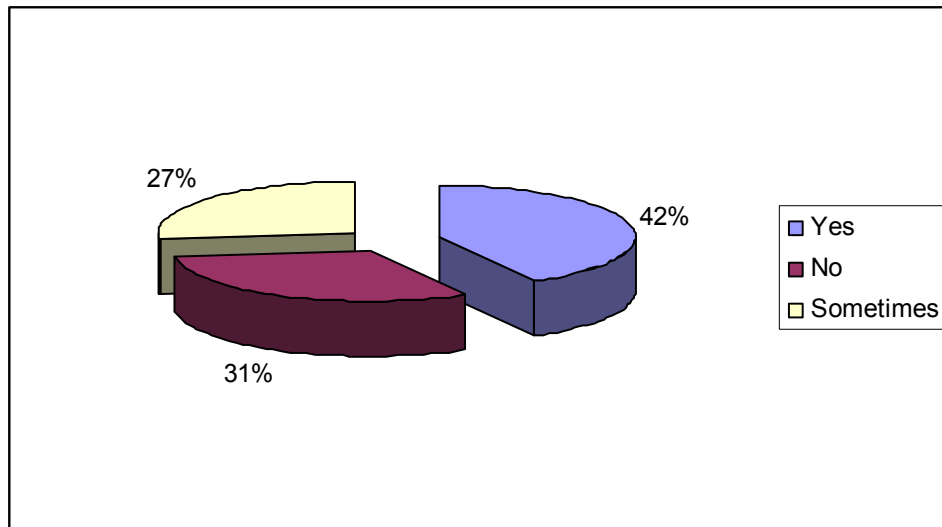
Chart 1. Personnel complying with Operating Guidelines



As to compliance with operating guidelines on the **management of educational sessions and the use of didactic techniques**, the visits revealed that 42% are following the manual's guidelines, 27% do so sometimes, and the remaining 31% do not. In other words, the participatory-life experience methodology which is the foundation of the educational strategy, is being applied in a way that is converting the techniques into "games" which are not then generating their full benefit as learning experiences. Healthcare personnel are still giving preference to the transmission of knowledge from a traditionalist perspective, which does not guarantee adequate acquisition of better health behaviors. One proof of this is the fact that the information being provided holds no great significance for the young people, who then are unlikely to apply it in their everyday life.

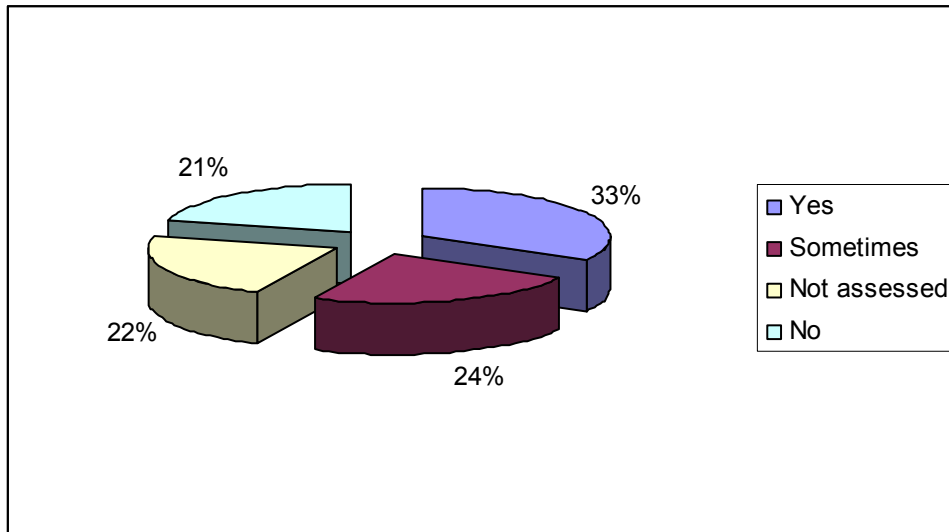
These results confirm that to achieve a significant change in the learning-teaching methodology of healthcare personnel, requires not only a training workshop, but also on-going monitoring, educational supervision and in-service training.

Chart 2. Personnel complying with Guidelines on Handling of Sessions and Didactic Techniques



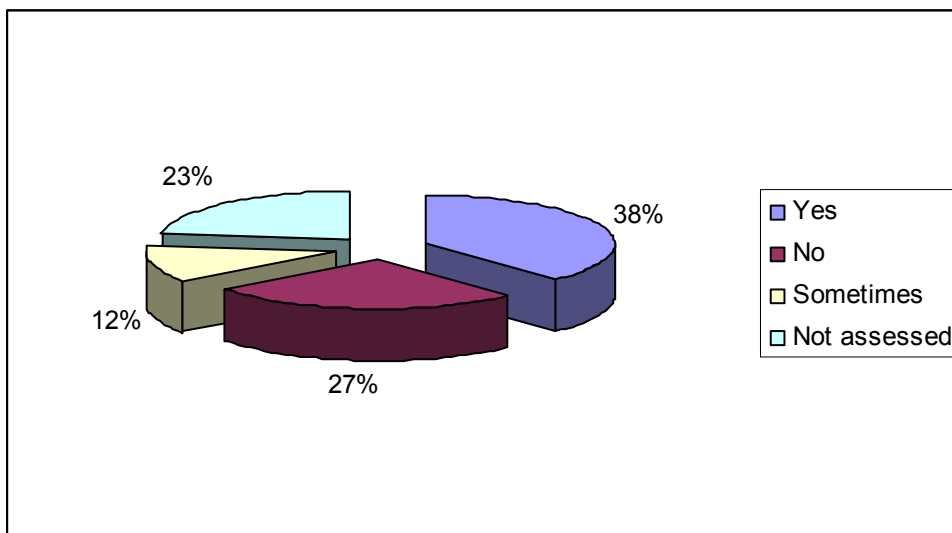
In items related to the management of *life skills and empowerment* in the educational activities, 33% of healthcare personnel were observed to be applying what they had learnt, by transmitting messages and attitudes that were promoting the development and/or reinforcement of these processes. For example, they formulated questions that prompted the adolescents to analyze their personal experience, and to identify and express their feelings and emotions. 24% of the healthcare personnel did so sometimes, whilst 21% are not doing this at all. It was not possible to make an assessment among the remaining 22%, either due to the way the educational activity was organized, or because of lack of time.

Chart 3. Healthcare Personnel promoting Life Skills and Empowerment



In items to do with the handling of *leadership* aspects in the educational sessions, 38% of the healthcare personnel were observed to be utilizing messages and attitudes that strengthen leadership in young people, 12% did so on some occasions, 27% did not do so, and in the case of the remaining 23% it was not possible to assess this aspect.

