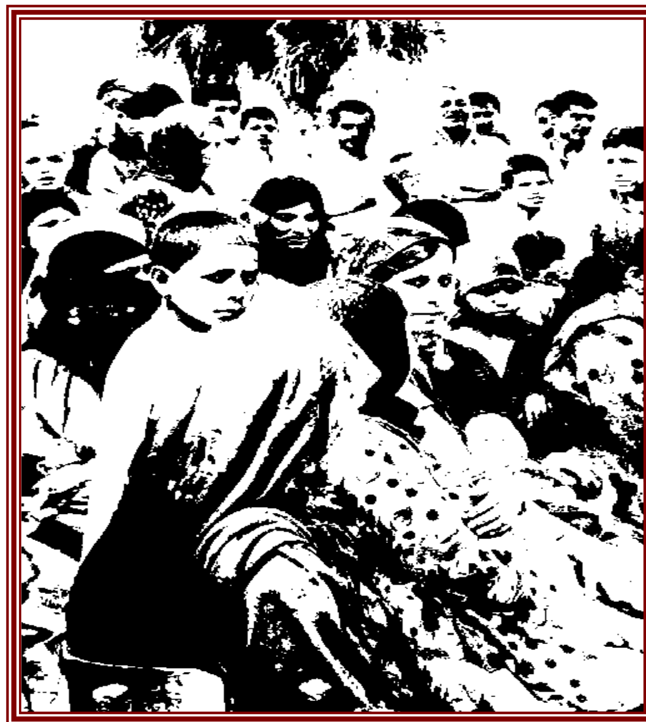
Family Health International

UNFPA

Formative Assessment of Youth Reproductive Health Needs in Menofia and Ismailia Governorates



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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
EFPA	The Egyptian Family Planning Association
FA	Formative Assessment
FGDs	Focus Group Discussions
FHI	Family Health International
FP	Family Planning
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
RH	Reproductive Health
SBC	Strategic Behavioral Communication
SES	Socioeconomic Status
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNFPA	The United Nations Population Fund
VCT	Voluntary Counseling and Testing
YFCs	Youth Friendly Clinics

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BACKGROUND

Young people aged 10-24 represent (41.9%) of the total population of Egypt [1]. This large and ever-growing segment of the population faces problems and challenges which are unique to them and which require interventions and information specifically designed to address their needs. The major constraints affecting the Egyptian youth today include high rates of teen marriage, high school dropout rates, poor nutritional status in general, lack of information on their sexual and reproductive health (SRH) and the inability to make informed choices.

Promoting comprehensive youth-friendly health services is essential in assisting youth to make responsible sexual and reproductive decisions, and empowering them to enforce these decisions. This vision is strongly supported by Family Health International (FHI), which has worked for more than 30 years to improve maternal and child health, to improve the availability, safety, acceptance, and use of modern contraceptive methods, and to prevent sexually transmitted infections (STIs), including HIV/AIDS. In collaboration with local, national, and international organizations in more than 80 countries around the world, FHI has conducted studies and strengthened reproductive health (RH) and HIV/AIDS programs by:

- Building institutional capacity through study and program management
- Generating new knowledge to improve health services and promote family health
- Sharing knowledge to improve health policies and practices
- Strengthening RH service delivery
- Establishing communication and information programs related to adolescent RH

From 2001 to 2006, FHI led Youth Net, a global flagship program committed to improving the RH of youth 10-24 years old. Youth Net was designed to meet the unique, complex and often wide-ranging RH and HIV prevention needs of young people, as well as those of their parents and other adults who worked with youth and influenced their well-being. As such, FHI brings a cadre of youth experts in Strategic behavioral communication (SBC), services, gender, training, program management, study, evaluation, tool development, and a number of technical areas.

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[1] Central Agency for Public Mobilization and Statistics. The Statistical Year Book, June 2006.

The United Nations Population Fund (UNFPA) and the Egyptian Family Planning Association (EFPA) closely collaborated to establish the *Meeting Adolescents Reproductive Health Needs in Egypt Project* in 2003. The goal of the project was to increase adolescents' knowledge of reproductive rights and reproductive health by building the capacity of several existing EFPA clinics to provide youth-friendly reproductive health services.

Since October 2007, FHI has been working in close collaboration with UNFPA and EFPA to address the shortage of RH services for youth in Egypt. The project includes plans to build the capacity of eight EFPA youth friendly clinics (YFCs) supported by UNFPA to provide youth with comprehensive services, counseling, and information that improve their SRH knowledge and related behaviors.

Table 1 List of EFPA Clinics by Governorates and Districts in 2007

Serial	Governorate	District	Clinic
1	Qalioubia	Banha	Banha Clinic
2		Shebin El-Qanater	Shebin El-Qanater Clinic
3	Dakahlia	El Monsoura	El Shenawy Clinic
4		El Senbelawein	El Moqataa Clinic
5	Ismailia	Ismailia	Abu Attwa Clinic
6		Ismailia	El Mabara Clinic
7	Menoufia	Shebin El-Kom	Shebin El-Kom Clinic
8		El Bagour	El Bagour Clinic

During Phase 1 (October 07 –January 08), FHI focused on gathering evidence to support the design and implementation of a longer and sustainable intervention and developing training manuals to standardize the training of service providers as well as peer educators. FHI conducted a rapid mapping of the eight UNFPA- supported YFCs, highlighting their areas of strengths and weaknesses. Baseline measurements have been established to ensure effective monitoring and evaluation throughout the various phases. The main aim of the baseline survey has been to enhance the performance of YFCs by identifying training needs of service providers and peer educators, determining gaps in service delivery and pinpointing "youth friendliness"

issues. Additionally, focus group discussions were held with youth who were familiar with the YFCs whether or not regularly utilizing their services to assess their SRH knowledge, attitude, practices and whether or not their needs were adequately met. These findings helped FHI respond to issues meriting prompt attention that arose from the assessment and take action to remedy shortcomings including orientation of service providers and peer educators towards HIV/AIDS and sexually transmitted infections (STIs) in addition to supplementing the information corners with books and brochures focusing on the same topics. (See annex 1 for the executive summary of the baseline survey). Furthermore, to ensure the delivery of high quality standardized youth friendly services, FHI developed various training manuals covering the following topics:

- Voluntary Counseling and Testing for HIV/AIDS
- Family Planning and Reproductive Health for the Providers of Youth Friendly Services
- Monitoring and Evaluation of Youth Friendly Services
- Reproductive Health for Peer Educators

Throughout Phase 2 (February–December 08), FHI trained the service providers and peer educators in the eight YFCs using the developed manuals and established voluntary HIV counseling and testing (VCT) services in three clinics in Menofia, Dakahlia and Isamailia governorates. Furthermore, on-the-job training was regularly conducted during site visits in the areas of STI management, RH counseling for youth, peer education and VCT.

During Phase 3 (January- July 09), FHI will focus on Strategic behavioral communication (SBC) to promote utilization of the YFCs. SBC, the FHI brand of Behavior Change Communication, is the integration of marketing principles and behavioral and social science. With an evidence-based theoretical foundation grounded in behavioral science, SBC utilizes best practices from the commercial marketing sector and integrates a number of key marketing principles. With the goal of increasing knowledge, shifting attitudes, and ultimately impacting behavior, SBC drives environmental as well as individual change in an effort to create enabling environments that make health-seeking and low risk behaviors achievable. To ensure innovation and impact through all of its behavior change programming, FHI utilizes proprietary planning tools and quality criteria from inception to evaluation. SBC can help achieve the following:

- Identify and reduce barriers to utilization of the YFCs so that clients can receive the full benefits of the clinics.
- Include youth in the development of YFC strategies through ongoing consultation, involvement in formative assessments, pre-testing SBC approaches and materials, implementation and monitoring of activities, and feedback about intervention results.
- Encourage youth to become informed consumers of youth-friendly services and to make informed choices about their lives.
- Create a supportive environment for YFCs at the family and community levels to dispel myths, fears and misconceptions about YFCs.
- Raise awareness of and create demand for YFCs within the community.
- Promote the services of YFCs and manage community and youth expectations of them.
- Help build a reputation for respect, trust and confidentiality for youth friendly services among clients and communities.

1. ASSESSMENT METHODOLOGY

The baseline survey conducted in late 2007 revealed that youth friendly clinics have underutilized capacity and could provide even more services as follows:

- Youth who do attend often seek **FP** and ANC services rather than educational and counseling services.
- Most of the YFCs attendants were in-school youth and knew about the clinics from sessions held by peer educators at local schools
- Both males and unmarried females do not visit the clinics frequently due to fear of stigma because the clinics are reputable for their family planning **(FP)** and antenatal care (ANC) services.
- Some parents do not let their children go to the clinics for fear that they might discuss socially and religiously unacceptable topics.
- Some religious conservatives are not in favor of YFCs because they offer young men and women the chance to meet.

To promote utilization of YFCs, FHI will apply Strategic Behavioral Communication (SBC), where the first step is conducting a formative assessment in the catchment areas[2] of the clinics. Owing to money and time constraints, FHI in conjunction with UNFPA and EFPA agreed to focus on the four YFCs in Menofia and Ismailia governorates during the current phase. The formative assessment involved gathering in-depth information about beneficiary populations, including their attitudes, knowledge, practices, economic and social environments, barriers and motivating factors, social networks, entertainment habits, health care seeking patterns and other data relevant to the context in which behaviors occur in this population.

1.1 Objectives

The over all goal of this assessment was to address the reasons for not going to the YFCs among the potential beneficiaries in the catchment areas of the 4 YFCs in Ismailia and Menofia governorates , and, in turn, to develop strategies to promote them. The specific objectives were as follows:

- Identify the various conditions and circumstances that could lead to the decision to utilize the clinic (economic, social, physiological, etc.).

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[2] In human geography, a **catchment area** is the area and population from which a city or individual service attracts visitors or customers.

- Explore the influence of the community and the traditions (encouraging or discouraging).
- Assess knowledge regarding HIV/AIDS/STIs and sources of information.
- Identify risky behaviors.
- Formulate strategies to promote utilization of the clinics.

1.2 Study Instruments

The assessment was conducted during March and April 2009 using two instruments: participatory workshop with peer educators selected from the four YFCs and in-depth interviews with the potential beneficiaries in the catchment areas of the clinics. In order to ensure the reliability of data, different levels of quality control were taken into consideration:

- The same questions were repeated more than once.
- Peer educators worked closely with the interviewers during field work in order to monitor the performance of the interviewers and to remove any obstacles the study team might face.
- All interviews were recorded.
- During the participatory workshop, the peer educators covered all topics that would be discussed later on with the interviewees in order to have a detailed idea about the community. Thus, any discrepancies pertaining to information would be noticed.

Following is a detailed review of the adopted methodology.

1.3 Participatory Workshop with Peer Educators:

In order to ensure the ability of peer educators to express their knowledge, attitudes and skills in an open and innovative way and genuinely reflect their communities, a participatory workshop was organized for the peer educators of the respective four clinics. Participants of both sexes were selected based on their duration of experience as peer educators in their communities to adequately provide the required information and feedback. The workshop relied upon the peer educators' contribution through presentations, working groups and simulations. The workshop not only revealed information about communities and potential beneficiaries but also about the peer educators themselves (ability, skills, etc.)

1.3.1 Mechanisms of the Workshop

In order to fulfill the objectives of the workshop, the consultant relied upon three mechanisms as follows:

Working groups

- Working groups (1): The peer educators were selected randomly in order to measure their ability to work in a group, assess type of leadership they accept, collect information about their respective communities and types of information the young people need and work on the guide that would be used with the potential beneficiaries later on.
- Working groups (2): They were divided based on the governorate and gender in order to collect governorate and gender-specific data.
- Working groups (3): They were divided by gender only in order to get information based on gender and to encourage males to perform in a better way than working groups (2).

Presentations

Presentation is the practice of showing and explaining the content of a topic to an audience aiming at measuring the following:

- Presentation skills of the peer educators
- How they react when criticized
- Their ability to have a representative speaker for the group and the criteria of such peer

Simulation

Simulation or imitation is an abstraction of reality, aimed at measuring the responses of the peer educators to community rejection. The baseline survey conducted in late 2007 and discussions prior to the participatory workshop revealed that peer educators had already received many training sessions focusing on youth RH, STIs, FP, etc. so they had experience regarding health issues. Therefore, the consultant tried to introduce them to a different mode of thinking by simulating a play for an illiterate woman who refuses to become literate. The name of the simulation was "I am illiterate and I will not learn." This mechanism is a simulation portraying community rejection to acquiring needed health information. The role of the peer educators in this exercise was to convince the woman pursue literacy.

