

**A Review of Program  
Approaches to Adolescent Reproductive Health**

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## List of Acronyms

ABBEF	Association Burkinabe pour le bien-être Familial
AED	Academy for Educational Development
AIDS	Acquired immunodeficiency syndrome
ARH	Adolescent Reproductive Health
BCC	Behavior Change Communications
BLO	Better Life Options
BRAC	Bangladesh Rural Advancement Committee
CA	Cooperating Agency
CBD	Community-Based Distribution
CCP	Center for Communications Programs
CEDPA	Centre for Development and Population Activities
CEMERA	Center for the Reproductive Health of Adolescents
DISH	Delivery of Improved Services for Health
DR	Dominican Republic
FGM	Female genital mutilation
FHI	Family Health International
FLE	Family Life Education
FP	Family Planning
FPA	Family Planning Association
FPAK	Family Planning Association of Kenya
HARP	Health of Adolescent Refugees Project
HIV	Human immunodeficiency virus
HRC	High Risk Clinic
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
IEC	Information, Education and Communication
IFA	Iron-folic acid
IMIFAP	Instituto Mexicano de Investigacion de Familia y Poblacion
IPPF	International Planned Parenthood Federation
JHU	Johns Hopkins University
JSI	John Snow Inc.
KAP	Knowledge, Attitudes, Practice
LAC	Latin America and the Caribbean
LUDHMT	Lusaka Urban Health Management Team
MOE	Ministry of Education
MOH	Ministry of Health
NAFCI	National Adolescent-Friendly Clinic Initiative
NGO	Non-governmental organization
OR	Operations Research
PAHO	Pan American Health Organization
PALS	Partnership for Adolescent Sexual and Reproductive Health
PATH	Program for Applied Technology in Health
PCS	Population Communication Services
PLA	Participatory Learning and Action
PMI	Prevention Marketing Initiative
PPASA	Planned Parenthood Association of South Africa
PRA	Participatory Rural Appraisal
PSI	Population Services International
RH	Reproductive Health

RRA	Rapid Rural Appraisal
RSDP	Rural Service Delivery Program
SEATS	Service Expansion and Technical Support
SMASH	Social Marketing for Health
STD	Sexually transmitted disease
TA	Technical Assistance
TBA	Traditional Birth Attendants
TOP	Teen Outreach Program
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling & Testing
WAGGS	World Association of Girl Guides and Girl Scouts
WHO	World Health Organization
WHR	Western Hemisphere Region
YAMs	Youth Advocacy Movements
YFS	Youth Friendly Service
YSO	Youth Serving Organization
YWCA	Young Women's Christian Association
ZNFPC	Zimbabwe National Family Planning Council

## EXECUTIVE SUMMARY

Adolescent reproductive health (ARH) is recognized as a key development concern. Adolescence is both a transient stage, between childhood and adulthood, and a formative period during which many life patterns are learned and established. The pronounced risk-taking associated with adolescence abates with age, yet many risk-related actions have lasting consequences. Acquiring knowledge, skills, and behavioral habits set the stage for adult expectations and outcomes.

While reproductive health information, counseling and service delivery, have been identified as necessary programs for adults for decades, availability of such programs has been more recently endorsed for adolescents. The International Conference on Population and Development (ICPD), which met in Cairo in 1994, and the Fourth International Conference on Women, in Beijing in 1995, endorsed the rights of young people to reproductive health information and services. Health and development professionals and policy leaders are building on this consensus to formulate and deliver needed programs that are viewed as requiring special designs and broader components to meet adolescents' developmental needs. These include adaptations and youth-appropriate versions of adult information, counseling and services, and also skills training (both related to ARH and more broadly) and linkages to key areas of their emerging adult concerns, especially job training and income generation.

### **Scope of the Report**

This report identifies effective approaches to addressing ARH needs based on a review of program efforts undertaken in developing countries, with some reference to developed country programming. Conclusions are based primarily on evaluated projects, and to some extent, on observations by program implementers and assessors. Information gathering and analysis included interviews with over 70 professionals and on a review of a wide array of documents including published evaluations, program reports, organizational publications, issue reviews and analyses, project descriptions and proposals, presentations, informal memos and other materials.

### **Current State of ARH Programming**

Serving young people with reproductive health information, education, counseling and services has been challenging, not only because such programming is new and groundbreaking, but also because the issues and actions involve matters of great cultural sensitivity. Most societies have long-standing traditions about what is expected -- and allowed -- regarding sexual activities and reproduction among the young, and well-defined ways of transmitting relevant sexual information and values. Many societies customarily withhold information from young people until it is felt necessary to impart it; this typically occurs at puberty or marriage, which historically have occurred close together.

Given the extended period between puberty and adulthood, now occurring nearly everywhere though to different degrees, young people are not necessarily receiving information they need to manage their sexual lives at a time when they need it. This is compounded by modernization and urban migration, which have broken down some of the ritual transmissions of information and guidance and have made intra-family communication less likely. Service provision to counsel and provide protection against sexually transmitted diseases and pregnancy has been fraught with even greater concerns about encouraging or condoning sexual activity.