Chart 4. Fostering Leadership



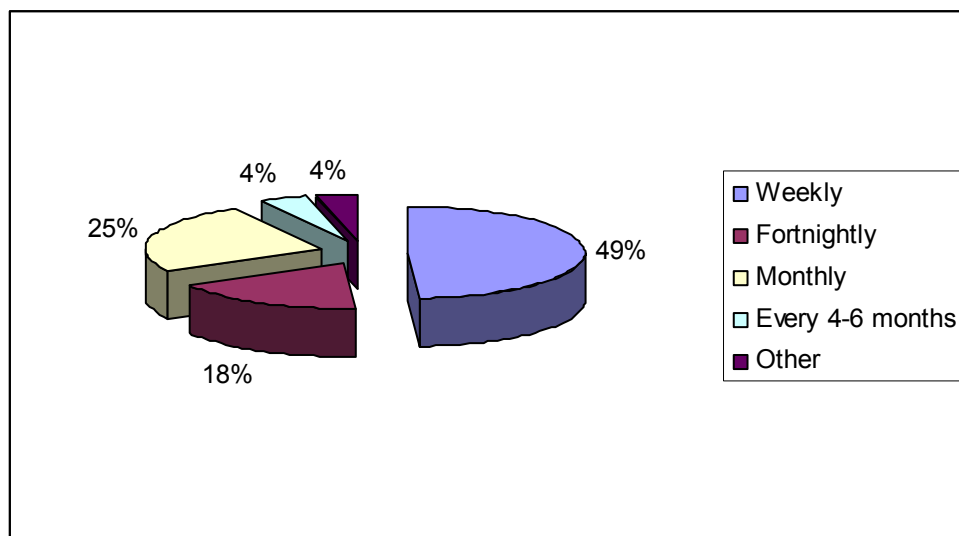
The visits made it possible to observe that 80% of the RMUs and Rural Hospitals visited have a youth team, in other words, a group of motivators and leaders who support activities being undertaken with their peer groups. The

remaining 20% did not have adolescents complying with this function. This situation is related to what was observed at the demonstration workshops during the training phase, in that some young people attending did not fit the required profile: that they should be CARA motivators or leaders.

Of the total 80% of the communities visited that do have a youth team, 79% have a team receiving advice from the healthcare personnel, whilst the remaining 21% have teams that are not receiving support from the healthcare personnel.

Of the teams receiving advice, 49% do so every week, 18% every fortnight, 25% every month, and the remaining 4% receive advice every 4 to 6 months. This indicates that, overall, some efforts are being made to give importance to the work these young people are engaging in. However, one point that needs to be checked is whether, in the instances of CARAs receiving advice very infrequently, the purpose of having a youth team is nothing more than to appear to be complying with the relevant operating guideline. It is therefore necessary to work more emphatically with the healthcare personnel, to ensure they realize the importance of promoting leadership among the local adolescents, so that the healthcare services actually reach young people who are not currently attending the CARAs.

Chart 5. Frequency of Advisory Sessions provided for Youth Teams



The results observed on each occasion of a VMEIST were reviewed together with the respective healthcare personnel at the end of each visit. On the basis of this feedback, personnel undertook commitments to improve their attitudes and the way in which they are supporting the development of life skills, empowerment and the promotion of youth leadership among the adolescents participating in the CARA educational activities.

The response of the healthcare personnel to suggestions from the Thais team was very favorable. Indeed, all of them made a commitment to improve when offered this feedback. It is worth mentioning that they actually remarked on how motivating they found it to receive visits of this type. They said they felt it helped them optimize their own work, because it allowed them not only to detect aspects that require reinforcement, but also to generate alternatives for action according to the needs of the young people in their own local community.

Another aspect evaluated with healthcare personnel was their perception regarding the changes effected as a consequence of the training. The results show that 96% of the healthcare personal visited reported changes in the CARAs as a consequence of the workshop. These changes occurred basically on two levels: 1) personally, in other words in the way each one works with teenage groups; and 2) in the young people themselves, in modifications to the way in which these young people behave during the activities.

Among the healthcare personnel, 31% reported having improved their communication with the young people, that they were now listening to them more and felt more involved with them; 27% said they had better tools for handling the dynamics as a means to foster learning; 23% mentioned having themselves learnt more about how to train teenagers; 12% knew more about the dynamics which they felt they could then use in applying these dynamics with their groups; and 8% felt more confident about themselves and comfortable about working with the group.

As regards the adolescents, 42% of the healthcare personnel mentioned noticing greater and better participation on the part of the young people. Their

comments can be broken down as follows: 23% said they had observed the young people to be more active; 15% reported them as being less shy; 12% felt they visited the clinic more; and 8% considered the young people were taking better care of their own health, and showing an interest in getting ahead.

As mentioned above, in addition to the evaluations made in the course of the VMEIST, two focal groups were held, consisting of adolescents who attend CARA sessions: one group in Michoacán, at which 15 young women aged 15 to 19 took part; and the other in Oaxaca, at which 14 young women and 9 young men of the same age range took part. The most relevant results are set out in the following table:

Table 4. Results from the Focal Groups on the Skills of Healthcare Personnel and CARA Leaders

COMMUNITIES	
Santa Fe de la Laguna Michoacán May 19, 2005	Quetzaltepec Oaxaca June 14, 2005
<p>In general the “talks” given by healthcare personnel</p> <ul style="list-style-type: none"> • made them think about looking after themselves, because the talks were given for the good of young people. <p>In the case of the leaders</p> <ul style="list-style-type: none"> • they felt the leaders worked very little at the talks, and they therefore trusted the nurses and doctors more; also because they know the leaders personally, they are afraid the leaders may tell others any personal information revealed to them. <p>They consider that:</p> <ul style="list-style-type: none"> • neither the healthcare personnel nor the motivators help them in making decisions, because this only concerns their parents and themselves. 	<p>The CARA sessions</p> <ul style="list-style-type: none"> • helped them think about their own health and that of their community, because the sessions taught them how to think and provided practical advice on how to look after themselves. <p>They think that:</p> <ul style="list-style-type: none"> • it doesn't matter whether it is the healthcare personnel or the motivators who try to help them take decisions, because anyway they make their own decisions. Nevertheless, the talks helped them feel more certain about what they plan to do.

The data suggests that, even though there have been changes in the practice of healthcare personnel, the changes have not been radical. Nevertheless there has been observable progress among the healthcare personnel, towards actions more likely to foster the development of skills in young people. This itself is contributing to greater empowerment and leadership in such a way as to increase the participation of youth leaders in improving the sexual and reproductive health of other young people in their own community.

At a joint meeting of the IMSS Opportunities and Thais teams, the IMSS mid-level central management remarked that evaluations of institutional supervision in the state of Oaxaca (from which data was collected regarding CARA functioning), actually indicate some progress, and they attributed this at least in part to Project actions. Information from these institutional forms helped to classify CARA functioning into four broad levels: “blue” signifying excellent compliance, “green” signifying good compliance, “yellow” signifying average compliance, and “red” signifying poor compliance.