1.4 In-depth Interviews with Potential Youth Beneficiaries:

An in-depth interview guide was designed to collect the required data, pre-tested with peer educators and youth then subsequently applied among 60 potential beneficiaries in the catchment areas of the clinics in Ismailia and Menofia Governorates (two clinics in each governorate).The interview covered the following topics:

- Basic information
- Social network
- Attitudes and practices
- Entertainment habits
- Social perceptions towards (sexual practices, female mobility information, etc.)
- Health care seeking behavior
- Risky behaviors
- HIV/AIDS/STIs information
- Channels/tactics to promote the utilization of YFCs

In order to maximize the use of this tool, the study team aimed at investigating the acceptance of talking about sexual issues among males and females. Two female interviewers were selected to work with males. The males talked freely with the female interviewer and did not feel any restrictions when speaking about detailed sexual issues. Regarding female interviewees, it was a risk to discuss taboo issues like sexual relations and STIs with a male interviewer in the streets and youth centers. Peer educators who attended the participatory workshop recommended that male interviewers not interview females.

The in-depth guide was tested during the workshop conducted with peer educators and with youth in order to define the vague questions and the problems associated with the guide as well as to ensure that the questions were well-phrased and understood.

In addition to the aforementioned tools, the formative assessment relied upon the results of the YFCs baseline survey conducted in late 2007 (See annex 1 for the executive summary of the baseline survey).

1.4.1 In-depth Sample

A purposive sample was selected to be able to investigate different community groups. The following procedures were applied to cover possible target groups during a short period of time:

- A clear definition for the target groups was set: those who have never visited the YFCs (as the 2007 baseline study already covered those who were familiar with the YFCs, whether or not regularly utilizing their services). A diverse pool of respondents was required as it was necessary for the sample to be representative of variables such as gender, level of education/educational status and employment status. Procuring such a sample necessitated dedicated preparation by the study team and the peer educators (not the easiest of tasks).
- Based on clear and detailed criteria, the sample was selected during field visits to the two governorates from urban and rural areas in order to identify the norms and traditions among the two communities.
- The sample was interviewed in the streets, NGOs, youth centers, universities and schools in the catchment areas of the four YFCs.
- An informed oral consent was obtained from all interviewees after explaining the following: the purpose of the research, how they were chosen to participate, voluntary participation and assurance of confidentiality in addition to asking permission to record what they say.

This document uses the terms young people, young adults, youth, and adolescents interchangeably. All are defined as people from the ages of 10 to 24 unless otherwise specified.

2. PARTICIPATORY WORKSHOP WITH PEER EDUCATORS

A young person's peer group has a strong influence on the way he/she behaves. This is true of both risky and safe behaviors. Not surprisingly, young people get a great deal of information from their peers on issues that are especially sensitive or culturally taboo. Peer education makes use of peer influence in a positive way. The credibility of peer educators within their target groups is an important base upon which successful peer education can be built. Youth who have taken part in peer education initiatives often praise the fact that information is transmitted more easily because of the educators' and audiences' shared backgrounds and interests in various areas. Peer educators are less likely to be seen as authority figures preaching from a judgmental position about how others should behave. Alternatively, peer education is perceived as receiving advice from a friend who has similar concerns and an understanding of what it is like to be a young person. Additionally, peer education is a way to empower young people; it offers them the opportunity to participate in activities that affect them and to access the information and services they need to protect their health.

The participatory workshop approach was adopted to offer peer educators the opportunity to interact, express their thoughts and reflect on their communities outside the work environment. Simultaneously, they were being observed to assess their skills and attitudes.

2.1 Sample Description

The total number of participants was 16 peer educators out of the 24 peer educators affiliated with the four YFCs. Selection was based on the duration of being a peer educator (the longer the duration, the greater the expected contribution).

2.1.1 Gender and Age of Participants

Seven of participants were males and nine females. The age group of the peer educators was between 19-25 years. Having peer educators of both genders and of this age group enables them to communicate with males and females of

the same age as understanding and dealing with adolescents and young people is not an easy process.

2.1.2 Educational Status

Regarding educational status, most of the peer educators were university students or graduates and two peer educators had a vocational education. This variation of educational status enables the peer educators to deal with different community groups. However, the workshop revealed that the university graduates were adequately trained to deal with potential beneficiaries of low-no literacy skills.

2.1.3 Employment Status

All peer educators are volunteers at the EFPA/YFCs. Only four peer educators had paid jobs and the rest were still students. The four peer educators work in the following professions: X-ray technician, program coordinator and two counselors. Employment status was very important as it was a concern that volunteers may resign due to their current work constraints or may be searching for other paid work. To maximize the achievements of peer educators, and avoid their turnover, they should be provided with stable paid jobs. Peer educators can work as volunteers during periods of educational study, but later on, those whose performance is outstanding should be employed and provided with acceptable salaries. The EFPA is already applying such a promising system, which both motivates its peer educators to work hard and simultaneously maintains the input of outstanding ones.

2.2 Results of the Workshop

The workshop helped in gaining insight into peer educators' attitudes and skills and collecting extensive data about the potential beneficiaries as peer educators are an important segment of the target society. The main themes that emerged from the workshop are as follows:

2.2.1 Characteristics of Peer Educators

The participatory workshop conducted in Alexandria in March 2009 was an excellent opportunity to interact with peer educators and explore their characteristics outside the work environment. During the workshop, the study consultant relied upon observation, working groups' attitudes and simulation.
The observation period revealed the following characteristics of peer educators:

- Enthusiasm and eagerness associated with this age group
- Efficiency and dedication
- Ability to work as a team
- Ability of women to lead a team and the acceptance of this type of leadership by male counterparts
- Sense of humor that attracts beneficiaries
- Excellent presentation skills and variation in presenting
- Ability to control a group
- Full awareness of community problems
- Acceptance of criticism and ability to defend their methods of dissemination
- Good knowledge of FP and RH
- Autonomy
- Ability to discuss taboo and sensitive issues

Furthermore, as to the attitudes and skills of peer educators, the ability of female peer educators to organize their thoughts and present them efficiently was remarkable. Though the male peer educators had some creative ideas, their thoughts were not as organized as the females. This motivated the males and, subsequently, their performance during the presentation session was notably better. The simulation mechanism was then applied to predict how peer educators might react in response to community rejection. The simulation mechanism revealed the following:

- Some peer educators were able to utilize the language used within the community to convince an illiterate woman to learn.
- Some peer educators (particularly females) insisted on using the same slogans and phrases traditionally used during illiteracy eradication campaigns. Using existing ideas and slogans is not effective with all community members.
- Some female peer educators accepted rejection and were not persistent.
- Some peer educators became upset when rejected and began to act angrily. Such behavior necessitates simple training on communication skills and self control.

The variability of skills of both men and women enrich the services delivered through the YFCs, achieving maximum effect on target audience.

2.2.2 The Network of Social Relations

Social networks have an extensive effect on the behaviors, health practices and habits of individuals and are considered one of the main bridges through which to obtain information, though the degree of dependency on this information varies. This topic was discussed with peer educators on two levels: the level of peer educators themselves and the level of potential beneficiaries. In order to understand the opinions of the peer educators about this concept, there was a big determination to achieve almost an individual participation from youth although the work was done through a group. During the group discussion, the workshop facilitator urged all youth to discuss the topic individually.

Regardless of the lack of clear limits pertaining to the type of relation (as relatives or neighbors might also be friends), the network of social relations was divided into:

- Friends
- Neighbors
- Parents
- Relatives

Relatives were covered as part of the family members in extended families (in-laws, siblings, cousins). During the preparation for the discussion, no clear classification for the meaning of relatives was defined. Relatives can also be neighbors or friends.

Friends:

Working through a network of friends represented the core of peer educators' activities. Within the discussion, peer educators described the nature and limitations of friendship, and the characteristics of a good friend. Peer educators agreed among themselves and the potential beneficiaries that three levels of friendships exist. These stages were determined to be at the level of colleague, then friend, then "brotherly" closeness. A good friend can be described as: loyal, devoted, discreet, supportive, well-mannered, ambitious, highly intelligent, brave, strong, honest, flexible, funny and able to maintain functional social relationships. Friends often enjoy each others' company during activities like going to the cinema, school, university, youth centers, and public places or events.

Analyzing peer educators responses revealed that a good friend:

- Represents psychological and moral safety (discreet and loyal).
- Is a source of mood enhancement (funny, flexible and loving).
- Is a trusted figure among his/her peers ("brotherly closeness").

Information that could be obtained from friends could be about anything, without limitations or restrictions. Regarding the credibility of information delivered through friends, peer educators are viewed as credible source of health related information among their peers. On their part, peer educators face check the information, especially health related information, obtained through friends. This trait was expected from them, as they acquired the skill of searching for trustworthy information from multiple sources through the trainings and work experience.

Neighbors:

Neighbors play a major role not only in exchanging information but also in safeguarding norms and traditions. Peer educators mentioned that for themselves and the potential beneficiaries, there are different levels of neighbors; some considered neighbors as friends or relatives, as they were raised near to them, while others reported very limited relations with neighbors. Although some peer educators live in rural communities that are famous for tight relations with neighbors, discussions revealed that superficial

relations were prevalent among neighbors due to the modern living conditions. In both urban and rural areas, the relations among neighbors are mostly limited to attending social events as funerals, weddings, etc. Close relationships generally occur with neighbors who are simultaneously friends or relatives.

A loved neighbor was described by peer educators as: respectful, brave, cooperative, honest and funny. These characteristics do not indicate intimacy with neighbors. As for the activities carried out with neighbors, they did not exceed attending different social occasions.

Knowledge exchange among neighbors was based on the type of information (social, political, health, etc.). Peer educators pass health information to their neighbors and they receive non-health related information from them; the credibility of which is based on the educational level of the neighbor. The peer educators reported that the potential beneficiaries have a similar pattern of relations, more or less, with neighbors. They might be friends, meet only in social events or have no relationship at all.

Parents:

With regards to themselves and the potential beneficiaries, peer educators reported that parents play a critical role in their children's lives. During the transition from childhood to adolescence to adulthood, parents not only provide information, but also shape their attitudes and transfer social norms and traditions. However, parents do not discuss sexual issues with their children and consider them taboo. Additionally, adolescents prefer to act individually and separately from their parents. "During adolescence, parents and their children establish new kinds of relationships with one another. Adolescents begin to express themselves as individuals separate from their parents and with needs and feelings of their own, make decisions about their own lives, and learn to take the responsibility of their lives."[3] Hence, they count on their peers and information from the internet to fulfill that unmet need for SRH knowledge.

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[3] El Tawela, Sahar. *Transition to Adulthood, A National Survey of Egyptian Adolescents*. Population Council- Regional Office for West Asia & North Africa. Social Research Center – The American University in Cairo 2000.

Relatives:
Relationships with relatives may be shallow or alternatively relatives might be close friends, neighbors or living in the same household as part of an extended family. In the latter case, relatives represent endless sources of information for the potential beneficiaries though their influence is not remarkable. This applies for both peer educators and potential beneficiaries.

2.2.3 Norms and Traditions

Peer educators revealed different norms and traditions within their respective communities during the working groups. From the point of view of the peer educators, there was a great variation between the implications of norms and traditions for young males and females. The mobility of girls was restricted: it was forbidden for females to access youth centers regardless of rural/ urban areas and they were not allowed to stand with males in the street. Attendance of conferences and seminars would be high because females were busy with domestic obligations and chores. On the contrary, males have no restrictions regarding mobility. They are able to access youth centers of their own volition and choose to do so frequently.

As for the norms and traditions pertaining to the exchange of sexual information, it was totally forbidden to discuss sexually-related information among family members and could only be discussed in limited scope before weddings. It was acceptable to discuss such information among friends at any time. One of the peer educators clarified that the potential beneficiaries are not allowed to talk about such issues, as the culture of community is named after "the culture of silence." This title is a reflection of an avoidance of discussing such issues.

Regarding spaces visited for the purpose of receiving health care, hospitals and private doctors were the trusted outlets. However, in certain cases, some females approach natural healers and utilize herbs.

2.2.4 Entertainment

The means of passing leisure time varied between male and female peer educators. Table 2 illustrates the different methods for passing leisure time among male and female.

The table reinforces the different norms and traditions governing the mobility of female versus male peer educators, as they exist in their respective communities.

Table 2 Means of Spending Leisure Time for Peer Educators

Means of passing leisure time	Females	Males
Watching television	X	X
Wandering in the streets		X
Sitting in coffee shops		X
Going to youth centers		X
Shopping	X	X
Going to net cafes		X
Playing football and play station		X
Trips		X
Discussions	X	X
Reading	X	X
Visiting neighbors	X	X

2.2.5 Information about Sexually Transmitted Infections (STIs), AIDS and Reproductive Health

Reflecting the frequent trainings they attended, peer educators had accurate extensive knowledge about STIs, AIDS and reproductive health. Having a well-trained cadre of peer educators promoting their SRH knowledge in their communities ensures the ability to fulfill the unmet SRH needs of youth via credible sources. Regarding the perception of peer educators towards the SRH knowledge of the potential beneficiaries, they reported low knowledge levels among beneficiaries. This finding is consistent with the data collected through the in-depth interviews

2.2.6 Sexual Behavior

Regarding the relationships between males and females, peer educators indicated that the prevalent types of relationships in their communities fall

into the categories of love, colleagues, friendship, marital relationships and extramarital relationships.