As adolescent sexual activity, pregnancy rates, non-marital childbearing, complications of unsafe abortion, STD rates and HIV have increased in many countries, a greater concern has developed to address these issues, even if it requires overcoming sensitivities and resistance. The HIV pandemic, disproportionately affecting young people, has made this task more urgent.

To date, however, most program responses have been scattered, poorly documented and not rigorously evaluated. This relates, in part, to a lack of clearly defined adolescent reproductive health policy, whether part of youth policy, youth health policy or reproductive health policy. Because of weak policy mandates, hesitant leadership, and low levels of funding, small projects have been implemented, usually with no plans for expansion or scaling up. Typically, even if successful, these projects run out of money, limp along for a short time and leave faint footprints. With certain exceptions (especially in Latin America, but also in a few African countries and in Thailand), there is a project mentality that dominates. Until larger mandates are articulated and larger programs are implemented to reach more people, few adolescents will be served, and only for short periods of time.

## **Review of ARH Interventions**

The array of program approaches covered in the review relate to three objectives: fostering an enabling environment; improving knowledge, skills, attitudes, self-efficacy; and improving health-seeking and safer sex practices. Major conclusions regarding each objective follow.

### Fostering an Enabling Environment

A supportive environment is critical to the initiation and successful continuation of ARH programs. While specific policies and laws sometimes follow demonstrated advantages of ARH programming, advocacy must precede any efforts – to ensure adequate receptivity and support. Increasingly, advocacy is carried out through participatory approaches, working with and mobilizing the community. Collaborating initially with existing allies, a broader range of key shareholders can become involved and supportive. Communities have demonstrated a greater willingness to take risks if involved in this way, though the process is long and labor-intensive. Both mass media and localized communications play necessary roles in placing the issues in the public forum, in framing the rationale for program interventions and in publicizing project activities and successes. Young people themselves appear to play an effective role in identifying and advocating for their own needs.

Advocacy and policy initiatives also help address social norms, which can comprise significant barriers to ARH programs. Although research attention is increasingly paid to the cultural and social context of young people's lives and risk-taking behavior, more programmatic formulations need to be designed and implemented. This is especially important on the fundamental issues of gender dynamics and inequities, which are often at the heart of program failures to enhance ARH. Some successful activities involving small groups of women, especially in HIV-prevention projects, have been carried out but questions remain about how such efforts can be taken to scale.

### Improving Knowledge, Skills, Attitudes, Self-efficacy

Information about sexuality is a basic need and right – and a necessary but not sufficient part of what young people require for good reproductive health. Although studies, mainly from the U.S., have identified components of a successful sex education curriculum, such criteria may be difficult for developing countries to meet in the short run. Youth development approaches, based on antecedent research and holistic principles, provide a good model for addressing broader youth needs but may be less easy to implement in developing countries, especially on a broad scale, which would require intersectoral coordination at the policy level. A characteristic of successful programs that appears critical to success is an interactive and experiential learning environment where young people can comfortably and safely explore issues and concerns and develop skills to practice safer sexual behavior. New information technologies involving computers offer potential for confidential information and diffusion of new ideas.

Information and education approaches have succeeded in a variety of settings, including schools, youth groups, community locations, and the workplace. Peer projects are often part of these efforts and, although they are very popular and used widely, many questions about their sustainability and the quality of peer communications remain. In all of these educational efforts, ways to go to scale are the big challenge. Media activities can successfully reach a large portion of the population, and result in knowledge and behavioral changes, but these changes do not appear to survive the campaigns. Sustainability and intensity of intervention, not reach, are the challenges with media programs. However, media can introduce new ideas and foster social change, thus contributing to a positive climate for other interventions. With all of these approaches that inform and motivate, it is essential to have RH services in place as increased demand is created.

### Improving Health-Seeking and Safer Sex Practices

Services for counseling and method provision for safer sex need to be available to young people and in ways that are responsive to their needs for privacy and confidentiality. Given young people's preference for retail purchase of condoms and private physicians for RH methods and care, more programmatic attention should be given to these approaches, as well as to other avenues such as CBD agents and community health workers. Social marketing programs have demonstrated that a combination of media, peer education and youth-relevant sales outlets can succeed in increased condom acceptability and use – if coverage of these components is great enough. Challenges remain in fostering more regular condom use, however, especially related to use with regular partners, and purchase and negotiation by young women.

While more emphasis should be placed on non-clinical services, some attention should be directed to making existing clinical services more youth friendly, especially because of the far-reaching networks of public health facilities and, in some countries, NGOs. The major challenge in these settings is negative provider attitudes, which can be addressed through better pre-service training in the long run and remedial adjustments in the short run. Use of public health facilities by young people for RH has been shown to be viable in developed countries and in Latin America. Experience to date with youth centers offering a broader array of recreational and vocational activities has proven costly and ineffective in attracting youth for RH services. Some promising efforts seem able to draw youth to RH services, but these conduct focused, but entertaining, activities around RH more directly. VCT efforts have succeeded in attracting young people, though perhaps more for information and advice.