In the case of Oaxaca, the data indicated that CARA functioning had moved up from “red” alert to “yellow” alert status, which in itself signifies positive progress.

Objective 1.4. *To increase the skills of adolescent leaders in the use of tools and strategies for the promotion of sexual and reproductive health*

During the visits a total of 24 observations were made, and 59 questionnaires were applied to motivators. The table below sets out the distribution by state:

Table 5. Distribution of Application of Instruments

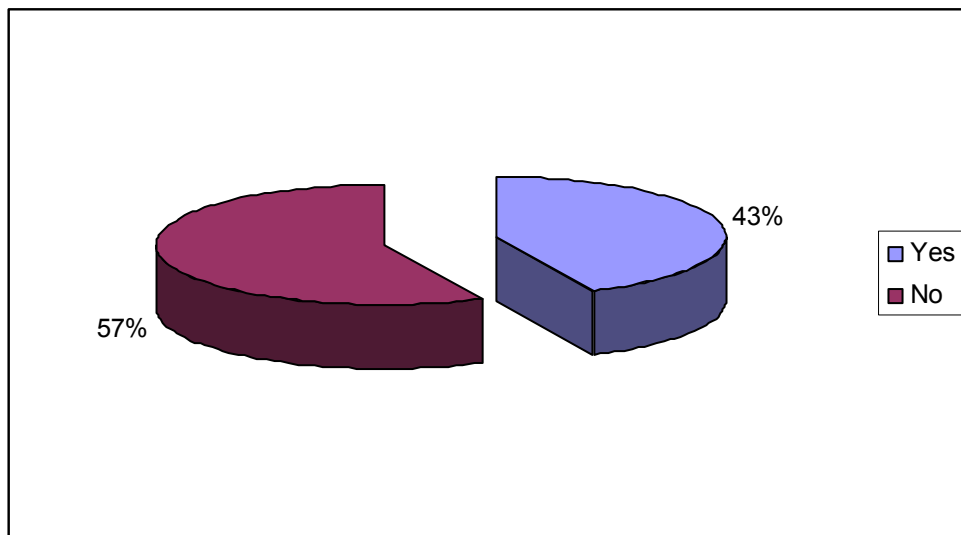
State	Observation Guide Motivators	Questionnaire Motivators
SLP	10	24
Michoacán	8	12
Oaxaca	6	23
TOTAL	24	59

The number of observations and questionnaires varied because the decision was taken to apply the questionnaire to adolescents who, even though they had

not taken part in the demonstration workshops, still form part of the Youth Teams and were participating in the educational activities being observed during the visits.

Results noted in the Observation Guides show that 43% of the motivators observed are complying with the **operating guidelines** as laid out in the CARA guide, regarding general aspects such as: group composition by sex and age; content percentage theoretical vs. life experience; and the material utilized. The other 57% of motivators observed, were found not to be complying.

Chart 6. Motivators complying with Operating Guidelines

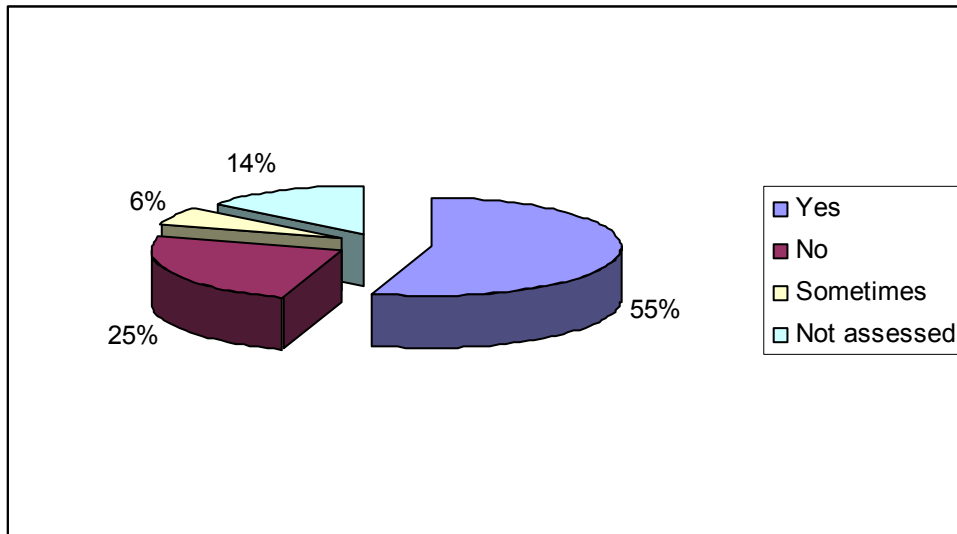


As to compliance with operating guidelines on the **management of educational sessions and use of didactic techniques**, the VMEIST reflected that 55% follow the manual's guidelines, 6% do so sometimes, and the remaining 25% do not. A further 14% carried out activities where it was not possible to assess this aspect.

It is interesting to note that the results for motivators are very similar to those seen among the healthcare personnel, and seem to indicate that the adolescents stick closely to the models they observe. This situation could be turned to advantage by improving training processes and feedback for the healthcare personnel, which would then trickle down to the young people in the

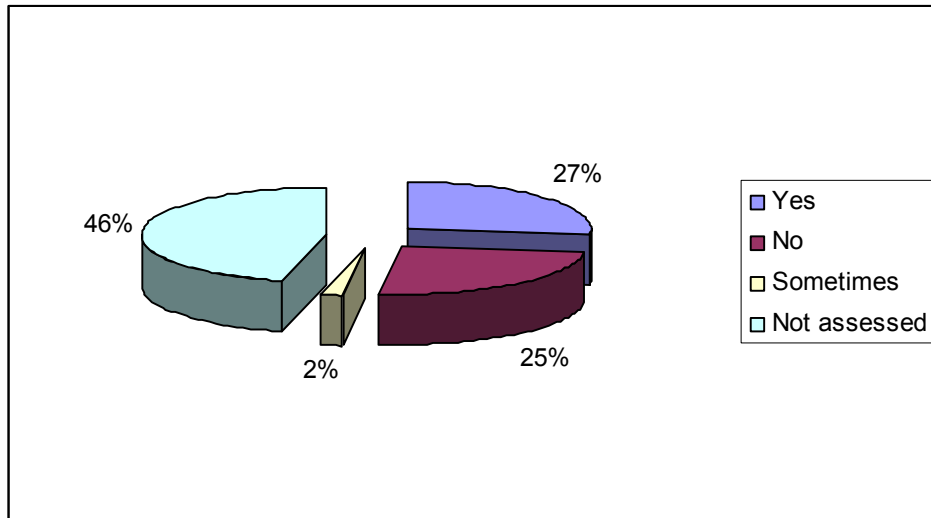
form of better attitudes and practices towards the adolescents whom they train and with whom they work. The adolescents would hopefully continue to be drawn to these positive role-models with whom they are in contact.