Regarding the perception of peer educators towards the practice of masturbation in their respective communities, they reported that it is widely practiced among males and females and was accepted as a mean of avoiding adultery. An alarming perception reported by peer educators was that the masturbation might lead to full sexual relations.

Masturbation was totally rejected by peer educators who reported that it weakens the body, has a destructive psychological impact and could lead to full sexual relations. Thus, the practice must be discussed via a youth-tailored and culturally-sensitive approach.

2.2.7 Sources of Information

The sources of information for peer educators include the following:

- Training courses
- Specialized books
- Television and mass media
- Mosques and churches (as places to receive religious information, not health-related information)

2.2.8 Channels/Tactics for Encouraging Youth to Visit the Clinics

Peer educators proposed several methods to encourage the potential beneficiaries to visit the YFCs and to advocate for YFCs in their respective communities.

Media

- Television advertisements (although advertisements are costly, they are regarded as the most effective channel)
- Radio
- Newspapers and magazines
- Television serials and films

Advocacy

- Key figures within local communities and villages
- Religious leaders, who are currently informants pertaining to religious issues but could become effective advocates for the clinics
- Doctors of health units

Trips, Entertainment and Sports Day

- Such excursions are considered the base for promotion and for gaining attention.
- Entertainment trips can be used as prizes for RH competitions.
- Sports days are an important element for providing simple information through activities or through distributing simple promotional presents (shirts with the logo of the clinic).
- Competitions can be organized inside the clinics.

Educational Materials

- Illustrative films for low level education audience
- Booklets
- Posters in areas surrounding the clinic
- Educational and promotional materials to be distributed at health units and pharmacies
- An information corner (already available) to be stocked with scientific books in all spheres that interest youth

Religious Lessons

- Coordination with religious figures to promote the clinics and provide correct information for visitors with their respective sermons

In addition to the aforementioned channels, peer educators developed tactics tailored for encouraging specific groups of potential beneficiaries such as people with low-no literacy skills, housewives, craftsmen and those at risk for HIV infection as injecting drug users and men who have sex with men. The working groups were divided by gender of participants. Female peer educators were more organized in discussions and the output. Males were creative in their suggestions but their output was not organized.

Box 1: Male Peer Educators Presentation

How to reach craftsmen, housewives, people with low-no literacy skills and those at risk of HIV infection

- Provide well-prepared TV and radio programs
- Screen films that contain accurate information about STIs
- Host sports and cultural days at the youth centers
- Conduct conferences and seminars at factories and schools
- Hold seminars for the craftsmen
- Develop billboards
- Promote the role of female clubs inside the youth centers
- Promote volunteer work
- Coordinate and network with the organizations that serve groups at risk for HIV infection
- Support community members capable of dealing with at risk populations
- Employ different visual methods to attract at risk groups
- Encourage at risk populations to visit YFC when they visit FP clinics
- Cooperate with health promoters in order to reach housewives
- Cooperate with the factory owners in order to conduct conferences inside factories

Box 2: Female Peer Educators Presentation

How to reach craftsmen, housewives, people with low-no literacy skills and those at risk of HIV infection

Craftsmen

- Cooperate with their syndicates to provide awareness conferences for them
- Create a partnership with social insurance to provide the needed support
- Develop peer educators among craftsmen capable of dealing with their colleagues

Housewives

- Pay house visits
- Provide health convoys
- Transfer information through the health units
- With the help of schools, information might be transferred through the parents committees. Mothers attend parents committees regularly, so it might be useful to transfer services through such meetings
- Through TV and media

People with Low-No Literacy Skills

- TV and radio
- Through FP Clinics

Those at Risk of HIV Infection

- Through the VCT
- Through the STI clinics
- Through pharmacies
- Through the gathering areas
- TV programs
- Conferences and recreational activities

2.3. Conclusion

Peer educators represent the main pillar of the YFCs. They are the main channel through which young people can be reached. They are efficient, reliable and fully aware of their communities. Thus, all their suggestions offered during the pre-testing of the in-depth interview guide were taken into consideration and they accompanied the interviewers during data collection to conduct the study. This helped interviewers avoid problems as the peer educators understand the idiosyncrasies of their respective communities. Furthermore, they had a holistic view towards the best channels and tactics for reaching potential beneficiaries and encourage them to visit the clinics.

Observation of peer educators during the workshop revealed that they worked in a comprehensive and integrated way; the females appear to be more disciplined and organized, while males seem creative and spontaneous. Such diversity is needed to enrich the clinics. Tailored trainings in the area of SBC can result in a cadre of peer educators capable not only of promoting youth-friendly services within their communities but also of transferring gained knowledge and skills to future generations, ensuring sustainability of established services.

3. IN-DEPTH INTERVIEWS WITH POTENTIAL BENEFICIARIES

In order to apply any communication intervention it is essential to know about the target groups, especially their knowledge, attitudes, behaviors, social networks, and risk settings in addition to barriers and opportunities to the intervention. Hence, the study team tried to diversify the interviewed youth. The main criterion for their selection was that they had never visited the YFCs. Other selection criteria included age (between 15 – 24 years), gender (male and female), education (high and low levels of education[4]). Within both governorates, one clinic exists in an urban setting and the other in rural environment. Accordingly, diversification of residence was achieved while conducting the interviews in the catchment areas of the clinics. In-depth interviews were conducted outside the clinics: in the streets, NGOs, youth centers, university and secondary schools.

3.1 Sample Description:

In-depth interviews were conducted with 60 potential beneficiaries in the catchment areas of the four YFCs in Ismailia and Menofia Governorates (two clinics in each governorate).The main characteristics of the sample interviewed were as follows:

3.1.1 Gender of Participants

The total sample surveyed was 60 persons (30 from each governorate); among whom 33 were males (17 from Menofia and 16 from Ismailia) and 27 were females (13 from Menofia and 14 from Ismailia). The sample was designed to have equal distribution based on gender. However, the work having been based within the youth center, mainly attended by males, it held that more males than females were interviewed.

3.1.2 Age Distribution

The target group was made up of individuals aged between 15-24 years. Table 3 shows that the majority of the sample (65.0%) was between 16-20 years of age.

[4] Community members with low level of education are defined according to this study as those who are out of school. They may either be illiterate or have the ability to read and write or have attained less than secondary education.

Table 3 Age Distribution of In-depth Sample by Governorate

Age (years)	Governorate		Total
	Menofia	Ismailia	
15	1	1	2
16	2	3	5
17	3	4	7
18	4	2	6
19	4	6	10
20	6	5	11
21	2	1	3
22	2	2	4
23	2	1	3
24	4	5	9
Total	30	30	60

3.1.3 Educational Status

The study team faced a major challenge in locating illiterate community members to interview in the catchment areas of the four clinics. Evidence from the literature review revealed that in the two governorates, the standard level of education is relatively high; 71.6% and 75.5% of the population over 15 years old are literate in the Menofia and Ismailia governorates respectively.[5] Almost half of the sample was among university education group. A quarter of the sample had received vocational education. Only four people interviewed were illiterate.

Table 4 Educational Level of In-depth Sample by Governorate

Educational Level	Governorate		Total
	Menofia	Ismailia	
Illiterate	3	1	4
Primary	2	1	3
Preparatory	4	2	6
Secondary	3	4	7
Vocational Secondary	5	10	15
Above intermediate	0	1	1
University	13	11	24
Total	30	30	60

[5] Egypt Human Development Report 2008.

3.1.4 Employment Status

This issue is very crucial as people acquire much information through their various work experiences. The in-depth interviews revealed that the type of information acquired differs among employed people versus unemployed groups. About one-third of the sample was unemployed (36.7%). Among the employed population, salespeople represented (20.0%) due to the targeting within the catchment areas of the four clinics where many vendors and salespeople are present. Salespeople reported that they find many obstacles to participating in any activity other than their jobs. Therefore, their contribution was important to investigate tailored tactics that can encourage them to visit and utilize YFCs. Interviewing salespeople presented another challenge to the study team as the shopkeepers were present and were not comfortable with much time being spent away from work. The sample also included vocational workers i.e. barbers, carpenters, etc. in addition to administrative and professional employees.

Table 5 Distribution of In-depth Sample by Occupation

Occupation	No.	Percent
Unemployed	22	36.7
Salesperson	12	20.0
Worker	4	6.7
Work in a factory	4	6.7
Secretary	3	5.0
Security	2	3.3
Driver	2	3.3
Barber	2	3.3
Supports father in work	2	3.3
Accountant	1	1.7
Teacher	1	1.7
Employee	1	1.7
Runs own business	1	1.7
Carpenters	1	1.7
Watch repair	1	1.7
Mattress makers	1	1.7
Total	60	100.0

3.1.5 Marital Status

Due to the age group targeted, the majority of the sample was single. In total, only three females were engaged and four people were married (two males and two females). The married individuals had vocational education. Consequently, all RH-related information garnered by the single individuals was derived from others' experiences, media and friends.

3.1.6 Socioeconomic Characteristics

This section aims at presenting a demographic and socioeconomic profile for the households within the sample which will provide decision makers with all essential information about the sample surveyed. This will facilitate development of communication strategies tailored to potential beneficiaries of different socioeconomic conditions.

Family Size

The size of the family is important in its relation to socio-economic status (SES). Low SES populations tend to concentrate primarily on survival. "As the size of the household becomes larger, the rate of poverty steadily and dramatically increases"[6]. It is understood that about a third of the households represented by the sample contained less than 6 people. This figure matches the low fertility rate in both governorates[7].

Table 6 Family Size of the In-depth Sample

Family size	No.	Percent
4	3	5
5	16	26.7
6	10	16.7
7	15	25
8	6	10
9	5	8.3
11	4	6.7
12	1	1.7
Total	60	100

[6] Nagi, Saad Z. "*Poverty in Egypt: Human Needs and Institutional Capacities*". Lanham Maryland: Lexington Books 2001.

[7] El-Zanaty, F; Hussein, Ann Way, *Egypt Demographic and Health Survey, 2005.*

Educational Status of Parents

It is important to measure education levels of parents, as they are associated with poverty[8], the life quality and the information they pass on to their children. Nearly one third of the mothers (38.3%) and one fifth of the fathers (20%) were illiterate. A quarter of the parents had received vocational education. Only (10%) of the mothers and (15%) of the fathers completed their university education.

Employment Status of Parents

The data revealed that most of the mothers (75.0%) were housewives and (20.0%) work as clerks, while all fathers were employed. This indicates that most of the sample surveyed were supported by males. Only two households were supported by females. About a quarter of fathers worked as craftsmen (i.e. carpenters, plumbers, etc.) while about (13.8%) worked as clerks.

Income and Poverty Level

Incomes and expenditures for individuals and for households are used as indicators of poverty in both absolute and relative terms. Expenditures are narrower in scope but are considered more reliable[9] .Poor health seeking behavior is associated in most of literatures with the poverty The poor often lack food, shelter, and high levels of education and health, which prevent them from leading stable and sustainable lives . They also face extreme vulnerability to ill health, economic dislocation, and natural disasters as well as exposure to ill treatment by institutions of the state and society. Often, these populations are powerless to influence key decisions affecting their lives. These are all dimensions of poverty[10].

Two questions garnered data about income, asking about amount and stability of income per month. Information about income is still unreliable in Egypt, as *"I don't know"* is a common response. It was difficult to procure an accurate figure pertaining to household income. The data revealed that about (58.3%) of the sample earned between 500-1500 EGP. The average of income was 1393.40 EGP and the mode value was 1000 EGP.

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[8] Ramdan, M., Hamed, *"Social Contract Survey"* – Egypt 2005, Social Research Centre

[9],[10] Nagi, Saad Z.. "*Poverty in Egypt: Human Needs and Institutional Capacities".* Lanham Maryland: Lexington Books 2001.

Table 7 Distribution of Household Income of In-depth Sample by Governorate

Income groups	Governorate		Total
	Menofia	Ismailia	
Less than 500 EGP	10.0%	0%	5.0%
500- Less than 1000 EGP	26.7%	33.3%	30.0%
1000- Less than 1500 EGP	20.0%	36.7%	28.3%
1500- Less than 2000 EGP	13.3%	3.3%	8.3%
2000- Less than 3000 EGP	10.0%	3.3%	6.7%
More than 3000 EGP	10.0%	10.0%	10.0%
Don't know	10.0%	13.3%	11.7%
Total	100.0%	100.0%	100.0%

Regarding the stability of income, 58.3% of the total sample surveyed reported stability of income. The proportion of stability of income in the governorate of Menofia (73.3%) was higher than in Ismailia (43.3%). Regardless of the type of work, whether craftwork or vocational work, the interviewees estimated their income earned by month. The ability to cull such information is an indicator of the trust achieved between the interviewees and the data collectors accompanied by the peer educators (who live in the same governorate and know how to acquire the trust of potential beneficiaries).