### **Summary of Conclusions**

- Programs should be conceptualized and designed to move from the current “project mentality” of scattered, one-time efforts into a more sustainable and comprehensive program framework using multiple interventions;
- Program planners must undertake preparatory actions to foster an enabling environment before introducing an ARH intervention and select designs appropriate to the community's readiness to support these activities;
- The choice of partner agencies and the selection and training of staff are critical to achieving ARH program objectives;
- Youth should be viewed as assets within ARH programs, which should serve them early in adolescence, be responsive to their needs and seek their active involvement;

- Given the significance of gender dynamics for young women’s ability to practice safe sex and establish good reproductive health, program options need to be devised, and successful approaches expanded;
- Mass media and informal communications can be selectively used at all levels of program readiness and development, and can help programs achieve the three major program objectives related to a supportive environment, enhanced information and skills and improved health services;
- Both formal and informal sex/HIV education programs should be increased, going to scale where possible, and, in addition, identifying youth-popular venues for reaching young people with needed information;
- Young people should have access to a variety of commercial, private, NGO and public health services, where they can receive respectful and confidential treatment for their RH needs; and
- Considerable research is needed to better understand determinants of adolescent risk-taking in developing countries, the potential for alternate venues to provide ARH education and services, ways in which programs can be expanded and scaled up and more effective ways to conduct research with young people and assess ARH programs.

## 1.0. INTRODUCTION

Adolescent reproductive health (ARH) is recognized as a key development concern. Adolescence is both a transient stage, between childhood and adulthood, and a formative period during which many life patterns are learned and established. The pronounced risk-taking associated with adolescence abates with age, yet many risk-related actions have lasting consequences. Acquiring knowledge, skills and behavioral habits set the stage for adult expectations and outcomes.

The concept of adolescence is relatively new. Until last century, the passage from childhood to adulthood occurred relatively quickly, usually coinciding with puberty. Most societies marked this biological readiness for the adult task of childbearing with rituals bestowing social and economic privileges and status in addition to acknowledgment of sexual maturity. Childbearing occurred early in a young woman's life, soon after she developed the biological capability.

In recent centuries, both biological and socioeconomic landmarks bracketing the transition to adulthood have moved in opposite directions. Menarche occurs earlier, probably due to changes in diet, and many societies' adjusted definition of social and economic maturing and independence has moved upward in the teen years, and well into the twenties in developed countries. This increase in the "biosocial gap" at the older end reflects both greater time needs for education and training in industrialized societies and the recognition that investments in this formative phase have significant benefits for individuals and society in the future.

In view of varying stages of development among countries, coupled with cultural underpinnings that contribute to each society's social construct of adolescence, this stage is still viewed in different ways, covering different age ranges. Some countries barely recognize the concept or give scant attention to it politically or programmatically. In contrast, some countries have begun to place an emphasis on this age group, logically on education and training, but increasingly on health and well being.

There is some variation, as well, in the age definitions of this transitional phase. "Adolescence" is often synonymous with the teen years, thus identified as 10-19. "Youth" usually covers the ages 15-24, and "young people" is used for 10-24. "Young adults" are typically considered in the age range 20-24. For the purposes of this review, "adolescence" will be used interchangeably with "youth" except where precise ages are important to note.

While reproductive health information, counseling and service delivery have been identified as necessary programs for adults for decades, and have become increasingly accessible, availability of such programs has been more recently endorsed for adolescents. The International Conference on Population and Development (ICPD), which met in Cairo in 1994, and the Fourth International Conference on Women, in Beijing in 1995, endorsed the rights of young people to reproductive health information and services. Health and development professionals and policy leaders are building on this consensus to formulate and deliver needed programs that are viewed as requiring special designs and broader components to meet adolescents' developmental needs. These include adaptations and youth-appropriate versions of adult information, counseling and services, and also skills training (both related to ARH and more broadly) and linkages to key areas of their emerging adult concerns, especially job training and income generation.

This report will identify effective approaches to addressing ARH needs, based on a review of program efforts undertaken in developing countries, with some reference to developed country programming, where relevant. The conclusions about program "effectiveness" will be based primarily on evaluated projects and, to some extent, on observations by program implementers and assessors in the form of "lessons learned" and conclusions based on experience. The process of identification of projects, issues, program considerations and future needs was based on interviews with over 70 professionals (Annex A),

including representatives from USAID supported cooperating agencies (CAs), other donor agencies, other implementing organizations, researchers, and private foundations. A wide array of documents was reviewed (Annex B), including published evaluations, program reports, organizational publications, issue reviews and analyses, project descriptions and proposals, presentations, informal memos and other documents. Finally, while the emphasis in this paper is placed on recent program documentation and evaluation, the assessment also builds on previous program reviews by the author for the Population Reference Bureau, the World Bank, UNFPA and the FOCUS on Young Adults Program.

## 2.0. BACKGROUND

### 2.1. ARH Programming: An Overview

Serving young people with reproductive health information, education, counseling and services has been challenging, not only because such programming is new and groundbreaking, but also because the issues and actions involve matters of great cultural sensitivity. Most societies have long-standing traditions about what is expected -- and allowed -- regarding sexual activities and reproduction among the young, and well-defined ways of transmitting relevant sexual information and values. Many societies customarily withhold information from young people until it is felt necessary to impart it; this typically occurs at puberty or marriage, which historically have occurred close together.

