Knowledge hub
-
Collection of best practices

Summary of the best practice

1. Title of the best practice (e.g. name of policy, programme, project, etc.) *

Reaching those most left behind through CSE for out of school young people

2. Country or countries where the practice is implemented *

Ghana

3. Please select the **most relevant** Action Track(s) the best practice applies to *

- [x] Action Track 1. Inclusive, equitable, safe, and healthy schools
- [ ] Action Track 2. Learning and skills for life, work, and sustainable development
- [ ] Action Track 3. Teachers, teaching and the teaching profession
- [ ] Action Track 4. Digital learning and transformation
- [ ] Action Track 5. Financing of education

4. Implementation lead/partner organization(s) *

UNFPA/Ghana

5. Key words (5-15 words): Please add key descriptive words around aims, modalities, target groups etc. *

HIV/AIDS, reproductive health, CSE, young people, Out-of-school, Detention, SDG's, YPiD, YPLHIV, livelihood skills

6. What makes it a best practice? *

There are extensive intervention strategies that target young people with SRHR information. However, there are limited programmes targeting out of school young people specifically, young people living with HIV (YPLHIV) in Ghana. This approach ensures no one is left in reaching young people with CSE.

Description of the best practice

7. Introduction (350-400 words)
This section should ideally provide the context of, and justification for, the practice and address the following issues:

i) Which population was affected?
ii) What was the problem that needed to be addressed?
iii) Which approach was taken and what objectives were achieved? *

In January 2018 six UN agencies launched a fully updated edition of the International Technical Guidance on Sexuality Education (ITGSE), which provides national authorities with the tools to design comprehensive curricula towards positive impacts on young people's health and well-being. Providing CSE, particularly for out of school CSE, is essential to the achievement of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs), which makes a commitment to leaving no one behind and reaching the furthest behind first and to empowering people who are vulnerable, including all children, youth, persons with disabilities, people who are at high risk of acquiring or living with HIV, indigenous peoples, refugees, internally displaced people and migrants.

There is widespread support for in-school sexual and reproductive health (SRH) education in Ghana; policies and curricula have been developed and continuously updated to meet the changing needs of adolescents. Enrollment in primary and junior high school is high (85–90%), but only 48% of 15–17-year-olds continue on to senior high school. Most students (77%) had received some SRH education by the time they completed primary school; 20% first learned about the topics in junior high, and the remainder were first exposed in senior high. 95% of students considered SRH education useful or very useful in their personal lives, and half (48%) reported that they did not receive this information from their parents.
With an overall goal To empower and equip adolescents and young people from specific left behind groupswith the information and the skills to make informed choices about their sexual and reproductive health and rights, and well-being through out of school CSE.
The programme aims to empower adolescents and young people from specific groups to receive the skills and capabilities to make informed choices about their sexual and reproductive health and right, and well-being of young people living with HIV Ghana.
Despite the recognition of RHE as a key intervention for young people, UNFPA while implementing existing CSE programmes to reach and empower adolescent girls, extended its out of school CSE components to be complementary and to demonstrate the effectiveness of both strategies towards achieving the organization's set outcomes and goals.

8. Implementation (350-450 words)
   Please describe the implementation modalities or processes, where possible in relation to:
   i) What are the main activities carried out?
   ii) When and where the activities were carried out (including the start date and whether it is ongoing)?
   iii) Who were the key implementation actors and collaborators? (civil society organizations, private sector, foundations, coalitions, networks etc.)?
   iv) What were the resources needed (budget and sources) for the implementation?
   *

At national level existing UN Delivering as One mechanisms are utilized to ensure the programme is owned by implementing partners for sustainability.
The program was implemented in partnership with Hope for Future Generation (HFFG) Ghana, a CSO, to provide Reproductive Health Education (RHE) to marginalized out of school young people specifically young people living with HIV and AIDS through structured sessions whilst ensuring an enabling environment by engaging in community and parent dialogues.

The programme employs a human right based and gender sensitive approach, intrinsic to all UNFPA's programmes and since 2019, has providing platforms for media engagements on treatment, literacy and adherence. It has also strengthened YPHIV associations reducing stigma. UNFPA continues to provide SRHR training, orientations on disclosure skills, adherence defaulter tracing as well as engage in community outreaches, livelihood skills training sessions to ensure that the sessions ae meaningful for holistic development

Together with HFFG, and other relevant Government partners, this program was implemented in 3 regions of Ghana; Ashanti Region, Greater Accra Region and the Northern Region. Activities under this program are capital intensive and relied on funding from the Norwegian government with support from other programmes funded by the Canadian government.
The available resources determined the number of young people that could be reached at any time.