Expenditures of Households

Data on expenditures was gathered through a direct question about the total expenditures. Accuracy of reporting was most likely due to the follow-up questions pertaining to household expenditures and, in the case of any discrepancy; the interviewer would inquire further for clarification. All interviewees shared such information about their expenditures save for one person who insisted that expenditures were greater than his income. The data collected revealed that (61.6%) of the sample spent between 500-1500 EGP per month. The average was 1084.1 EGP and the mode value was 500 EGP. These figures were consistent with reported income.

Table 8 Distribution of Household Expenditures of In-depth Sample by Governorate

Expenditure Groups	Governorate		Total
	Menofia	Ismailia	
Less than 500 EGP	13.3%	6.7%	10.0%
500- Less than 1000 EGP	26.7%	50.0%	38.3%
1000- Less than 1500 EGP	23.3%	23.3%	23.3%
1500- Less than 2000 EGP	16.7%	3.3%	10.0%
2000- Less than 3000 EGP	6.7%	13.3%	10.0%
More than 3000 EGP	3.3%	3.3%	3.3%
Don't know	10.0%	0%	5.0%
Total	100.0%	100.0%	100.0%

Conclusion

All above-mentioned information indicate that the sample was representative of different social groups (based on educational, employment and income conditions). Such diversity will be reflected in the data provided regarding social networks, RH information and proposed channels/tactics to encourage young people to utilize YFCs.

3.2 Social Networks

Humans cannot live without social interaction. In most of the cases, human beings live in an environment of friends, relatives and neighbors. Mutual interest might have an influence in such relations. Figure 1 shows the social networks of young people.

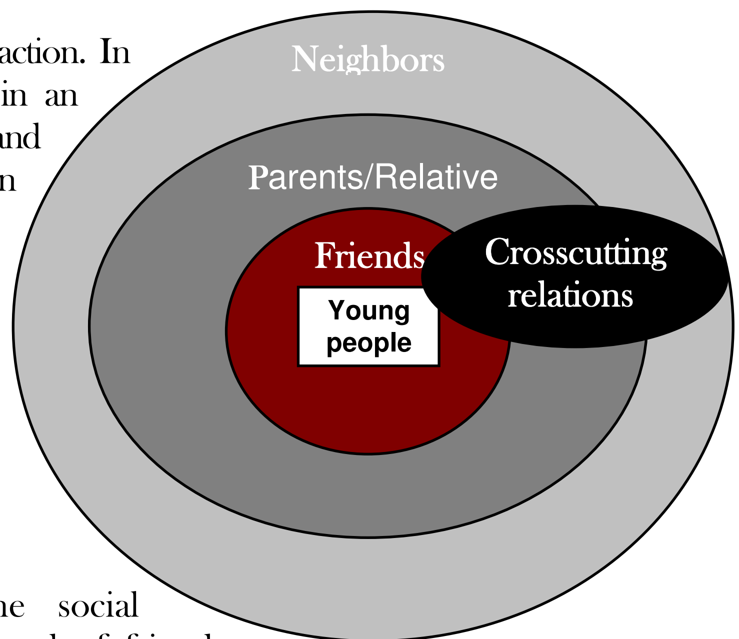

Figure 1 Social Networks of Young People

3.2.1 Friends

The first crucial circle within the social networks of young people is composed of friends.

Based on the responses of the sample surveyed, young people have stronger relationships with friends than with parents, neighbors or relatives. *"My friend*

is my soul mate," said more than one interviewee. All types of activities are practiced or shared with friends, especially among males. Additionally, a friend may also be a relative or a neighbor.

Friends are appreciated for different reasons: loyalty, honesty, confidentiality, religious advice, courage, sense of humor and intelligence. All these characteristics instill within young people feelings of safety and security in addition to providing an outlet for amusement and enjoyment

Friends serve as the cornerstone within the social networks for many young people. All activities are done with friends: going out to different places (clubs, gyms, cinemas, cafes, conferences, parties, etc.), watching TV, studying, playing games and chatting. The last activity is very crucial when analyzing the passage of information between friends including health information, in addition to religious, cultural, sports-related, political, scientific, social, economic and artistic information. The information provided by friends is considered trustworthy and reliable as (70.2%) of the sample surveyed reported that they rely on and trust information from their friends. *"I fully trust my friend. He is educated,"* said one educated male in Menofia. Less than (30%) reported that they do not trust information provided by friends. *"No, I can't trust him, I don't know about his intentions. I should see by myself,"* stated an uneducated male in Menofia.

3.2.2 Parents/Relatives

The second circle of the social relationships includes parents and relatives inside and outside the household. The in-depth interviews reinforced what peer educators stated regarding the role of parents in the lives of potential beneficiaries. Parents play a crucial role in shaping their attitudes and transferring norms and traditions to them. However, parents consider SRH issues taboo and do not discuss them with their children (save for before wedding night). Furthermore, adolescents have an increased sense of autonomy. Relatives include brothers, sisters, in-laws, spouses and other members of the extended family. The strength of the relationship varies according to feelings of closeness and an understanding of young people. Some constraints related to the age and distance stand against full acceptance of relatives as part of the close community. However, for unemployed females, the family is the main social circle. As these women are not allowed to leave the arena of the home as often as men, mothers, sisters and/or sisters-in-law are very close. A young girl might acquire lots of information from adult sisters and sisters-in-laws. Most of the respondents reported accompanying

sisters or sisters-in-law to reproductive health units, which could account for the RH information they have.

3.2.3 Neighbors

Neighbors form the last circle of relations[11]. The relationship might differ from feelings of brotherly closeness to no relationship at all. Neighbors may be relatives or friends. Some people refuse to be in contact with their neighbors at all, while others do many activities with them. Young people might visit their neighbors occasionally for social events such as funerals, weddings etc. Young people might also participate in recreational activities with their neighbors (i.e. playing games and sports, going outside, taking trips and chatting). Through chatting, they exchange information about religions, domestic affairs, health, work, sport, culture, marriage problems and scientific issues. The reliability of information acquired from neighbors is not high. About (63.2%) of the respondents in Ismailia and (40%) of the respondents in Menofia reported that the information from neighbors is not reliable. The credibility of information is due not to being a neighbor but, in most of cases, due to another type of relationship. "*They are my neighbors and relatives, we brought up together. They are my best friends,*" reported an educated female in El Bagour, Menofia. Another illiterate female in El Mabara, Ismailia reported that, "*They will never provide good information. They push me to do wrong. Their information might be misleading.*"

The above-mentioned opinions generally matched the comments of peer educators during the participatory workshop: that is, the relationship with neighbors now is declining since people now try to avoid having deep relations with their neighbors.

3.3 Norms and Traditions

Participants of FGDs conducted in late 2007 who were familiar with YFCs, whether or not regular attendants, stated that community norms and traditions prevent single young men and women from utilizing YFCs. Therefore, it was crucial to discuss this issue with those who have never been to the YFCs in order to highlight the impact of norms and traditions on influencing the willingness of the potential beneficiaries to visit the YFCs.

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[11] Neighbors might be those around the house or in the work area for street community (shopkeepers, vendors and sales people.

The points that were discussed were as follows:

- Traditions affecting males and females as regards education and work, mobility, and activities
- Traditions related to FP
- Traditions related to seeking health care
- Traditions related to exchange of sexual information

3.3.1 Traditions Affecting Males and Females As Regards Education and Work, Mobility and Activities

Regarding the aforementioned items, the sample surveyed reported that there were no perceived differences between males and females. That was an indicator that the young people were not aware that the practices of discrimination against females are not defined as inequity. The detailed results per topic discussed are as follows:

Differences in Education and Work

The sample surveyed reported that there were no gender-related differences as regards education. These views are consistent with the 2008 Egypt Human Development Report that reported a low gap in education between males and females in the two governorates. One of the interviewees reported, "*Girls are educated but males drop out to be able to work.*" Another interviewee reported that females are allowed to be educated up to vocational secondary school but not permitted to continue on with a university education; however the males should continue university education to find a job.

Regarding job opportunities, they are rare for both males and females. However, finding a job is easier for females than males since they accept working as salespeople and in other low-income jobs.

Differences in Mobility

This issue is very important as engaging in outdoor activities may enrich the experiences of young people and widen their scopes of interest. The sample surveyed agreed that females and males both spend time outside of the home. However, females should not stay outside after 10.00 p.m while males can even stay outside their homes even overnight. Males are permitted to go almost everywhere. Females are not allowed to go to "Youth Centers." The Arabic wording for youth center is "*markaz el shabab* "translated as "center for young males," which does not encourage females to use the space. Furthermore, respondents revealed that most of youth centers lack female special activities and that harassment of females occurs there often.

The most important issues related to mobility are parents refusing to allow single females to access YFCs and unwillingness of single males to visit the YFCs. These sentiments parallel the participants' feedback during the FGDs conducted in late 2007 and they justified both refusal and unwillingness of the YFCs to be identified as for a provider of FP and ANC services. Norms and traditions restrict access to places responsible for delivering FP and ANC services (regardless of other services offered), to married women (or those people in their company) only. Both single males and females might be stigmatized if they access the YFCs.

Regarding the attendance of conferences and seminars, most of the sample agreed that males and females exhibit no difference. One interviewee even reported that women are more eager to acquire information; therefore, more women might attend the seminars. However, though the seminars may last until the evening, few of them reported that only males would be permitted to attend.

Differences in Activities

Regarding activities, the sample agreed that the males are allowed to participate in outdoor activities e.g. playing football, swimming, going to the gym or to cafes, traveling, etc. while females are not allowed to engage in many outdoor activities. This indicates that the females have less ability to acquire information through outdoor activities such as participating in sports competitions or trips. Tailored strategies for women should focus on indoor activities like reading, watching TV, listening to the radio or chatting with friends, neighbors or relatives in addition to creating safe spaces for girls who have been excluded from public spaces for historical and cultural reasons.

3.3.2 Traditions Related to Family Planning

"Contraceptives are the responsibility of women," is a general statement used by the sample interviewed regarding prevalent traditions. Participants of FGDs conducted in late 2007 mentioned the same statement and revealed that as contraceptives are associated with married women; young single males and females are unwilling and prohibited respectively to go to YFCs known in the surroundings for delivery of FP and ANC services.

The interviewees also agreed that condoms are not welcomed in the community, as they are associated with illegitimate sexual relations to avoid pregnancy and STIs.

Additionally, married men do not feel comfortable using condoms and believe they are expensive and ineffective as a contraceptive method especially condoms of bad quality.

The potential beneficiaries refer to condom by the prophylactic brand name "Tops." These responses echo those mentioned by peer educators during the participatory workshop. They agreed on the bad reputation of the condoms which affects the willingness of young people to buy them.

3.3.3 Traditions Related to Health Care Seeking

Potential beneficiaries seek health care through the following channels:

- Public hospitals, which offer suitable care for a low price. However, some people reported that these hospitals are more likely to be barns ("zeriba").
- Private doctors, who provide better service of good quality.
- Health centers ("mstawsaf") because the public hospitals are untrustworthy.
- School health insurance, which is suitable and accepted due to its low cost.
- For addicts, there is a hospital that provides health care (Fever Hospital in Menofia Governorate)
- FP clinics, to receive services related to reproductive health.

3.3.4 Traditions Related to Exchange of Sexual Information

The study team tried to investigate this topic based on gender of interviewee on two levels. The first was by asking a direct question about the ability to discuss sexual issues and the second was discussing sexual issues with the interviewers themselves. Furthermore, a female interviewer had to conduct eight interviews with males. Strangely enough, female interviewees did not speak freely with the female interviewers. On the other hand, males spoke freely with the interviewers regardless of their gender. Most of the male sample (68.3%) and nearly one third of the female sample (38.3%) reported that they can discuss sexual issues with their friends. This reflects what was previously mentioned by peer educators during the participatory workshop. Peer educators clarified that the potential beneficiaries are not allowed to talk about such issues with parents/relatives, as the culture of community is named after *"the culture of silence".* This title is a reflection of an avoidance of discussing such issues.