Given the extended period between puberty and adulthood, now occurring nearly everywhere though to different degrees, young people are not necessarily receiving information they need to manage their sexual lives at a time when they need it. This is compounded by modernization and urban migration, which have broken down some of the ritual transmissions of information and guidance and have made intra-family communication on the subject (by an auntie, for example) less likely. A prevailing notion that teaching young people about sex can encourage experimentation and promiscuity has endured in the face of strong evidence to the contrary.

Service provision to counsel and provide protection against sexually transmitted diseases (STDs) and pregnancy has been fraught with even greater concerns about encouraging or condoning sexual activity. These fears build on a sense that young people really do not require health services in any case: they are thought to be at a healthy stage in their lives. In addition, many health services feature a curative care approach in which counseling, prevention and health promotion play a small role.

Most countries' first efforts at serving an adolescent age group with reproductive health education and services were targeted at pregnant and parenting young people, presumably because they had already begun sexual experimentation, and because they had obvious needs that, if met, could improve birth outcomes and parenting practices. Thus, an early US program was "Education for Parenthood;" in Jamaica, the Women's Centre helped pregnant young women with care and education throughout their pregnancies; and in Mexico and Brazil, hospital-based services adjusted to the needs of young women giving birth in order to improve breastfeeding, adopt a contraceptive method and delay a second birth.

As adolescent sexual activity, pregnancy rates, non-marital childbearing, complications of unsafe abortion, STD rates and HIV have increased in many countries, a greater concern has developed to address these issues, even if it requires overcoming sensitivities and resistance. The HIV pandemic, disproportionately affecting young people, has made this task more urgent.

To date, however, most program responses have been scattered, poorly documented and not rigorously evaluated. This relates, in part, to a lack of clearly defined adolescent reproductive health policy, whether part of youth policy, youth health policy or reproductive health policy. Because of weak policy mandates, hesitant leadership, and low levels of funding, small projects have been implemented, usually with no plans for expansion or scaling up. Typically, even if successful, these projects run out of money, limp along for a short time and leave faint footprints. With certain exceptions (especially in Latin America, but also in a few African countries and in Thailand), there is a project mentality that dominates. Until larger mandates are articulated and larger programs are implemented to reach more people, few adolescents will be served, and only for short periods of time.

## **2.2. Documentation and Evaluation of ARH Projects**

Evaluations of ARH projects are scarce; those with a rigorous, scientific design are rarer. There are several practical and methodological reasons for this scarcity. The most common, and compelling, explanations are cost and an under-appreciation of the value of an assessment to the project's outcomes. Many implementing organizations' leaders view an evaluation requirement as "something the donor wants" and/or fears that the results will threaten future financial support. Staff may also sense that they lack the expertise to conduct evaluations and are unaware of how to obtain it.

Methodological challenges have also limited the number and quality of ARH project evaluations. Asking respondents about sexual knowledge and practices, difficult with any age group, is much more sensitive with adolescents who hesitate to admit socially unacceptable behavior. Validity of their responses is a major concern for researchers. Adolescent "lingo" and age-specific meanings further complicate this issue. There is significant concern in the field that the indicators developed for adult program assessments, such as "couple-year's protection," may not be as relevant for measuring success with adolescents. Importantly, there are logistical barriers to surveying adolescents: permissions are usually needed from parents and schools or other institutions where the survey occurs.

Researchers have made significant progress in overcoming these barriers and continue to do so. Program implementers have been assisted in seeing the value-added to assessing their activities in order to improve their outcomes. New techniques that involve the target audience and community in the needs assessment/design phase as well as in the ongoing monitoring and evaluation, have helped to increase involvement in the research process and allow it to become part of the intervention itself. (See Annex C, New Tools and Approaches to Evaluating ARH.)

While this progress is significant, there are still too few evaluations to date upon which to make program choice and design decisions. Few project types have been evaluated in a variety of settings. Even where good evaluations exist, project conditions may be unique to their implementation settings and not easily transferable to another environment. On the other hand, the need to address pressing concerns of the current generation of young people, and to design interventions that promote a healthier future, requires us to depend on what we can glean from existing sources.

This review places an emphasis on well-evaluated programs. Supplementing these findings are documentation and experience of program donors, designers, managers and researchers.

### **3.0. A FRAMEWORK for ADDRESSING ADOLESCENT REPRODUCTIVE HEALTH**

#### **3.1. Conceptual Framework**

A conceptual framework is attached as Annex C. Programs can address one or more of these intervention points. Traditionally, in the pregnancy and STD/HIV prevention area, projects have been designed to influence adolescent reproductive behavior, especially contraceptive use, healthcare use and, more recently with the HIV epidemic, safer sex. Combined with this has been an emphasis on certain individual factors, especially education and skills addressed through formal school settings, community-based educational programs and communications, including mass media, folk media and interpersonal communications. The educational approach has evolved, placing greater emphasis on interactive learning and the development of social, or “life skills,” often in a broader youth development and “life planning” framework interrelated with other key concerns, such as relationships, education and employment.

Community factors have become part of many program designs, in response to the broader realities of youth risk-taking behavior. Especially important are peer relationships, which have significant influence on adolescent behavior; in turn, interventions based on peer roles have proven an effective program component for education and service referral/delivery. Other community factors are also recognized for their influence on sexual risk-taking and, as with schools and religious institutions, as sites and channels for providing information and motivation for sexual responsibility.