9. Results – outputs and outcomes (250-350 words)
   To the extent possible, please reply to the questions below:
   i) How was the practice identified as transformative? (e.g., impact on policies, impact on management processes, impact on delivery arrangements or education monitoring, impact on teachers, learners and beneficiary communities etc.);
   ii) What were the concrete results achieved with regard to outputs and outcomes?
   iii) Has an assessment of the practice been carried out? If yes, what were the results? *

   The programme was transformative by impacting on beneficiary communities. By not only targeting young people living with HIV as was the initial design, the programme through a Participatory Action Research done at the beginning of the project, issues that affect the wholistic development were addressed. Issues such as how to handle disclosure was very critical as parents were not disclosing to young people many who had acquired HIV through MTCT. These sessions enable the parents to be able to disclose to their children to improve adherence to drugs. PLHIVs who were unable to adhere due to their inability to fend for themselves particularly because drugs made them hungry and they did not have the means to buy food, were supported to learn a skill to be able to generate an income. In all about 350 young people have been reached within the funding available, with the project demonstrating that there is a huge gap to be filled to ensure that these young people are not left behind.

   An assessment is yet to be carried out.

10. Lessons learnt (300 words)

To the extent possible, please reply to the following questions:

i) What were the key triggers for transformation?

ii) What worked really well – what facilitated this?

iii) What did not work – why did it not work? *

Key triggers for the transformation were the PAR research which enabled beneficiaries concerns to shape the project design and the obvious neglect of this target beneficiary which has been a rising concern of government AIDS agencies.
Involving ART Nurses during RHE proved extremely beneficial especially for young people who sought One -on One Counselling sessions after the main sessions for the day had ended. The opportunity for participants to hold debates and discourses on SRHR topics was essential to boosting their confidence in owning the content of the sessions and information that they learnt through the programme.
Young people were mobilized at the ART centres which ensured that they were more easily reached and made them feel at ease once they agreed to join sessions.
Additionally, the SRHR sessions worked extremely well especially for newly diagnosed YPLHIV because it provided them with information to better understand and cope with their situations, connect with peer groups and models of hope for psycho-social support.
Furthermore, engaging trained young people who served as facilitators also proved crucial for creating safe spaces for engagements for YPLHIV because young people felt comfortable engaging with their peers.

Due to budgetary restriction, numbers of young people reached were limited even while at the ART centres there were many more who would have liked to join. Activities were limited to only a few regions though there was a a demonstrated gap to be addressed in several others. Time of receipt of funds often meant that activities had to be rescheduled which meant some young people dropped off along the way and constant effort had to be put in mobilization.

11. Conclusions (250 words)
    Please describe why may this intervention be considered a “best practice”. What recommendations can be made for those intending to adopt the documented “best practice” or how can it help people working on the same issue(s)? *

    Even though significant progress has been made towards achieving the SDG on achieving universal health coverage, marginalized young people are often left behind because of the added effort and funding required for them to be reached. Young key populations such as YPLHIV remain underfunded globally and in Ghana when it comes to holistic support for their development including on reproductive health programming and interventions.
    Access to sexual and reproductive health and rights and services are fundamental human rights and should not be obstructed by any reason. However in addressing SRHR issues interventions become more meaningful when contributing factors and inhibiting factors are addressed to ensure that the target beneficiary is indeed meaningfully reached. Partnerships are key to provide a complete sphere of support for meaningful impact.
    Thus, this programme and its approaches are recommended to be replicated on larger scales to increase reach to left behind young people globally.
    As a best practice, this programme contributes to the efforts towards increasing reach of RHE among young people but in an unconventional yet innovative way to forgotten populations.
    Adopting this practice will require contextualization to suit the needs of left behind target group and taking into consideration the lessons learnt from the Ghana programme.

12. Further reading
    Please provide a list and URLs of key reference documents for additional information on the “best practice” for those who may be interested in knowing how the results benefited the beneficiary group/s. *

    UNFPA CSE Newsletter
    Out of School CSE annual reports