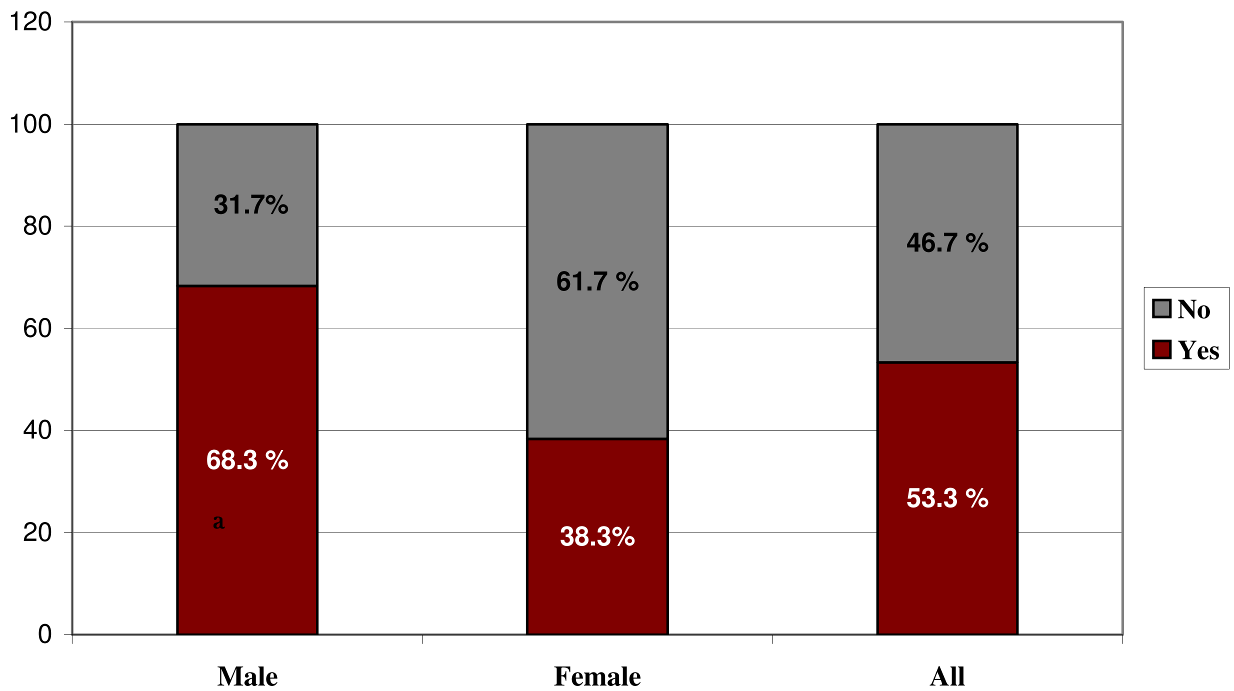

Figure 2 Discussion of Sexual Issues with Friends by Gender of Interviewees

The sample surveyed revealed the following about exchange of sexual information:

- Young people discuss such issues out of curiosity. *"People watch lots of hot scenes on TV and the internet, so they feel curious to talk more about,"* said an educated male in Ismailia.
- Females seek sexual advice from sisters and in-laws regarding marriage and the nuptial night.
- Spouses discuss sexual issues more than other social groups, followed by friends.
- Some interviewees reported that parents can't discuss such issues with their children. A day before the wedding day, mothers might pass some information to their daughters and fathers might do the same with their sons.
- Some adults don't discuss these issues with young people, lest they attempt such practices out of curiosity. For instance, when people discuss masturbation or drugs, young people might try drugs or masturbating in order to know more about these practices.
- Discussions among friends are most likely to be about sharing experiences or advice, entertainment or solving problems.

- Sexual issues are mostly discussed in the form of jokes. In some few cases, scientific information and advice is presented.
- In-depth interviews revealed that most SRH information understood by potential beneficiaries was not accurate or was misleading, except for the protective role of condoms in illegitimate sexual relations. "*We advise our friends who might have sexual relations to use condom in order to protect themselves from potential diseases and avoid pregnancy,*" uneducated male in Ismailia.
- Discussions were saturated with the use of slang language (i.e. prostitute, etc.). The discussions were likely to portray sexual relations crassly and not necessarily provide useful information.

The traditions related to the exchange of sexual information are crucial in determining how to hold SRH lectures/sessions/seminars; to what extent would the community accept such talks? The sample surveyed reported that it is socially unacceptable ("*eib*") to conduct such lectures. More than half of female and male interviewees, (59.3%) and (54.5%) respectively, reported that it is unacceptable to discuss such issues in lectures.

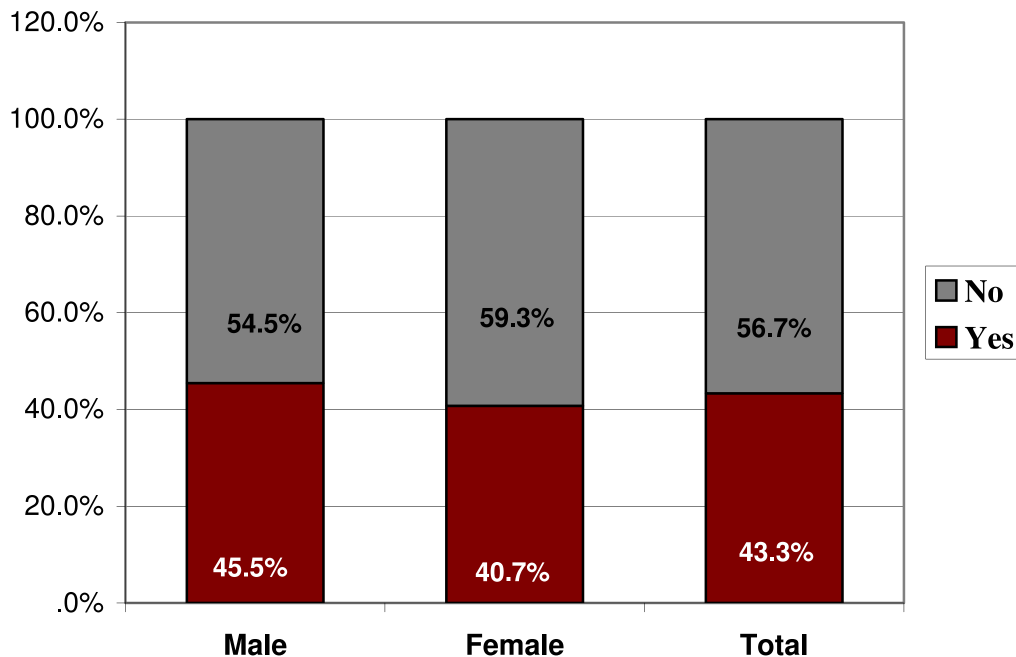

Figure 3 Acceptance of Discussion of Sexual Issues in Lectures among Potential Beneficiaries by Gender of Interviewees

3.4 Sexual Behavior

This issue was too sensitive to discuss with most of the sample surveyed. However, many agreed that men are free to engage in any sexual relation they want. One of the illiterate females in the Ismailia Governorate reported, *"A boy can have affair with hundreds of girls. No problem for him. However, if the girl tried to do the same she would be scandalized."* This is consistent with the peer educators report from the participatory workshop.

Regarding the practice of masturbation, the sample agreed that males are more likely to masturbate. Most of the male sample (72.7%) and nearly half of the females (43.5%) reported that masturbation is widespread more among males, "*as they need more for sexual satisfaction,"* according to an educated male in Ismailia. On the other hand, only (9.1%) of male sample and (4.3%) of female sample reported that masturbation is widespread more among females. "A *girl tries to satisfy herself sexually by doing that but the boy can have an affair in full sexual relation,*" said an educated female in Menofia. It is also worth mentioning that (43.5%) of the female sample reported that they know nothing about masturbation, which might be interpreted as an information void or refusal to talk about this issue.

More than half (60.7%) of the total sample surveyed reported that masturbation is more common among males due to the following:

- The need to sexually satisfy themselves
- As an act of imitating for the his friends
- A decline in rates of marriage
- Watching sexual materials
- Lack of religious awareness
- To be sure about sexual efficiency
- The types of clothes women wear

On the other hand, only (7.1%) of the sample surveyed reported it is more common among females due to the following:

- The desire is greater in females than in males
- Men can have sexual relations but females cannot

"*Masturbation is the first step to the sexual relation,*" was considered true by the majority (80.4%) of the sample surveyed due to the following reasons:

- It might increase sexual desire
- Masturbation is not sufficient to fulfill sexual needs

However, the remainder of the sample (19.6%) reported that it cannot lead to full sexual relations since it reduces sexual efficiency and might be so satisfying that a person might not get married.

The sample surveyed agreed that individuals who masturbate are unsavory. "*Such a person is rubbish, disgusting and rotten,*" said an illiterate male in Menofia. None of the female sample reported practicing masturbation while about half of the male sample surveyed reported that they practiced it owing to the following reasons:

- Sexual desire as a result of TV programming
- To satisfy himself
- "Normal" people should practice it
- Just to try it
- In order not to engage in illegitimate sexual relations

Those who never practiced masturbation reported the following reasons to avoid such a practice:

- It is harmful
- There is no need for such practice
- It is a sin ("haram")
- Feelings of disgust
- Never watching porno movies
- Does not know how to masturbate

As to the possible hazards of masturbation, some of the male respondents listed reduced visual acuity and weakness, followed by reduced sexual vitality, syphilis infection then sterility. A small number of female respondents listed reduced sexual vitality, followed by sterility then loss of virginity.

The interviewees agreed that romantic relations are the most common relations among young people. This was contributed to several reasons. Most of the targeted age group were students who preferred romantic relations not sexual ones. It is also socially unaccepted to have pre/extramarital sexual affairs and females are concerned about their virginity, which they might lose due to the sexual relations. However, it is worth mentioning that the service providers interviewed in the YFCs Baseline Survey conducted in late 2007 reported that some young females come to the clinic to check on their virginity, which might indicate engaging in illegitimate sexual relations.

The sample surveyed was inclined to label people who practice abstinence favorably, as suggested by the following quote: *"He is respectable, decent and*

honorable person." Some of the interviewees reported that abstinence is not realistic due to the lower rates of marriage and higher rates of poverty. *"Only 1% is abstinence and the rest are rubbish since the community itself is naked now. Everything is available, do whatever you want no one would blame you,"* said an educated male in Ismailia to a female interviewer. One of the key informants in Ismailia who talked freely about all issues reported that such person (the abstinent) is idiot and he will not do well after marriage. Indeed, such a say was used before in many movies, which have a real influence on the perception of community.

3.5 Entertainment

"Leisure serves an important function in the psychological development of adolescents and is an avenue through which important values such as teamwork, responsibility, and creativity are acquired"[12]. Young people engage in various activities to entertain themselves; some of these activities are socially accepted, while others are not. This section aims at describing such activities in order to find the best channels to provide SRH information and promote utilization of YFCs (e.g. if most of young people prefer to read, providing reading materials about SRH will be useful). Table 9 shows the most common activities practiced among the sample surveyed. The activities vary significantly by gender: males practice more outdoor activities while females practice more indoor activities (under the influence of gender norms and traditions). Hence, channels of communication and tactics for promoting YFCs should be tailored according to gender. About (42.3%) of females spend their leisure time reading versus (21.9%) of males. Nearly half of males interviewed (46.9%) played football in their leisure time. Watching TV was reported more among females (34.6%) whose outdoor mobility is limited compared to males.

Spending time (wrestling, running and playing football) at the youth center is a primarily male activity. In addition, men might attend seminars, read or study. Women rarely go to the youth center as the Arabic translation for the youth center is "*markaz el shabab* " or "center for young males" which does not encourage females participation. Furthermore, respondents revealed that most of youth centers lack female special activities and that harassment of females often occurs.

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[12] El Tawela,Sahar. *Transition to Adulthood, A national Survey of Egyptian Adolescents*. Population Council- Regional Office for West Asia & North Africa. Social Research Center – The American University in Cairo 2000.

Table 9 Distribution of Type of Activities by Gender of Interviewees

Type of Activity	Gender		Total
	Male	Female	
Reading	7	11	18
Walking around	9	7	16
Internet and chat	12	4	16
Play Football	15	0	15
Watching TV	5	9	14
Computer	7	5	12
Drawing	5	5	10
Visiting relatives/neighbors	4	5	9
Practicing sports	6	1	7
Play station	6	0	6
Go to youth center	4	1	5
listen to radio	1	4	5
Trips	1	3	4
Play cards	1	1	2
Other	5	9	14
Nothing	0	1	1
Total (multiple responses)	88	66	154

By analyzing the list of activities, it is understood that some activities can be completed indoors while others take place outdoors. Male activities are more likely to take place outdoors while females usually remain indoors. Men participate in more activities than the women, particularly those activities related to sports. Most of unemployed females can only watch TV or chat with friends or neighbors. Most of the above mentioned activities could be done individually or with friends. Watching TV is generally experienced with family members.