Based on research findings in the U.S., some researchers have begun to place more emphasis on household factors, in addition to community factors. While many of these associations are important in explaining risk-taking behavior, some of these factors are less amenable to program interventions, especially those related to social-economic status. Societal factors, especially social norms and gender dynamics, are increasingly addressed as barriers to youth reproductive health and development. The policy environment interacts with program interventions with defined policy and laws sometimes proceeding and other times following program implementation. Importantly, however, for broader, long-term approaches addressing multiple factors and determinants, policy efforts will be required to engage various sectors in collaborative support for youth health and development.

A consensus is developing that multiple levels need to be addressed: individual, relational (partner, family), community/institutional and structural (legal, political, economic).<sup>1</sup> Some of these must be understood as long-term goals, which must be balanced against short-term needs. The HIV/AIDS focus, in particular has shifted from a primary emphasis on individual behavior to embrace interventions involving social change, such as community mobilization and empowerment. This approach necessarily addresses inequality and human rights, including the critical issue of gender power relations and gender oppression.<sup>2</sup>

#### **3.2. Program Design Considerations**

Although not always adequately considered, many factors must be reviewed in selecting a strategic plan or program approach for ARH. These can relate to the needs of the target audiences, the status and needs of the community in terms of readiness and capacity to address ARH issues, resource availability (human, institutional and financial), appropriate balance between short-term needs and long-term goals, and the scale or scope of the initial intervention(s) as part of a larger plan. These are briefly reviewed below, not because this presentation will be used by program designers at the community or national level directly, but because such planners are often faced with after-the-fact constraints imposed externally, often by

fundors. Thus, it is instructive to consider design issues at an earlier stage, so they remain options for programs at the field level.

### 3.2.1. Developmentally Appropriate Interventions for Adolescents

It is especially important to design program interventions based on developmental stage. Thus, age, sex and physical development must be factored into project design and information/message development. Since this will vary from culture to culture, adaptation of any existing “model” must be carried out. FOCUS has created a tool "Developmentally Based Interventions and Strategies: A Tool for Promoting Health and Reducing Risk in Adolescents" that can help planners match programs to target audience.<sup>3</sup>

Project evaluations have shown that, in order to be effective, programs (and content/messages) must often be very different for young women and men. Another strong finding relates to age: many programs target middle and late adolescents, whereas early adolescents can have an ever greater need for information and guidance. Furthermore, reaching young people, as early (for example, as 10-14) before sexual debut, can be more effective for promoting responsible behavior.<sup>4,5</sup> At the same time, while age and sexual activity (which are related) are important variables, it is important to remember that adolescent behavior is fluid, moving from one sexual status to another, with varying needs.

A key way to ensure the design of appropriate interventions is by involving youth themselves in the program planning. They will also become invested in the project, helping to promote activities and recruit participants. Such involvement also supports a positive approach of viewing young people as assets, an not merely as embodiments of problems.<sup>6,7</sup>

### 3.2.2. Target Group Segmentation

Given that an adolescent target group is likely to be heterogeneous, segmentation is needed to plan for selected subgroups. This should be based on needs assessments, but might also include organizational reach and capability, sequencing of target groups, linkage possibilities with existing projects and resource availability. A balance is needed here, however: although it would be ideal to design special messages/project components for each identifiable market segment, in practice, there is a limit to how many variations are possible. Some media and service programs found that they could reach several segments within the same general program.<sup>5,8,9</sup> In most cases, however, selection of defined target groups, and careful matching of program approach and information/message/service content is needed.

An issue within the HIV/AIDS community is whether specific at-risk subgroups should continue to receive program attention or whether the general population should be included in HIV information and prevention programs. Many now believe that both are necessary, with priorities depending on the extent of the epidemic and the ability to identify those at risk. Before identification, general approaches are needed; more targeted interventions can be implemented when those at greatest risk can be distinguished. A return to a more universal approach may be required if the epidemic moves into the general population.<sup>10</sup>

### 3.2.3. Developmental Stage of Community/Country

A project or program cannot be inserted into a setting without carefully considering that community’s developmental stage, readiness to address sensitive ARH issues, existing efforts, and potential for implementing new activities. If the community has never addressed ARH issues and significant cultural barriers exist, a great deal of preparatory work is necessary. Phasing in of program ideas, issues and actions must be planned and executed. Collaborative work with the community in introducing issues, bringing them into the public and policy arena, identifying existing allies and identifying feasible initial

actions are all critical. (See “Advocacy and Policy Activities, Chapter IV.A.1.) If the community and/or country is at a more advanced stage vis-a-vis ARH programming, other interventions can be implemented.

Developing regions, and within them, developing countries, are at very different stages of ARH program development. For example, many countries in Latin America have had considerable experience with this issue, have tested approaches, developed consensus and/or policy initiatives and are beginning to scale up programs. Thus, for this region, scaling up of sex education might be a priority, whereas in other areas, disagreements over sex education per se (not to mention what issues, at what grade level, taught by whom, etc.) suggest that such a pursuit would be neither timely nor effective.