Chart 7. Motivators complying with Guidelines on Handling of Sessions and Didactic Techniques



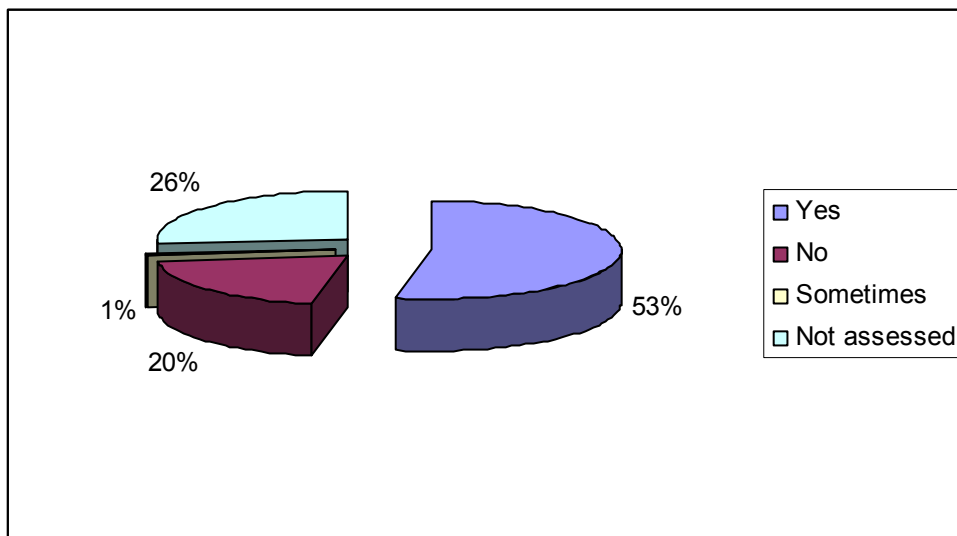
In items related to the management of *life skills and empowerment* in the educational activities, it was observed that 27% of the motivators applied what they had learnt, by transmitting messages and attitudes that were promoting the development and/or reinforcement of these processes. For example, they formulated questions enabling their peers to consider their personal experience, and to identify and express their feelings and emotions. 2% of the motivators did so sometimes, whilst 25% did not do so at all. It was not possible to make an assessment among the remaining 46%, either due to the way the educational activity was organized, or because of lack of time.

Chart 8. Motivators promoting Life Skills and Empowerment



In items to do with the handling of **leadership** aspects in the educational sessions, 53% of the motivators were observed to be utilizing messages and attitudes such as how to join in, how to leave their fellow participants free to organize themselves during joint activities, or how to involve themselves generally in CARA activities, in such a way as to strengthen leadership among their peers. 1% did so on some occasions, 20% did not do so at all, and in the remaining 26% it was not possible to observe this aspect.

Chart 9. Motivators fostering Leadership



It is interesting to observe that adolescent leaders have a better attitude and transmit more messages related to this subject than do the healthcare

personnel. This may perhaps be because the young leaders have greater confidence in the capabilities of other people of their own age.

Objective 2.1. To increase the participation of adolescent leaders in CARA promotion activities

A study was made of the information motivators have about CARA activities, and their degree of collaboration in these, because both factors are basic to being able to encourage the participation of others in any given activity.

Analysis of the questionnaire was carried out using a Pearson bivariable statistical correlation test². The analysis produced the following data:

a) There is a significant correlation (0.482) between the items: “When they organize an activity can you make suggestions?” and: “Do the healthcare personnel take your suggestions into account?”. This correlation is important because if the adolescents feel the work they do with the CARAs is a product of their own contributions and creativity, they are more likely to involve themselves in a given strategy and make it their own.

b) Relating the item: “When they organize an activity can you make suggestions?” to: “Do you make an activities plan?”, gives a correlation of 0.413, which indicates that the motivators are capable not only of making proposals, but also of carrying them out in their plan of activities.

c) The correlation between items such as “Are you helping other adolescents?” and variables such as “Have you ever invited an adolescent to the CARA?” and “Are you engaged in any activity to invite other young people to the CARA?” is interesting, because the results produced are negative (-0.273 and -0.341

² The Pearson product correlation is an index of the linear relationship between two variables, and describes the degree to which two variables are linearly related. The correlation is expressed as a coefficient in the range 1.00 to -1.00. A value of 1 indicates a perfect linear relationship, to the point that knowing the value of one variable allows perfect prediction of the value of the related variable. A value of 0 indicates no prediction is possible by means of a linear model. Negative values indicate that when the value of one variable is greater than the average, the value of the other is less than the average (and vice versa); and positive values indicate that when the value of one variable is high, the value of the other is also high (and vice versa).

respectively). This indicates that the actions of the leaders are focussed on already existing groups and their relationship with healthcare personnel, overlooking those adolescents who do not attend school or any healthcare services. This is a situation that requires greater analysis and study, both of the moment at which healthcare personnel assign duties to those who motivate the groups, and of the way in which motivators involve themselves in and understand their task, because SISPA data reveals scant cover for adolescents not attending CARAs or school, and who are thus outside the established groups.

In contrast, the perception of motivators as to the function of a leader shows they realize this is related to: "Do you contribute ideas to improve the CARAs?" and: "Do you help other adolescents?" (0.424 and 0.458 respectively). However, at the moment of carrying out their duties, motivators seem to forget that "other adolescents" is not limited only to those who already attend CARAs.

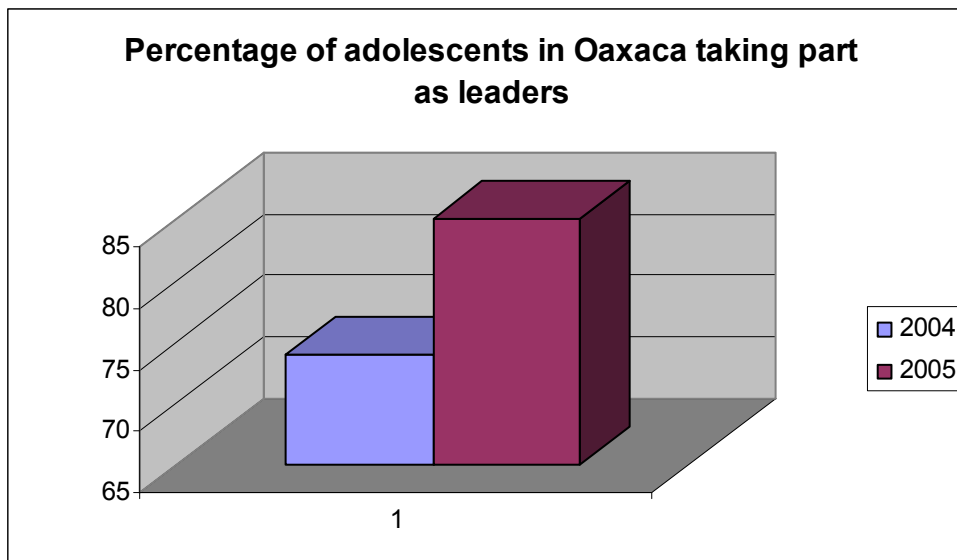
e) One interesting correlation related to empowerment is the item: "Do you tell the healthcare team when you don't agree with something?" in relation to: "Do you comply with planned activities?", where the significance is 0.352. This indicates that adolescents not only have the ability to make clear to the healthcare personnel what they like and do not like, but that they are also capable of committing themselves with greater efficacy and efficiency to the activities they themselves propose.