Reading is one of the important activities that was further explored. Through a direct question about reading most (80%) of the interviewees reported that they read particularly females, though some reported, "*Reading is boring,*". However, the type of reading materials and frequency with which they read served as other indicators. Table 10 shows that the most favorable materials are the religious books (65.2%) of females and (41.70%) of males reported reading religious works. Almost half of the sample surveyed reported reading novels and poetry. Females were more interested in scientific issues (34.8%)

than males (16.7%). Males were more apt to read newspapers. Regarding health materials only one female reported that she read about health issues. Accordingly, to encourage young people to read about health issues, the materials should be developed in a creative medium, such as a novel or a poem, be culturally sensitive and include sections on religious perspective.

Table 10 Distribution of Reading Materials by Gender of Interviewees

Type of Reading Materials	Gender		Total
	Male	Female	
Religious books	10	15	25
Novels	12	12	24
Scientific books	4	8	12
Newspaper	6	0	6
Magazines	3	2	5
Cultural books	1	4	5
Sports books	3	1	4
History	1	1	2
Political books	0	2	2
Cooking books	0	1	1
Health books	0	1	1
Total (multiple responses)	40	47	87

As per the frequency of reading, very few of the sample reported that they read every day (newspapers and Holy Quran), others reported that they read every week, month, or during vacations. Others reported that they read infrequently. The reasons mentioned for reading were related to entertainment and fun. Few reported that they might benefit from these books.

3.6 Information about Family Planning, HIV/AIDS, Sexually Transmitted Infections and Risky Behaviors

Making FP, STIs and HIV/AIDS information available is one of the main objectives of the YFCs. Hence, the study team focused on available information and misconceptions, in addition to risky behaviors and sources of

information, in an effort to identify information gaps and methods for addressing them.

3.6.1 Family Planning

The interviewees suggested that within marital relationships women are responsible for using contraceptives. This was considered a community tradition. A male uses contraceptive methods only if his wife is sick or he is pursuing an illegitimate relationship. The types of contraceptives that can be used by females include the intrauterine contraceptive device and the pills. Condoms are linked with illegitimate relations. Thus, males feel embarrassed to buy them ("*eib*"). Condoms are available at pharmacies, hospitals and reproductive health units at affordable prices (1.5 EGP-10 EGP).

These finding parallel the information offered by participants in the FGDs in late 2007 and the peer educators during the participatory workshop.

3.6.2 HIV/AIDS

The topic of HIV/AIDS was covered thoroughly through a group of questions as follows:

Methods of Infection

The main channel of infection reported was illegitimate sexual relations, followed by coming in contact with contaminated blood. The third channel reported was the use of contaminated syringes. Transmission from infected mother to baby was mentioned by few. Young people reported false misconceptions related to contracting HIV/AIDS such as contact with an HIV-positive individual belongings, flies, exposure to sneezing and coughing, etc.

Correction of misconceptions and provision of accurate HIV/AIDS-related information represents a missed opportunity that necessitates tailored approaches. Linking HIV infection mainly to illegitimate sexual relations will eventually result in stigma and discrimination against those affected, in addition to overlooking the possibility of infection being transmitted by an unfaithful partner within a marital relationship.

Table 11 Reported Methods of HIV/AIDS Infection by Gender of Interviewees

Methods of Infection	Gender		Total
	Male	Female	
Illegitimate sexual relations	27	25	52
Contaminated blood	12	11	23
Contaminated syringe	7	9	16
Using an HIV-positive individual's affects (plates, clothes)	5	7	12
Drugs through injections	5	6	11
A mother can infect the fetus	2	3	5
Cough and sneezing	1	1	2
Saliva	1	0	1
Working in dirty places (waste collectors)	0	1	1
Through having cancer	0	1	1
Through monkeys	0	1	1
Flies	1	0	1
Polluted environment	0	1	1
Using polluted tools (blade)	0	1	1
Don't know	0	1	1
Total (Multiple responses)	61	68	129

Manifestations of HIV-positive Individuals

Nearly one third of the male sample (37.5%) mentioned that a person who is HIV positive appears "normal" versus only (3.7%) of the female sample. Some interviewees reported exhaustion and weakness as the main manifestations, in addition to change of skin color.

Differences between HIV-positive Individuals and AIDS Cases

More than half of the female sample surveyed listed differences between the HIV positive individuals and AIDS cases versus nearly one fifth of the male sample. It is worth mentioning that most of those who reported differences existing between HIV-positive individuals and AIDS cases could not pinpoint them; indicating that the information they have is inaccurate.

Manifestations of AIDS Cases

More than half of the female sample (55.6%) and one third of the male sample (31.2%) replied that they did not know what symptoms manifest themselves in AIDS cases.

Weakness and weight loss were listed by nearly one quarter of the sample. Other manifestations reported included coughing, stomachache and diarrhea.

Stigma

The entire sample agreed that HIV-positive individuals and AIDS cases were not welcomed in the community. One respondent reported that one of his neighbors was HIV-positive, *"He closed his workshop, waiting for death in his house. No one wants to deal with him."* Avoiding contact with HIV-positive individuals and AIDS cases was listed as a method of prevention of infection by (15.6%) and (29.6%) of interviewed males and females, respectively.

Prevention

The sample surveyed reported many methods for preventing HIV infection. Abstinence was mentioned by most of the interviewed sample: (78.1%) of males and (70.4%) of females. Condoms were mentioned by only (9.4%) of the male sample versus none of the females.

Fear of HIV/AIDS

Most of females (77.8%) experienced feelings of fear of HIV/AIDS versus only (59.4%) of males. Fear of HIV/AIDS is a "normal" feeling associated with the adolescence, regardless of whether or not adolescents are engaging in risky behavior.

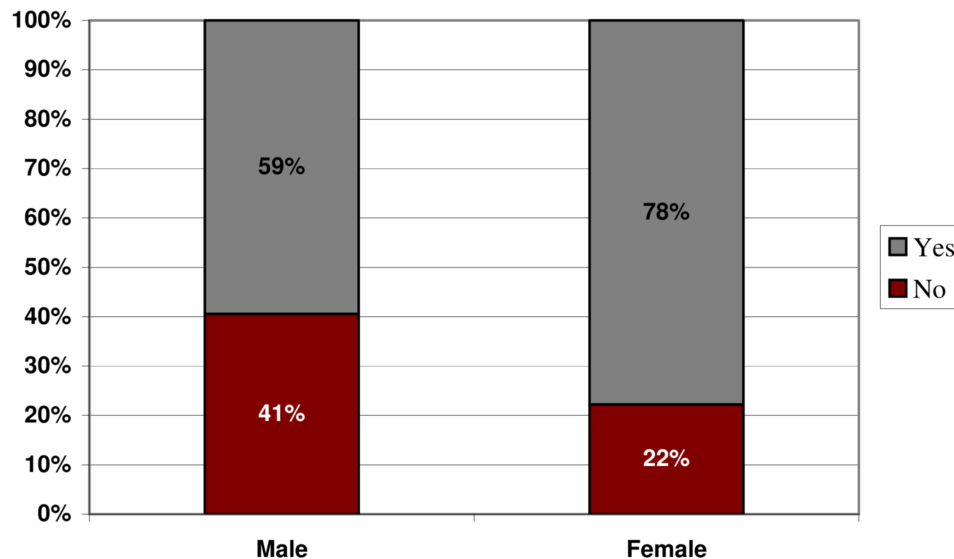

Figure 4 Fear of HIV/AIDS by the Gender of Interviewees

Perceiving HIV/AIDS as a Threat

To gain more insight into how potential beneficiaries perceive their vulnerability to HIV infection, a question about perceiving HIV/AIDS as a threat was used. The majority of the sample (98.3%) reported that HIV is not a threat for the following reasons:

- Not dealing with patients
- Not having any sexual relations
- HIV is uncommon in the community
- It is curable
- Not going to the communities notorious for the high rate of infection

The remainder of the sample (1.7%) reported that HIV/AIDS is risky for the following reasons:

- It is an infectious disease
- It is not curable and causes death

Consequences of HIV Infection

The sample surveyed reported many consequences of HIV infection. Death was the main consequence noted followed by different types of social and economic problems as listed below.

- Death
- Destruction of the lives of others
- Psychological problems
- Social problems
- Loss of employment
- Family problems (infection of family members, divorce, etc.)
- Health problems
- Causes sterility in women
- Causes paralysis
- Affects the ability to have sex

3.6.3 Sexually Transmitted Infections

The study team agreed that the discussion about STIs with the interviewees would focus on their actual observations of someone who was infected with an STI concentrating on possible causes, manifestations, seeking health care and consequences rather than listing irrelevant names and manifestations (a tactic utilized previously with the participants of FGDs conducted in late 2007). This decision was also supported by the peer educators with whom the in-depth interview guide was discussed during the participatory workshop and from whom feedback was garnered regarding STIs knowledge among the potential

beneficiaries. Nearly one-tenth (8.3%) of the male sample surveyed reported that they knew someone who was infected with syphilis but did not mention observed manifestations or consequences owing to:

- The sensitivity of discussing such issues with the affected.
- Feelings of embarrassment in discussing such issues.
- Individuals with STIs fear people might make fun of them.

As to health care seeking, the infected persons sought treatment at hospitals, with private doctors and from pharmacies in order to receive the appropriate medication.

3.6.4 Risky Behaviors

Illegitimate Sexual Relations

The participants mentioned illegitimate sexual relations between males and females, particularly sex workers, as a risky behavior. Homosexuality was mentioned not as illegitimate sexual relation, but as abnormal relation. In both cases, the respondents mentioned that condoms should be used.

Addiction

The interviewees reported that addiction as a risky behavior was common in most of their neighborhoods among the craftsmen, university students and the unemployed. The most common drugs were hash, followed by marijuana and injections. The information related to drug addiction was consistent with what was revealed by the participants in FGDs conducted in late 2007 and the peer educators during the participatory workshop.

3.7 Sources of Information

The interviewees were asked to list the sources through which they usually acquire their information in general. TV was listed as the first source of information (40.6%) for males versus (55.6%) for females, followed by books (31.2% of males versus 55.6% of females). Other sources listed were doctors, internet resources, friends and attending conferences with slightly higher share among females. The observed gender differences coincided with the restricted mobility of females as compared to males and their reliance on indoor activities as sources of information. Sources of SRH information of interviewee were further investigated according to the type of information as illustrated in Table 12.

Table 12 Sources of Sexual and Reproductive Health Information of Interviewees According to Type of Information

Type of Information	Source of Information			
	Social Networks	Media	Printed Materials	Others
HIV/AIDS	▪ Friends ▪ Parents	▪ TV/Radio ▪ Commercials ▪ Magazines & Newspapers	▪ Books	▪ Internet ▪ Conferences ▪ School ▪ Doctors ▪ Hospitals ▪ Patients
Sexual Relations	▪ Friends ▪ Sisters ▪ In-laws	▪ TV/Radio ▪ Commercials ▪ Magazines &Newspapers	▪ Books	▪ Internet
Masturbation	▪ Friends ▪ Neighbors ▪ Fiancé	▪ TV/Radio		▪ Internet ▪ Conferences
Addiction/Drugs	▪ Friends			▪ Observing surroundings
STIs	▪ Friends ▪ Sisters ▪ In-laws		▪ Books	▪ Doctors ▪ Pharmacy
Condoms	▪ Friends ▪ Sisters ▪ In-laws			▪ Doctors ▪ Pharmacy

Further discussion with the interviewees revealed the following:

- Currently, STI-related messages conveyed through TV films were inaccurate and focus on consequences such as death and loss of employment. "Love in Taba" and "Red Agenda" are two movies from which many people acquired inaccurate information about HIV/AIDS and STIs.
- Information about the red ribbon and AIDS hot-line was mentioned by one of the interviewees as acquired through TV.
- A pharmacist is a very important source of information about STIs and condoms since many people feel embarrassed to seek health care else where.

- The majority (87.9%) of the sample surveyed reported that they can receive health information from school and that they might rely on such information being accurate and provided in a decent way.
- The remainder (12.1%) stated that schools are useless sources of information since the information provided is inaccurate or manipulated.

The perception of potential beneficiaries towards listed sources of SRH information was further investigated as revealed in the table below.

Table 13 Perception towards Different Sources of Sexual and Reproductive Health Information[13]

Radio	TV	School	Printed Materials
	Pros		
▪ Provides accurate information ▪ Large audience	▪ Provides accurate information ▪ Presents the opinion of famous doctors ▪ Extremely large audience, including illiterate individuals	▪ Provides accurate information ▪ Much time is spent in school	▪ Provides accurate information ▪ People enjoy reading
	Cons		
▪ Decline in audience		▪ Schools are worthless now	▪ People do not enjoy reading ▪ People do not buy printed materials ▪ People prefer TV

[13] The perception of friends as a source of SRH information was investigated before while discussing friends as a component of the social network.