Another phasing issue involves program design along the behavior change communications (BCC) continuum. Whereas introduction of topics and information is necessary and appropriate at an early program stage, different program components, aimed more at skill-building, self-efficacy and use of services must be designed at the next program stage. Some program designs remain too long in the early BCC stages.<sup>11</sup>

#### 3.2.4. Resource Availability

All project designs must consider the level of human and financial resources available for project implementation and evaluation. Research is beginning to stress this point, which will allow programmers to factor in costs when choosing among several alternatives.<sup>12</sup> Although start-up resources limit the project’s size and scope, expansion of resources (or income generation) can constitute part of the design. Available trained staff (human resources) need not be a barrier, if financial resources are available for training. Often, with limited resources, planners design a model or demonstration project, presumably to be replicated after the pilot phase. Yet, this larger plan is not always conceptualized or intended. (See “Replication/Scaling Up”, below). Overall, given the certainty of resource limitations, less costly ways to reach adolescents must be identified.<sup>13</sup>

#### 3.2.5. Replication/Scaling Up

As noted above, project designers plan “demonstration” interventions often because they lack funds to go beyond a small activity. Given the limited financial and political support for ARH, this approach has dominated the field, leaving a program landscape littered with defunct pilot projects – whether they proved successful or not. This “project mentality” has also rendered projects isolated from one another, incapable of working synergistically within a larger program framework, and unable to reach broad segments of the population in need of ARH programming. Whenever possible, therefore, in order to increase potential program effectiveness, planners should articulate at the design stage mechanisms for replication and scaling up.<sup>14</sup> This requires identification of an institution or network capable of expansion, either as the pilot stage implementer or collaborator. In most cases, full expansion, that is, scaling up to a nationwide program, involves the government’s role in policy and/or implementation.<sup>11</sup> Successful scaling up, in the few instances where it has occurred, has featured NGOs and governments working together, as with sex education programs in Mexico and Ecuador.<sup>14</sup>

While reaching more of the target audience should be a goal, the issue of cost necessarily enters the design decisions. An assessment of replication costs, and how the project could be implemented at less cost, should be part of what the project demonstrates.<sup>15</sup> Successful planning for replication has involved researching “the most-effective, least-expensive intervention that would be easy to expand on a national level,” as carried out by the (PSI) social marketing program in Botswana.<sup>14</sup>

Scaling up is a way to reach large numbers at a reduced cost per program participant/recipient.<sup>11</sup> However, not all projects have sorted out operational issues and cost concerns nor have they developed to a stage suitable for scaling up. Project resources could be stretched too thin if expansion occurs too quickly.<sup>12</sup> The setting for scaling up is not always conducive politically. Thus, the timing of a move to a broader audience is critical. The nature of the project is also relevant; sometimes planners must make a decision between wider reach and greater intensity of the intervention to a smaller target group.<sup>9</sup> Yet, in the long run, projects must have a reach or effect beyond a few adolescents. If the pilot cannot be replicated at a reasonable cost, or if scaling up is not feasible because of cost or institutional reasons, a demonstration is usually not in order. On the other hand, if a limited time project can change the political climate or alter social norms as a result of its actions, it is a valuable contribution to the ultimate goal.

### 3.2.6. Short-term Needs and Long-term Goals

Many of the critical actions to improve ARH involve addressing deeply rooted social norms, cultural traditions and resistant economic conditions. Actions to foster social and economic change on these matters are discussed in the program sections. It is important to stress here that programming such activities must be considered long term undertakings. At the same time, there are urgent situations, such as high HIV transmission to adolescents that demand more immediate steps, such as making condoms as available and acceptable as possible within current social realities. While most ARH professionals agree that major changes are needed, which, in turn, will foster positive developments in ARH, most also support the implementation of more rapid responses to foster safer sexual activity. Working on both is not incompatible. For example, short-term responses to the HIV epidemic could be “consciously planned and articulated within the framework of a more long-term vision ... of social change.”<sup>2</sup>

## 4.0. ARH INTERVENTIONS

Adolescent reproductive health outcomes depend on many factors, including those related to individual characteristics, the social and community context, relationships with adults and peers, access to information and services and motivation and use of methods and safe sexual practices. Annex D depicts a flow chart of reproductive health outcomes and service needs. While program interventions (depicted in the shaded boxes) are needed to address all of the stages and outcomes of ARH behavior, this analysis focuses on a supportive environment, and knowledge and skills and access to methods for sexual responsibility and safe sex practices –for both pre-sexually active and sexually active youth.

The array of program approaches covered in the review is identified, by objective, in Annex F. These objectives include: foster an enabling environment; improve knowledge, skills, attitudes, self-efficacy; and improve health-seeking and safer sex practices. Although fewer than those identified by WHO for youth health, these objectives are in keeping with a focused reproductive health framework. While only limited examples could be included, the analyses are based on a larger number of projects and considerations. Also, it was necessary to cluster projects into broad groups and categories to review and assess them, but it is important to keep in mind that many programs cross objective lines or combine two or more of these approaches. In fact, multiple approaches and channels have been identified as generally fostering better outcomes.<sup>16,9, 15</sup>

### 4.1. Fostering an Enabling Environment

The climate into which a project or program is introduced is critical for its success. How much and what type of groundwork must be undertaken depends on a community's traditions and norms, experience in addressing the relevant issues and current views towards what is needed. Careful preliminary assessment of the environment must be done, followed by plans to work with the community to ensure receptivity to the program. Specific policy articulation may precede, parallel or follow some program implementation, but advocacy to create at least a minimal amount of support must come first.<sup>14</sup>