f) Analysis of the correlations between the questionnaires applied to CARA motivators and the healthcare personnel questionnaire, revealed interesting data worth studying. For example, of interest was the case of the following variables on the healthcare personnel questionnaire: "When did you begin applying what you learnt at the workshop?" and "Have you noticed differences in your work with adolescents since the training workshop?", against the following variable which appears on the questionnaire applied to the adolescents: "Do you take part in any CARA activity?", where the results show a degree of significance of 0.439 and 0.406. This demonstrates that when healthcare personnel begin to apply what they have learnt at the workshop, the

motivators begin participating more in the carrying out of CARA activities, because the young people feel they are in a space which is favorable and where their ideas will be taken into account, which leads them to take a greater interest in the CARAs.

Added to the above, the data from the IMSS Opportunities supervision analysis matrix, specifically in the case of Oaxaca, reports progress of 11 points in the percentage of adolescents taking part as leaders, or forming part of the Youth Team when comparing 2004 and 2005 figures (74% and 85% respectively).

Chart 10. From the Supervision Analysis Matrix



Objective 2.2. To improve CARA promotion activities

As mentioned above, an evaluation was made of the perception of the quality of CARA services. To do this, a sample comprising 33 surveys was applied to two groups in the state of Oaxaca³: Group 1 consisted of 16 adolescents from communities where the Project is not operating; and Group 2 consisted of 17 adolescents from communities participating in the Project.

³ This evaluation was carried out at the "First National Meeting of Indigenous Adolescents" held by IMSS Opportunities in Oaxtepec, Morelos, 5th-9th December 2005.

Table 6. Communities to which the Group 1 adolescents belong

RMU
San José Tenango
Guadalupe Villa Hermosa
Santa Ana Ateixtlahuaca
San Miguel
Eloxochitlan de Flores Magón
De la Cofradía II
El Carrizal Zenzontepec
La Ciénega Paxtlan

Table 7. Communities to which the Group 2 adolescents belong

RMU
San Miguel Santa Flor
Coicoyan De Las Flores
San Andres Paxtlan
Santa Lucia Miahuatlan
San Lorenzo Texmelucan
Micro Region XV
Santa Cruz Zenzontepec
Micro XVII

Results show that:

- a) A greater number of adolescents participate as motivators in communities where the Project is operating vs. communities without the Project (52.9% and 31.3% respectively).
- b) The perception of the young people regarding the convenience of CARA attention schedules was also studied. In communities where training is being given, 88.2% of the young people felt that CARA attention schedules are adapted to the hours when they can actually go; whilst the figure is 81.3% in communities not receiving training. This is interesting because the work schedule is exactly the same in both cases.
- c) As to the services provided, survey data shows that adolescents perceive there is a greater number of services, and/or know more about them in

communities where the Project has been operating, as shown in the following table:

Table 8. Comparison of Perception of Services Provided

SERVICE	COMMUNITIES	
	IN THE PROJECT	NOT IN THE PROJECT
Advisory Service		
YES	64.7	56.3
NO	35.3	43.8
Day-After Pill		
YES	52.9	31.2
NO	47.1	68.8
Papanicolaou		
YES	82.4	62.8
NO	17.6	31.3
Access to contraceptives		
YES	100	81.3
NO	0	18.8

d) On being asked whether the personnel respond satisfactorily to all their questions, the percentage in the number of satisfied community members in the communities where the Project is operating, is greater: 94.1% as opposed to other communities where the percentage is 81.3%.

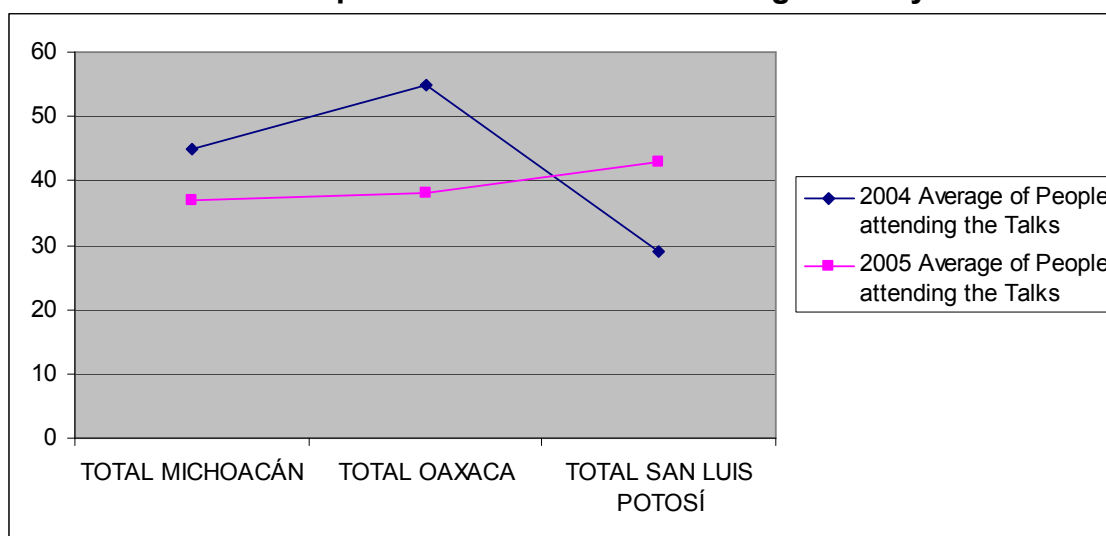
Objective 2.3. *To increase compliance with the activities assigned to each CARA (in terms of number)*

One key element in the CARAs, is the provision of educational activities which are evaluated in SISPA according to the **Average number of people attending the Talks**. Data regarding this aspect shows a reduction in the IMSS delegations of Michoacán and Oaxaca (8.0 and 17.0 respectively). However, in San Luís Potosí, the first state where training was given, figures show an increase of 14 people on average when comparing 2004 and 2005 figures.