Interviewees were then asked to suggest methods to improve the efficiency of the sources of SRH information. Their suggestions are revealed in table 14.

Table 14 Methods for Increasing the Efficiency of the Sources of Sexual and Reproductive Health Information Suggested by Interviewees[14]

Radio	TV	School	Printed Materials
▪ Present famous doctors ▪ Campaigns dedicated to raising awareness ▪ Develop high quality, creative programming ▪ Increase religious programs	▪ Present famous doctors ▪ Develop high quality, creative programming ▪ More commercials ▪ Campaigns dedicated to raising awareness ▪ Prevent sexual shoots ▪ Increase useful soap operas ▪ Increase religious programs ▪ Health commercials should be broadcasted all day long, mainly on satellite channels .i.e. Dream, Rotana, Iqraa, Cairo Cinema and local channels ▪ Clear simple messages focusing on STIs and HIV/AIDS should be developed by media experts	▪ Campaigns dedicated to raising awareness ▪ Organize conferences ▪ Provide scientific books	▪ Reading campaigns dedicated to raising health awareness ▪ Publish more attractive articles about health issues in newspapers and magazines ▪ Reduce the prices of printed materials ▪ More advertisement about health issues in newspapers and magazines ▪ Pay more attention to printed materials tailored to young people

[14] The role of friends as a source of SRH information was investigated before while discussing friends as a component of the social network.

Further discussion with the interviewees regarding different sources of information revealed the following:

Religious Leaders:
The absence of the mention of religious leaders as sources of SRH information was further investigated with the potential beneficiaries. The majority (98.5%) of the sample surveyed reported that they accept receiving information from religious leaders, particularly religious, cultural, scientific and social information. Most (80.4%) of the sample reported that they rely on the information provided, while only (8.5%) reported that credibility of the information depends on the religious leader who delivers them. Regarding health information, (72.9%) of the sample reported that religious leaders might present health information as such information will be useful. They may also provide opinions regarding the religious aspects of such information. However, about a quarter of the sample surveyed reported that they can't rely upon religious leaders to provide health information since they are not health specialists.

3.8 Advocacy of Youth Friendly Clinics

The over all goal of this assessment was to address the reasons for not going to the YFCs among the potential beneficiaries in the catchment areas of the 4 YFCs in Ismailia and Menofia governorates , and, in turn, to develop strategies to promote them. It is worth mentioning that one of the major roles of YFCs is to provide accurate information and correct misconceptions related to SRH and HIV/AIDS. Therefore, discussion with the interviewees also focused on the best channels/tactics for providing information about SRH and HIV/AIDS.

Accordingly, the following sets of questions were discussed with the potential beneficiaries:

- Specify influential organizations/persons who can work as advocates for youth-friendly clinics providing SRH and HIV/AIDS information and services.
- What advocacy activities can the above specified organizations /persons do to promote youth-friendly clinics?
- Are you willing to work as a peer educator? Where are the best places to offer peer education?

Discussion of the aforementioned topics with the potential beneficiaries revealed the following:

3.8.1 Influential Organizations/Persons Who Could Work as Advocates of Youth-Friendly Clinics

The sample surveyed recommended many types of organizations/persons to advocate YFCs. The results revealed no gender difference. However, differences between governorates were observed. Hence, ranked results will be displayed by governorate. As revealed in table 15, potential beneficiaries in Ismailia suggested that the most effective advocates for YFCs should be doctors followed by MoH, NGOs, and then the Ministry of Mass Communication.

Table 15 Suggested Organizations/Persons by Interviewees to Advocate for Youth Friendly Clinics in the Ismailia Governorate

Organization/Persons	No. of respondents
Doctors	12
Ministry of Health (MoH)	8
NGOs	7
Ministry of Mass Communication	5
Youth	4
Health Unit	3
Parents	3
Youth Center	3
FP Clinics	1
Teachers	1
Religious Leaders	1
Friends	1
Brothers/Sisters	1
Social Workers	1
Hospitals	1
Total (multiple responses)	52

As revealed by table 16, potential beneficiaries in Menofia suggested that the most effective advocates for YFCs should be MoH, followed by doctors then health units, parents and FP clinics. Surprisingly, NGOs were not suggested.

Table 16 Suggested Organizations/Persons by Interviewees to Advocate for Youth Friendly Clinics in Menofia Governorate

Organization/Persons	No. of Respondents
Ministry of Health (MOH)	16
Doctors	9
Health Unit	3
Parents	3
FP Clinic	3
Ministry of Mass Communication	2
Teachers	2
University	2
Ministry of Culture	2
Youth	1
Youth Center	1
Religious Leaders	1
Ministry of Education	1
Governor	1
Pharmacy	1
YFC	1
Ministry of Youth	1
Total (multiple responses)	50

3.8.2 Proposed Advocacy Activities to Promote Utilization of Youth Friendly Clinics

- Awareness raising campaigns on TV.
- Billboards and signs in visible areas like stadiums, clubs, squares, near schools and universities, in the metro station or train station, pharmacies, youth centers, governmental authorities, hospitals and FP clinics
- Promotion during religious sessions.
- Provision of printed materials (books, brochures).
- Conferences in schools, universities and youth centers.

- Organization of sport activities which will also serve as leisure time activity for young people thus protecting them from engaging in risky behaviors.
- Acting as role models to set a good example for young people.

3.8.3 Willingness to Work as Peer Educators

All the interviewees agreed that working as peer educators requires special personality traits and intensive training. Assuming that both were guaranteed, females were more willing to work as peer educators (66.7%) versus males (36.4%), who clarified that females have more time than males who are committed to work.

3.8.4 Appropriate Places to Deliver Peer Education

Interviewees were further asked to list the appropriate places to offer peer education. As revealed in the following table, nearly one third of the sample did not know and hospitals were the first places mentioned by both genders followed by health units. This reveals that the concept of peer education is unclear and confused with health education, as most of respondents are limiting peer educator/youth interaction to health services delivery points such as hospitals and health units.

Table 17 Appropriate Places to Offer Peer Education by Gender of Interviewees

Places	Gender		Total
	Male	Female	
Hospitals	7	4	11
Health Units	3	3	6
Youth Centers	4	2	6
NGOs	1	3	4
FP Clinics	1	2	3
University	2	1	3
Clubs	2	0	2
YFCs	1	1	2
Public Libraries	0	1	1
Do not Know	12	10	22
Total	33	27	60

3.9 Channels/tactics for Providing Sexual and Reproductive Health and HIV/AIDS Information to Youth and Promoting Youth Friendly Clinics

The potential beneficiaries suggested the following tactics/ channels, which were ranked as follows:

- The first channel/tactic was to approach young people in cafes, clubs, youth centers, at home, through NGOs, at the workplace, at schools and universities. Locations would differ based on gender, as highlighted prior (i.e. cafes are suitable places to provide information for males, while NGOs are much more suitable for females).
- The second channel/tactic reported was arranging trips outside the governorates (a tactic that might be more useful for males than females).During the trip YFCs promotional materials are distributed and orientation towards delivered services will take place.
- The third channel/tactic was organizing competitions focusing on YFCs and SRH among young people in youth centers and other places such as NGOs.
- The fourth channel/tactic was organizing competitions focusing on YFCs and SRH at schools among students.

For both third and fourth channels/tactics, interviewees added that the prizes should attract the attention of potential beneficiaries. Coordinating with famous companies to present the prizes will reduce the cost and make young people more enthusiastic about participation. Additionally, mobiles, play stations and computers could be very useful prizes for those who conduct SRH and HIV/AIDS researches.

- The fifth channel/tactic was providing computer classes with the help of highly qualified peer educators at low cost. During these courses, the information can be passed to young people.
- The sixth channel/tactic was a hot-line that provides the needed information with the maximum confidentiality.
- The seventh channel/tactic was conferences and seminars that should be conducted at a variety of locations that appeal to youth such as youth centers, NGOs, schools, universities, etc. Interviewees recommended that potential beneficiaries should take part in the organization of such conferences to develop feelings of ownership among them. Furthermore, conferences and seminars should not be too

sophisticated and the language used should be simple so as to be understood by illiterate people and people with low levels of education.

- The eighth channel/tactic was brochures and booklets which are very useful for the reading community. In addition, advanced books should be authored, containing full and complete information.
- The ninth channel/tactic was trips inside the governorate which are cost-effective.
- The tenth channel/tactic is health campaigns that might be useful to identify misperceptions and communicate correct information. Sensitivity to family beliefs and gender norms should be considered.
- The eleventh channel/tactic was language classes which are useful in attracting young people to the clinic.
- The twelfth channel/tactic was meetings with stakeholders to find the support needed from people in the community.

Similar to the approach applied during the participatory workshop with peer educators, interviewees were then asked to identify channels/tactics tailored to specific groups of potential beneficiaries such as people with low-no literacy skills, housewives, craftsmen and those at risk of HIV infection including injecting drug users and men who have sex with men. They added the following:

- House visits will be useful with housewives and females with lower education. This should be done cautiously as dealing with people of a lower education level may not so very simple (e.g. in the case of mentioning HIV/AIDS, the peer educator might be asked to leave). Therefore, having a good relationship with these targeted groups first would be useful.
- Encouraging housewives to seek family planning and peer educators can pass information to them later on.
- If the peer educator can establish a good rapport with some of the housewives, they may recommend her to their friends/other housewives.
- Religious leaders can play a critical role in convincing low-no literacy skills individuals to get information. During Friday prayers or Sunday sermon, religious leaders might reinforce the importance of abstinence (the benefits versus the hazards of adultery). They can also clarify that the clinic works against risky behaviors (e.g. illegitimate sexual relations and drug addiction) and thus gain the support of critics.
- Many of the above-specified potential beneficiaries use microbuses as a mode of transportation. Furthermore, some of the microbus drivers

have good connections with those who engage in risky behaviors such as drug addiction and illegitimate sexual relations. Most of sample surveyed reported that the drivers themselves are marijuana and pill addicts. To gain the support of the community of microbus drivers, the respondents proposed developing and broadcasting music tape of popular singers like *Shaban Abd El Rehim* and placing commercials in between the songs to promote YFCs. In addition, the driver may receive a set of free tapes if he is willing to display YFC stickers on his microbus. Thus, the microbus customers will learn about the clinic.

4. CONCLUSIONS AND RECOMMENDATIONS

Youth friendly clinics are essential for young people, since, in addition to providing many services of great importance for young people, they represent a comprehensive communicational channel. Youth friendly clinics have underutilized capacity and could provide even more services. Youth who do attend often seek FP and ANC services rather than educational and counseling services. A number of factors directly and indirectly influence adolescent sexual and risk-taking behaviors. These factors fall broadly into five categories:

- The individual characteristics of young people, including their knowledge, attitudes, beliefs, values, motivations, and experiences
- Peers and sexual partners with whom youth interact
- Families and adults in the community
- Institutions such as schools, workplaces, and religious organizations that support youth and provide opportunities
- Communities through which social expectations about gender norms, sexual behavior, marriage, and childbearing are transmitted.

The social context in which young people grow up and become adults will influence their choices and their RH behaviors. Some group norms may lead to negative RH outcomes like gender discrimination, community norms that do not value education, restrictions on girls' mobility, norms that promote early sexual activity or that stigmatize using condoms, and cultural expectations to marry and bear children early in adolescence. Young people may perceive that their parents expect them to behave in ways entirely different from the way their friends expect them to behave. If parents instill their values and rules early in a young person's development and do so clearly, through supervision and monitoring, young people may be more likely to learn to regulate their own behavior as they grow older. If not, they may be more prone to following the expectations set by their friends, often to gain acceptance.

The results of this assessment clearly show that there is still a long way to go to meet the SRH needs of youth. That calls for a strategic behavioral communication (SBC) plan that encourages youth to visit YFCs and facilitate their utilizing services offered. Suggestions below are meant to be a starting point for further discussions among stakeholders. Drafting an SBC plan with input from stakeholders will more likely ensure buy-in and acceptance.

4.1 Peer Education:

Based on the findings of this assessment, the SBC strategy should place a special emphasis on peer educators who are clearly most influential among potential beneficiaries. Interventions tailored to the needs of peer educators, such as the following, will be likely to deliver practical and tangible results that increase utilization of youth friendly services.

- Development of training modules to improve interpersonal communication skills which will focus on peer educator/youth context and contain exercises and role plays tailored to the local culture. The modules will be developed based on FHI's expertise in training peers educators. These training modules will need to be adapted to the local needs and realities through on going collaboration with stakeholders to ensure buy in and acceptance of the training.
- Training sessions based on modules developed.
- Further emphasis should be placed on developing the YFC brand, including reinforcing the visual identity of the clinics as well as training peer educators as 'brand ambassadors'
- Job aids describing available services at YFCs, in addition to STIs and HIV/AIDS related information. These can take the form of flip charts, cue cards, digital stories, games, and posters.