#### 4.1.1. Advocacy and Policy Activities

A first step in fostering an enabling environment is often breaking some taboos and increasing the discussability of ARH. Communications, ranging from street drama to mass media, is critical in this regard, as demonstrated, for example, in a PSI ARH program in Paraguay<sup>17</sup> and a CEDPA project in Mali. In the Mali program -- Advocates for Increased Awareness of Adolescent Reproductive Health and Family Planning Needs -- it was the young people who opened the dialogue on issues never before discussed "just because tradition and habit had rendered them mysterious and taboo."<sup>18</sup> They assessed their needs and developed views and recommendations and then presented these thoughts – face-to-face, on local radio and at a press conference with high-level governmental officials. They were very compelling, and program managers credit them with reaching parents and the community with the importance of the ARH issue, and with generating greater cooperation with the government, including a pledge for increased attention from the Ministry of Health (MOH).<sup>18</sup>

Youth can be among the best advocates for their own interests. Young people, who spoke forcefully in demanding a clear youth agenda, also helped move the policy development process forward in the Dominican Republic.<sup>19</sup> Recognizing the power of youth advocates, IPPF/WHR is fostering the establishment of Youth Advocacy Movements (YAMs) in their affiliates which would empower young people to influence ARH programs within their family planning associations (FPAs) and exert influence on broader country and regional issues.<sup>20,21</sup>

Media can play a key role in helping to change social norms by presenting subject matter as discussable, acceptable – and even desirable. Soul City, a South African health and development organization, uses popular media formats targeted at disadvantaged communities in a wide age range (12-45). It includes storylines specifically developed for 12-18 year olds and 8-12 year olds. Using high quality television and radio dramas, Soul City aims to increase discussion around health and lifestyle issues and change attitudes and behavior related to certain diseases and health risks. Supporting the electronic media activities are articles in newspapers, educational packages built on the storylines for use in-school and within the community (including a life skills program for ages 11-16) and publicity, advertising and advocacy. Within the first four years, Soul City has reached 12 million South Africans and has begun airing in Zimbabwe, Zambia and Namibia.<sup>8</sup>

In addition to breaking taboos and being able to raise the issues publicly, all successful advocacy and community sensitization must start with accurate and relevant data upon which to base a case for ARH programming.<sup>14</sup> Either an implementing organization can use available data and information or it needs to collect data itself. Even if considerable information exists, additional assessment is almost always required to effectively identify prime target groups and appropriate interventions, ideally with the involvement of youth and the broader community. Increasingly, needs assessments and program identification are becoming important parts of the interventions themselves, and are particularly important for awareness raising, advocacy and positively affecting community norms.

Identifying allies to help in the advocacy effort is vital, and more effective if these allies are themselves leaders. A good starting place is with those leaders already supportive of the ARH goals. However, as demonstrated by JHU/PCS in the Kenya Youth Initiatives Project, local leaders can be assisted to become advocates. In this effort, a cadre of specially trained advocates educated and encouraged support from local leaders who, in turn, influenced national leaders to move the policy debate forward in a constructive way. Evaluation results showed that nearly 10,000 leaders were reached, including many at the highest levels. And while some resistance to addressing ARH remains, vocal opponents appeared to have “toned down their opposition” and ARH has become a greater priority at the policy level.<sup>22</sup>

Identifying institutional allies is another key preparatory action. As with leaders, the program gets a jump-start when it chooses to partner with an already committed organization and moves on from there. CEDPA builds its programmatic base on carefully selected partners, rooted in their communities.<sup>23</sup> Collaborative activities with these partners always include advocacy efforts, both with organizational leaders and with the youth participants. Especially effective is engaging the power of organizations coming together in coalitions to press for action and change; the “Year of the Girl Child” was declared as a result of a petition from such a coalition of NGOs attending a CEDPA-sponsored conference. CEDPA assists youth to develop advocacy skills and to put them into action through their participation in regional and global conferences such as ICPD.<sup>23</sup>

Working with NGOs can be instrumental in developing national level policy. In Ghana, CEDPA provided technical assistance to its partners in establishing a National Youth Reproductive Health Policy.<sup>23</sup> NGOs were also important in Bolivia, where a coalition of youth-serving groups helped to keep the adolescent policy development process on course in spite of changing political power bases and leaders, according to a FOCUS case study report on Bolivia and the Dominican Republic (D.R.).<sup>19</sup> In both countries, the evolution of ARH policy, part of a larger policy effort on youth, was marked by uneven progress and significant stalls. The author points to several important lessons. In both cases, the health sector drove the policy, but worked strongly with various other sectors. It was important, as noted above, to have solid studies and evidence to bolster the case for action. Youth involvement played a major role in the D.R. effort. In addition to NGO allies, external assistance, both technical and financial from USAID and FOCUS in Bolivia and from PAHO in the D.R. was very important. Insufficient funding for

implementation plague both efforts, but country leaders view the policy achievements as having a positive effect on emerging programs.<sup>19</sup>

#### 4.1.2. Addressing Antecedents and the Social Context

The social, cultural and economic context of young people's lives has significant bearing on their reproductive health. The importance of factoring in, and addressing, contextual concerns has long been recognized in designing RH programs for the specific developing country settings where they are implemented. Recently, there has been an increased focus on these issues with an emphasis on the connection of various antecedents to adolescent risk-taking. Based on the evidence that certain sexual and non-sexual antecedents are associated with increased or decreased sexual risk-taking, some researchers argue that more programmatic attention must be directed to these broad determinants in order to reduce teen pregnancy to much lower levels.<sup>12,24,25,26</sup> These antecedents include such "clusters" as community disadvantage and disorganization, attachment to school, attachment to religious institutions, family structure and economy, biological factors, peer attitudes and others.<sup>24</sup> Depending on the positive or negative associations, these factors are also called "protective factors" and "risk factors."