Table 9. Comparison of Numbers attending Talks by State

STATE	2004 First semester	2005 First semester
	Average of People attending the Talks	Average of People attending the Talks
Michoacán	45	37
Oaxaca	55	38
San Luis Potosí	29	43

Chart 11. Comparison of Numbers attending Talks by State



It is important to seek the reason for the attendance reduction noted in Michoacán and Oaxaca following application of the Project. One point not to be overlooked, however, is the time period between the training workshops and the VMEIST when data was collected. The time lapse was very brief, and healthcare personnel had also noted on their questionnaires that not all of them began immediately to apply what they had learnt at the workshop:

Table 10. Time taken to begin Applying Lessons Learnt

Time taken to begin applying learning from workshop in their communities	%
Immediately	45
One month	25
From 2 to 3 months	17
From 4 to 6 months	13

It is logical that the changes will not be significant in the three states on taking the SISPA indicators, because these are based on productivity. By contrast,

however, there was an increase in San Luis Potosí of the number of people attending the talks. As this was the state where the training was first given, and consequently where the time lapse between the training and data collection was greatest, the significance is that an increase may also occur in the future in the other two states.

Objective 2.4. *To increase the demand for the sexual and reproductive health services provided by IMSS Opportunities*

To evaluate the impact of the Project as regards this objective, the baseline was taken as changes in 4 SISPA indicators regarding attention provided to adolescents. The analysis compares the data obtained in the 1st semester of 2004 against data obtained in the 1st semester of 2005.

The Indicators being compared are:

- **% Consultations with adolescents Vs total no. of consultations**
- **% Accepting birth control methods provided at IMSS facilities Vs provided at other sites**
- **% Teenage Pregnancy Consultations Vs total no. of pregnancy consultations**
- **% Adolescent gynecological internal exams Vs total no. of gynecological internal exams**

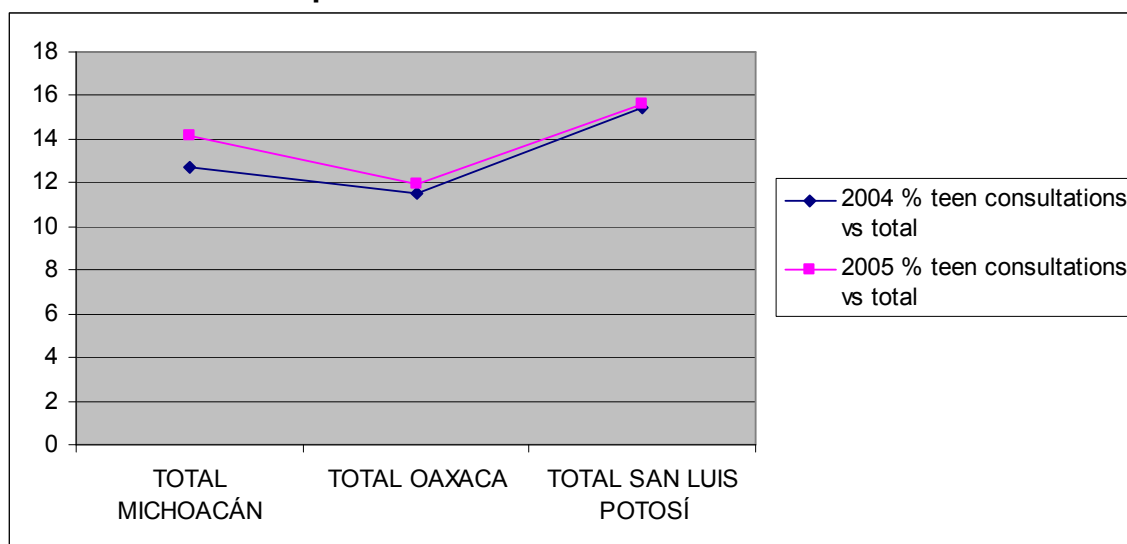
The indicator on the **number of teen consultations** shows that, despite small increases ranging from 0.12 percentage points in San Luis Potosí to 1.46 percentage points in Michoacán, there is not really any significant progress in the numbers of teenagers seeking this particular medical service.

Table 11. Comparison of Number of Adolescent Consultations

STATE	2004	2005
	% Consultations adol. vs total	% Consultations adol. vs total
Michoacán	12.70	14.16

Oxaca	11.48	11.98
San Luis Potosí	15.48	15.60

Chart 12. Comparison of Number of Adolescent Consultations



b) The indicator regarding **numbers accepting birth control methods** shows that these remain very low among young people in all three states, Oaxaca being the IMSS delegation registering least acceptance.

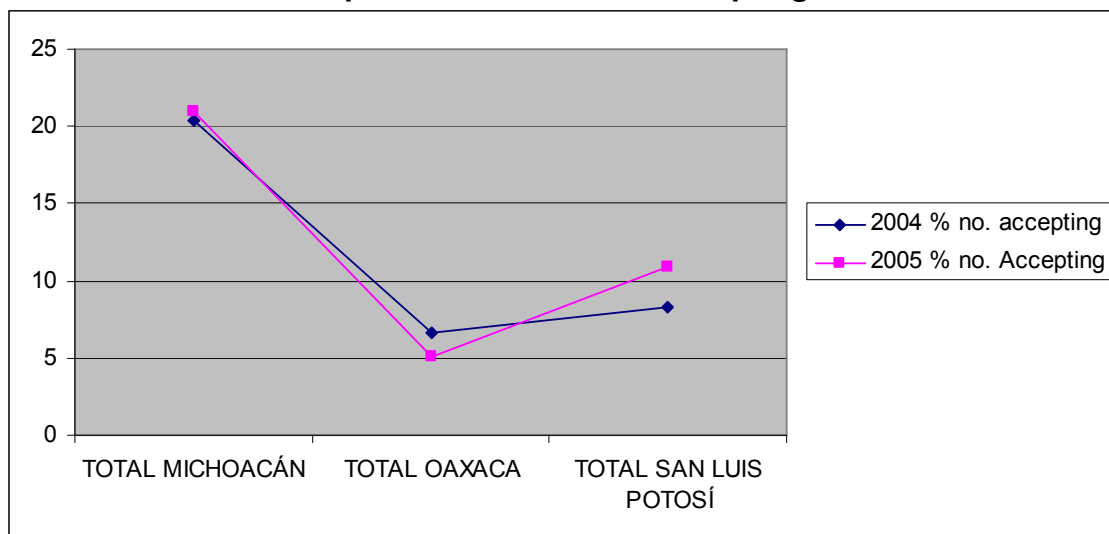
Moreover, results show that there were no substantial or significant increases during the periods compared. Indeed, the state of Oaxaca even registered a reduction of 1.5 percentage points.

At the same time, it should also be pointed out that this data does not include condom use, and this is the most commonly used method at this stage in life. Such information would be useful, but it is not currently registered.