4.2 Print& Collateral Materials

- Materials describing services available at YFCs, in addition to STIs and HIV/AIDS-related information. These could include brochures, photo albums, posters, and/or calendars to be displayed at medical facilities, NGOs, youth centers or distributed through community outreach carried out by peer educators.
- Signage at YFCs that reflects the brand identity and 'promise' to beneficiaries
- Articles in youth publications to encourage utilization of YFCs.
- Local print media which highlights young people/satisfied user's personal stories with circulation to community outlets.

4.3 Media Interventions and Community Mobilization

Media interventions and community mobilization activities have great potential to influence social norms. Considerable evidence shows that mass media interventions influence adolescent knowledge and attitudes.

4.3.1Examples of Mass Media Interventions Include:

- Digital stories that feature satisfied users who accessed YFCs with great success. These stories, if produced as audio recordings, have the potential to be broadcast on community radio stations in conjunction with call-in-talk radio programs, played and discussed in community group discussion settings, or posted on web sites frequented by youth. Audio stories also ensure confidentiality.
- Web-based media targeting youth with the capacity to provide an opportunity for consumer-generated content to share stories and experiences in a confidential manner.
- Other social media such as mobile phone technology and SMS provide an opportunity to tailor confidential messages, real stories, reminders, and healthy suggestions.

4.3.2 Examples Of Community Mobilization Include:

- Open house days at YFCs where the community at large is invited to view services provided, talk with providers, and meet satisfied users.
- Father-son and Mother-daughter-sister clubs where gender norms and, perhaps sexuality, are discussed.
- Trips, sports days, and competitions to be utilized as settings for promoting YFCs.

4.3.3 More Thoughts on Community Participation

Capacity building for community involvement should start with project staff, to give them a true understanding of participation and its practical application. Strengthening staff skills in facilitating community involvement is considered essential for moving beyond raising awareness and building knowledge within individuals to behavioral change community level.

- NGOs, youth centers, health facilities, workplaces, mosques, churches, classrooms and other places accessed often by youth fail to use the opportunity to provide young people with SRH and HIV education and should take better advantage of this access. Such outlets are cost effective and may be the only opportunity for youth to receive such information.

- A wide range of individual, social, and cultural factors influence the RH behaviors of young people. Peers, families, institutions and communities may all have an impact, positive or negative, on young people's decisions and actions. Understanding these factors and their relative importance is critical in designing effective respective policies and programs.
- Programs for youth have the additional challenge of helping adults and youth communicate and work together, despite differences in perspectives and experience.
- Adults, such as youth leaders and coaches, who play key roles in the lives of youth in a given community should be identified and engaged appropriately to facilitate youth access to YFCs information and services.
- Providing parents and other adults with training as community activists will increase support for YFCs activities and facilitate communication between parents and children.
- Teachers also need community support and education to facilitate effective school-based interventions.
- Structures and processes should be developed for facilitating community participation, such as village committees, and should be inclusive not only of the community, but specifically of sufficient numbers of youth, to enable them to take on leadership roles.
- Specific strategies need to be developed to involve special segments of the community i.e. housewives, out of school youth, and groups at risk for HIV infection who are much less likely to be present in public spaces or to be automatically given an opportunity to interact or make decisions. Youth centers could be a good channel for involving the more vulnerable groups, especially males.

4.4 Managing Community Resistance

Youth RH and HIV interventions raise culturally and socially sensitive issues, such as sex, sexuality and gender. In most societies, the sexuality of young unmarried people is particularly controversial. Widespread community opposition to YFCs activities may arise because:

- Adults feel threatened.
- Adults want to protect youth.
- Adults fear that educating youth about preventing pregnancy and sexually transmitted infections, including HIV, will increase promiscuity.

- YFCs related interventions may challenge deeply entrenched cultural norms, including expectations about gender roles.

As conflict arises, it must be managed in ways such as the following:

- Consider youth and community needs and common interests. An obvious common interest is meeting the needs of youth. Meeting those needs can also be considered an investment in a community's future.
- Stakeholder analysis is critical to help anticipate and prevent community resistance to a program.
- Involve youth in meaningful ways. Youth participation is often only a token involvement. Even when young people are asked to be involved, they may not feel comfortable doing so. Youth are not supposed to speak up in the presence of adults in many cultures. They may need opportunities to express themselves when adult community members are not present.
- Build the skills needed to overcome resistance. Program staff should expect resistance and be prepared to overcome it.
- Build good communication skills within implementing organizations and among community members involved. In addition to good interpersonal communication, skills are needed to depersonalize issues, define terms clearly, and tailor language and messages to the audience. Effective communicators are also mindful of culture, engage community members in communication activities, and use different communication methods.
- A particularly important strategy for overcoming resistance is the formation of local advisory committees involving community and religious stakeholders.
- Periodic assessment of community support for youth RH activities.
- The importance of using non-confrontational ways of challenging gender norms such as creating safe spaces, particularly for girls who have been excluded from public spaces for historical and cultural reasons.

4.5 Advocacy

- Advocacy targeting Ministry of Health to promote adoption and dissemination of YFCs
- Advocacy targeting NGOs, Ministries of Youth and Mass Communication to promote utilization of YFCs

- Advocacy targeting religious and community leaders to promote utilization of YFCs

4.6 Multi-sectoral Approach

Attention should be given to non-RH needs of young people that affect SRH/HIV such as livelihood skills, recreation, and employment opportunities. Interventions should take a more holistic approach, addressing social and economic issues that affect youth, and particularly girls and young women. Examples include:

- Integrating youth friendly services into broader literacy and education support.
- Developing sports programs for girls, establishing savings and vocational or livelihood programs.
- Building youth capacity and networks by establishing youth clubs.
- A pre-occupation with livelihoods is a reality facing young people; integrated programs may increase the intensity of interventions, along with their ability to engage youth by addressing a range of cultural, sporting, community, religious and economic needs and resources. Offering information and services through only one sector (i.e., the health sector) is less efficient in addressing needs holistically.
- Involving communities in YFC issues can create new possibilities for challenging norms that impede young women and men from making safer RH choices and can create public spaces for new, more supportive norms to be discussed and to evolve from prevailing norms.

Annex I: Baseline Survey of Youth Friendly Clinics

The overall goal of the survey was to assess the eight existing youth friendly clinics in the Menofia, Ismailia, Qaluobia and Dakahlia governorates to develop a strategy for enhancing the performance of the clinics and target reproductive health needs of adolescents. The survey was conducted in late 2007 using a participatory approach involving service providers, peer educators and young people familiar with YFCs, whether or not regularly attending them. The objectives of the survey were as follows:

- Assess the status of the YFCs
- Assess the peer educators' program
- Identify reasons for visiting the clinics and needs of the attendants
- Explore possible obstacles that prevent young people from visiting the clinics
- Determine the best routes to enhance performance of YFCs to meet the needs of young people

I.I Study Instruments and Methodology

The survey was undertaken in October and November 2007 using three study instruments as follows:

I.I.I Focus Group Discussions:

Sixteen focus group discussions with youth, who were familiar with YFCs, whether or not in regular attendance, were held in the eight clinics: two in each clinic, one with males and one with females.

I.I.II Semi-structured Questionnaire:

A semi-structured questionnaire was conducted with all (44) peer educators affiliated with the eight clinics.

I.I.III In-depth Interviews:

Twelve in-depth interviews were conducted with service providers: seven with gynecologists, three with nurses and two with social workers.

In addition to the above mentioned tools, the study team carried out observations of the clinics which were valuable in enabling the study team to determine the accuracy and reliability of the collected data.

I.II Main Findings of the Youth Friendly Clinics Assessment

I.II.I Characteristics of the Clinics:

These findings were based on observations.

- All clinics have a visible location on a main street and are easily accessible.
- All the clinics provide family planning (FP), antenatal care services (ANC), pre-marital exams and management of STIs, in addition to RH counseling and laboratory services.
- All clinics include an information corner which contains a library, video player and TV set, a printer, two computers and a cassette recorder.
- There is no cross-referral between visitors of the information corner and clinical services' youth clients.
- All the clinics are neat and clean.
- All the clinics have modern flush toilet with potable water.
- Some of clinics do not carry the sign of YFCs. Most of the people in the areas surrounding the clinics identify them as clinics for FP and ANC services.
- The staff of the clinics includes a gynecologist, a dermatologist (in some clinics), a dentist (in some clinics), FP counselors, nurses and janitors. Six volunteer peer educators of both sexes are affiliated with each YFC.

I.II.II Utilization of the Clinics by Youth

The FGDs' participants, peer educators and service providers agreed that the YFCs are reputable in the surroundings for delivering FP and ANC services. Unmarried young people visit YFCs for the following reasons:

- To read books from the library of the information corner
- To use the facilities of the information corners including computers, printers and internet
- To receive information that parents will not discuss regarding issues like menstruation and puberty problems

I.II.III Reasons that Could Prevent Youth from Utilizing the Clinics

The FGDs' participants, peer educators and service providers proposed the following as reasons that may prevent unmarried young people from utilizing YFCs:

- YFCs are identified in the surrounding neighborhoods as FP/ANC clinics that should be visited by married women only (i.e. no males and no unmarried females).
- Males believe that they know everything and can get required information from other sources. *"I can ask my friend, watch TV programs, log into the internet to get the information. Why should I come to the clinic?"* said a male participant of a FGD in Dakahlia.
- Parents refuse to allow their daughters to visit the clinics.
- The perception that such clinics have a hidden agenda, particularly religious fanatics who believe that YFCs offer young men and women the chance to meet.
- Some information corners lack privacy.

I.II.IV Reproductive Health Information of Participants of FGDs

- Information about contraceptive methods is widespread among community members who believe that FP is the responsibility of the wife.
- Condoms are ineffective as contraceptive methods, especially condoms of bad quality which may tear. Additionally, men do not feel comfortable using condoms and they are expensive.
- Condoms are associated with illegitimate sexual relations. *"Condom is only for those who practice sex outside marriage. Married people are not in favor of it because they might be scandalized."* Sources of FP information include mass media, own experiences and school curricula (information received at school was reported to be immediately forgotten after exams).
- Information related to STIs was inaccurate. Participants of FGDs were unable to identify names, manifestations nor consequences of such infections.
- Methods of transmission of HIV/AIDS were inaccurate. Most of the participants claimed that mosquitoes, toilets, food, sneezing and coughing were methods of transmission.
- AIDS is a stigma. All participants refused to deal with infected persons and did not want to be tested for AIDS.
- The prevention of AIDS should be carried out through abstinence and avoiding extramarital sex.
- None of the participants had ever heard about the mobile vans for HIV voluntary counseling and testing.

- All participants agreed that no medication is available for HIV/AIDS. Doctors provide some sedatives.
- Information about STIs and HIV/AIDS is acquired through TV, particularly through the films "Love in Taba" and "Red Agenda".
- Drug addiction is linked to HIV/AIDS through shared syringes and engaging in illegitimate sexual relations.

I.II.V Peer Educators Program

Peer educators are the channels that link young people with the YFCs. They provide information for young people, organize conferences for raising awareness, undertake advocacy among members of the community and raise funds through the services provided in the information corners e.g. internet search and printing.

Peer educators started work in the YFCs as volunteers since the year 2004. Interviews with peer educators revealed that they all share the following characteristics: "A peer educator is an intelligent person who has excellent communication skills and the ability to advocate for and mobilize people in the community. Peer educators are friendly, efficient, dedicated and have a good sense of humor." Indeed, it was these qualities that served as the basis for their selection as peer educators. Those who were selected received intensive training on different topics such as communication, presentation, RH, FP, female genital mutilation prior to their work in the community. Currently, some are members of EFPA board and participate in international conferences and meetings.

I.III Recommendations

Participants of FGDs, peer educators and service providers recommended the following to enhance the performance of YFCs to meet the needs of young people:

- Provide the information corners with different types of creative books
- Provide peer educators and service providers with the necessary training courses
- Target the out-of-school youth through awareness campaigns
- Establish good relations with religious fundamentalists and community leaders
- Secure funds to achieve sustainability of the clinics

- Develop a mechanism to reduce the turnover rate of peer educators
- Organize workshops for peer educators to share experiences and lessons learned
- Organize monthly meetings for YFCs staff to establish a common ground and vision for future steps.

Most of the above-mentioned recommendations in addition to the findings of the assessment have been addressed by FHI and EFPA including the following:

- Orientation of service providers and peer educators towards HIV/AIDS and STIs.
- Supplementing the information corners with books and brochures focusing on the same topics.
- Development of various training manuals covering VCT, youth RH, peer education and monitoring and evaluation to ensure the delivery of high quality standardized youth friendly services.
- Training of service providers and peer educators using the developed manuals.