Table 12. Comparison of Numbers Accepting birth control

STATE	2004	2005
	% no. accepting at IMSS vs elsewhere	% no. accepting at IMSS vs elsewhere
Michoacán	20.42	20.94
Oaxaca	6.63	5.13
San Luis Potosí	8.25	10.92

Chart 13. Comparison of Numbers Accepting birth control

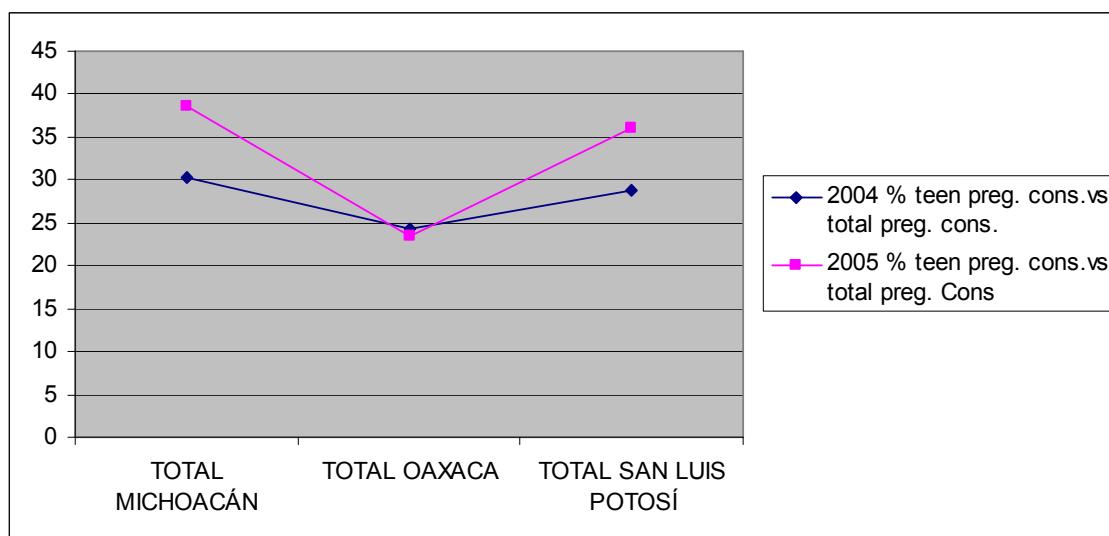


c) The **teenage pregnancy consultations** indicator shows a slight increase during 2005 in Michoacán and San Luís Potosí (8.41 and 7.32 percentage points respectively). However, Oaxaca presents a negative behavior pattern, with teenage consultations there falling by 0.88 percentage points.

Table 13. Comparison of Teenage Pregnancy Consultations

STATE	2004	2005
	% teen preg. cons. vs total preg. cons.	% teen preg. cons. vs total preg. cons.
Michoacán	30.22	38.63
Oaxaca	24.27	23.39
San Luis Potosí	28.8	36.12

Chart 14. Comparison of Teenage Pregnancy Consultations

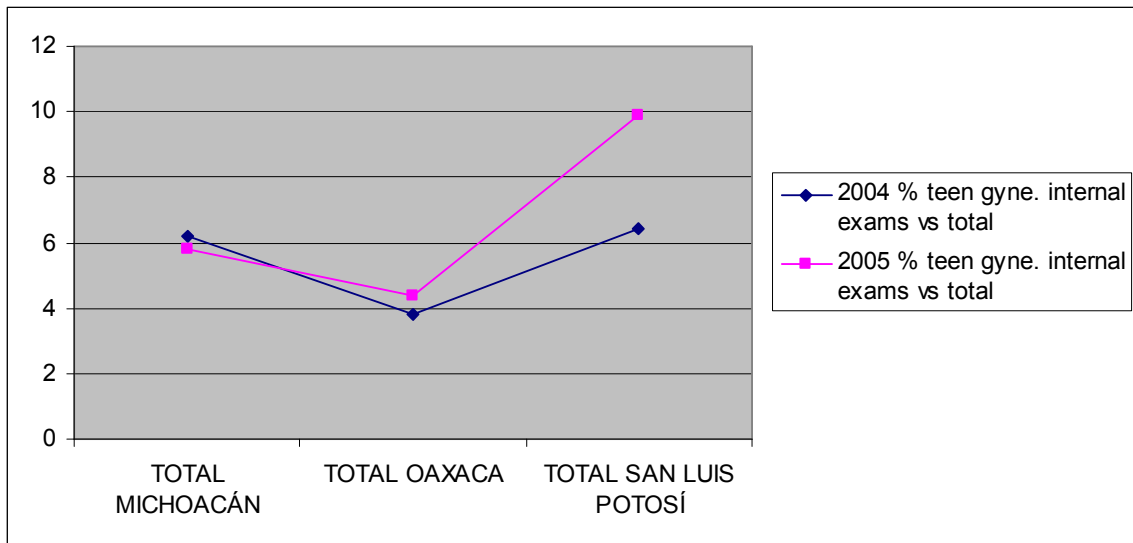


d) Lastly, the indicator regarding **gynecological internal exams in adolescents** shows there was an increase Oaxaca and San Luís Potosí (0.56% and 3.48% respectively), whilst in Michoacán there was a decrease of 0.39%.

Table 14. Comparison of Gynecological Internal Exams in adolescents

STATE	2004	2005
	% gynecological internal exams adoles. vs total no.	% gynecological internal exams adoles. vs total no.
Michoacán	6.18	5.79
Oaxaca	3.81	4.37
San Luis Potosí	6.4	9.88

Chart 15. Comparison of Gynecological Internal Exams in adolescents



e) The results of the indicators analyzed show the changes are not significant, and on occasion even negative. However, the changes are so small, that they may not actually be attributable to actions carried out during the Project.

If one takes into account that the time lapse between the training phase (August to December 2004) and SISPA data collection regarding the four indicators mentioned (January to June 2005) is only six months, it is understandable that the data will not reveal significant changes. It is amply proven that changing attitudes regarding empowerment and sexual and reproductive health is a slow process, as exemplified by the National Family Planning Program which only began to bear fruit after two decades.

Another factor that needs to be remembered is that SISPA is an institutional register system recording the productivity of medical units. Significant changes in the short term will necessarily be slight, if any show up at all, and this is why it is necessary to have other types of sources (surveys, focal groups, etc.) that measure progress in the behaviors of people and not only in productivity.

Therefore other sources of information regarding the Project's impact, have been sought. One additional data was taken from an analysis of the IMSS Opportunities supervision matrix, specifically the one relating to Oaxaca, showing the percentage of users channeled to Family Planning comparing 2004 and 2005 figures. The results went from 76% to 88%, which is an advance of 12

percentage points. However, this data is a global figure without a break-down, and therefore is not very helpful in measuring the Project's impact on units where it is operating.

Nevertheless, the data does serve to confirm that it is necessary to design more tools and indicators to evaluate Projects in the short term.

5.2 Analysis of the target “Making an impact on training policy towards the teenage population in rural areas, instituting a Training Manual and Empowerment of Adolescent Leaders in Sexual and Reproductive Rights”

a) The Project created the Leadership Training Guide: “Skills Development: a first step towards promoting empowerment and transforming leadership”. (The Guide is actually the training workshop itself, see annexed unit.)

To complete the Guide, the Thais team spent the first months of 2005 finalizing the initial version, which was checked and enriched by the IMSS Opportunities team. Once their recommendations had been incorporated, and the details agreed on, a field validation test was carried out to determine whether the Guide actually complied with the objective of serving the healthcare personnel as a tool to replicate the training workshops held during the previous phase of the Project. In instances where this was found not to be the case, appropriate corrections were made to the Guide.

The final validation workshop was then held at the end of October, in Zacapoaxtla, Puebla, where the IMSS Opportunities healthcare personnel had no previous experience of the training workshop. The validation workshop lasted five days: three days for group replication of the training workshop; one day working with the team of facilitators in charge of workshop replication, and one day with the team of observers comprising members of the IMSS Opportunities Department of Sexual and Reproductive Health and Training plus Thais staff.

Evaluation of the validation process was effected by means of specifically created instruments (see Addendum 4).

The results of the observations, evaluations and meetings signaled that even though the Guide complied with the aim for which it was created, it was still necessary to refine the contents, add more information on some themes, or include alternative techniques. The Guide also needed small changes to its structure in order to facilitate replication of the training workshop.

One fundamental point to be taken into account on making the changes, was to take advantage of the welcome high degree of compliance with procedures that was observed among the healthcare personnel. This will amply compensate for their lack of specific training for working with groups.

The changes to the Guide were made jointly by the IMSS Opportunities and Thais teams working together, and based on the results of the validation field trial. The final version of the Guide is currently at the press being printed (a sample copy is enclosed).

This Guide will have a fundamental impact on future IMSS Opportunities training policy, not only as regards adolescents but the population in general, and on the training processes of the healthcare personnel themselves. This is because the Guide was based on a vision of empowerment and leadership as being unfinished personal processes, on which everyone needs to continue working, and to which processes everyone needs to make a life-long commitment.

The Guide also provides elements not only regarding the “what” but also the “how”, so that even non-expert facilitators with little experience of handling groups will be able to replicate the workshop with ease. This implies a flexibility in the training-in-series strategy (where one group is trained, and they then train others under them) which is the standard training strategy at IMSS. The way the Guide was constructed makes workshop replication practicable even at very local levels, ensuring as far as possible that the essence of the methodology and contents of the workshop are preserved in their original form.

b) In addition to contributions made to the Guide during meetings with the IMSS Opportunities central level team held to analyze the VMEIST process, the IMSS Opportunities team also expressed a positive perception overall regarding the training and supervision strategies employed by the Thais team. They even mentioned the need to adopt some elements into the supervisions they themselves make of the healthcare teams throughout the Institute.

The IMSS Opportunities team remarked that the supervision processes programmed in the state of Oaxaca, were noteworthy because of differences in the way in which the healthcare personnel undertook CARA strategy actions as a result of the training workshop. The healthcare teams demonstrated greater interest in their work, in relating to young people, and in their ability to establish closer relationships with the teenagers. This led IMSS Opportunities to acknowledge that the work undertaken by Thais, has contributed valuable elements in how to approach adolescents more openly and in accordance with their needs.

The IMSS Opportunities team even acknowledged the need to orient their own supervision methods towards a humanistic methodology which focuses on a perspective of life skills, empowerment and leadership, in order to encourage better personal and institutional growth.

It is in this context that we consider the work undertaken during the Project has had, and will continue to have a favorable impact on strategies and on liaison and co-ordination procedures of the CARA, the Youth Teams and even the healthcare teams.

The Thais team is pleased to report that, during 2005, we managed to engage in a more functional, dynamic, harmonious co-operation with the Medical Co-ordination personnel at central level. We have worked together more closely, the co-ordination mechanisms have been refined, and solid bases exist for continuation of the work into the future. In addition, Thais has asked the IMSS Medical Co-ordination to provide a written evaluation of our team's

performance, so that we may improve our practices at all levels. We are currently awaiting delivery.

6. Conclusions

- The visits for evaluation, monitoring and in-service training (VMEIST) proved extremely useful in improving attitudes, work and leadership promotion by healthcare personnel. They also served to increase the skills of adolescent leaders in the use of tools and strategies for the promotion of sexual and reproductive health. This was because the methodology is based on a process of positive feedback from a humanistic perspective, in order to strengthen the processes of leadership and empowerment begun during training.
- In the opinion of the IMSS Opportunities authorities themselves, this form of “supervision” could even influence strategy for the good, and at central level they will continue to follow up on and evaluate the achievement of aims and objectives in the various IMSS delegations.
- The changes in practice made by healthcare personnel, and by Youth Team leaders and motivators, have been modest. Nevertheless, they demonstrate some progress towards actions more likely to foster development of skills in the young people, contributing thus to an enrichment of empowerment and leadership processes in such a way as to involve these young people more in an improvement of the sexual and reproductive health of other young people in their community. The data gathered in San Luis Potosí suggests that the changes deriving from the training need time to take effect.
- Employing a strategy of involving local administrative and medical officers in the actions required for the visits phase, was fundamental in achieving a commitment on the part of these personnel, and this ensured the success of the activities.

- The data collected during the different evaluation activities indicates progress in the number of adolescent leaders taking part in CARA promotion activities, as well as in an improvement of the activities themselves.
- Indicators coming out of SISPA do not reveal any significant increase in compliance of activities assigned to the CARAs, nor in the demand for sexual and reproductive health services. This demonstrates that the impact of the training strategy proposed in the Project needs closer evaluation over the long term. On the other hand, it is also necessary to recognize that said training strategy or any other strategy is very unlikely on its own to have an impact, at least in the short term, on indicators as complex as maternal mortality and morbidity.
- The Leadership Training Guide will be an extremely useful instrument to influence future IMSS Opportunities training policy. The validation process made it possible to incorporate elements into the Guide in accordance with the characteristics and needs of healthcare personnel, so that they will be able to utilize the Guide even without being training experts, because both the “what” and the “how” are given. This will have an impact on IMSS training policy by allowing diversification of the training-in-series strategy. Focusing on the process of empowerment and skills development of the healthcare personnel themselves, also leads to sensitization and enhancing of the work in these same aspects with the adolescents too.
- It should be noted that IMSS Opportunities has not yet initiated replication activities of the educational strategy validated in the Project, due to changes made in the General Directorate of the Institute and to the natural disasters Stan and Wilma.
- It gives all at Thais great satisfaction to observe the achievements that have come out of this work undertaken in co-ordination with IMSS Opportunities, as reflected both in the results and in the products

generated. It is also heartening to see the great interest expressed by IMSS Opportunities in continuing the Project by means of a scaled expansion. Altogether, the Thais team is particularly pleased to have received so much favorable feedback regarding the actions already undertaken.