While the geographic focus of concern has moved toward identifying such antecedents in the developing world, most of the research, analysis and momentum derive from US data and studies. Such an application raises several issues and challenges. Aside from being very Western (and very American), many of the antecedents identified as associated with lower risk-taking among adolescents would be difficult to affect (e.g., non-divorced parents), incorporate into a program (high residential turnover) or easily address (poverty), especially in developing country settings. Several of the stronger protective factors would be impractical – or inappropriate – for an ARH program to take on, such as parental disapproval of their adolescents' using contraception. Some, even if amenable to program interventions, could work at cross-purposes with other RH objectives, such as increasing religiosity or encouraging existing community norms.

In these analyses, family and school status and involvement are identified as strongly associated with health and risk behaviors.<sup>25</sup> However, the realities of family and schooling in much of the developing world may make such conclusions impractical to apply. For example, significant proportions of young people, especially in sub-Saharan Africa, do not live with their families or attend school. The majority of adolescent girls in this region are not in secondary school.<sup>27</sup> For them, school connectedness, attitudes toward school, and high average daily attendance at "their" school<sup>25</sup> are not meaningful.

Other programmatic concerns with the current application of antecedent analysis, as indicated by the researchers themselves, include: there are large numbers of antecedents, their causality is not well-determined, there is not very definitive evidence of their relative importance, no one is highly related to behavior and several have shown conflicting associations.<sup>24</sup> However, further research, especially conducted in developing country situations, can help to further refine some of these issues. This is currently planned. There may be some important variations on these US antecedents that do apply to feasible program development in the Third World, such as the role of certain caring adults in young people's lives. At the same time, there is a critical antecedent curiously unmentioned in all these analyses: gender dynamics (see below).

Several meetings of the international youth health, development and ARH communities have occurred to discuss ways to design and further investigate approaches based on this construct, including developing country-specific antecedents. An important conclusion of the working group was the need to conduct impact evaluation of antecedent-based programs to discern "what works."<sup>12,16</sup> The challenge will be to identify relevant factors in particular country settings that lend themselves to intervention possibilities. One study that addressed some of these matters -- "Antecedents of Adolescent Pregnancy in La Paz,

Bolivia: Findings from a Case-Control Study" -- identified some explanatory factors underlying discordant pregnancy outcomes among matched pairs of female adolescents. These potential factors include: family structure, partner relationships, knowledge of pregnancy risks, self-esteem, and locus of control. This information can help provide a basis for youth program design.<sup>28</sup>

Another interesting perspective on antecedents and contextual issues comes from analysis of European (and other developed country) norms, attitudes and programs related to ARH, including studies of countries considerably more successful in addressing teen pregnancy and responsible sexual behavior than the US has been. In a 37-country assessment, including five case studies, researchers found that openness about sexuality, a more secular society (less religiosity), more exposure to contraception, information available through the media, a clear government commitment to reducing adolescent pregnancy and legitimizing contraception and sex education were associated with lower adolescent birth rates.<sup>29</sup>

A more recent study, conducted by Advocates for Youth in connection with their European Study Tours (to better understand successful approaches carried out there), supports many of these findings. The assessment suggests that societal norms, especially an openness regarding sexual issues and acceptance of young people's sexuality, make a critical difference in rates of adolescent pregnancy, births and abortion. Accurate information and access to confidential services are viewed as not just needs, but also as rights. Parents support teens' making responsible sexual decisions. And mass media plays an important role in both encouraging open and frank discussions and in helping to educate the public.<sup>30</sup>

Although it may be enlightening to look at a country or society, or segments within one, that has had success in addressing ARH, it is also important that "Western concepts of young people, as an age cohort dependent on family, community and/or the state in an extended process of preparation for adult and productive life are not applied uncritically to developing countries," according to a UNAIDS report.<sup>31</sup> This report, a comparative analysis of contextual factors affecting risk among youth for HIV/AIDS in seven developing countries, surfaces the growing focus on sexual culture and sexual contexts within which different kinds of sexual conduct occurs. In looking at adolescent sexual activity according to its social construction, it points to realities and concerns as expressed by young people themselves in rapidly changing circumstances. As in other work being conducted on antecedents and explanatory models, this research recognizes the disparity between levels of knowledge and related changes in risk-taking practices and is designed to channel the implications of these findings into appropriate program interventions.<sup>31</sup>

Although it underscores the cultural differences that must be understood, the UNAIDS report concludes that there are some striking similarities as well. Foremost among these are gender dynamics, most concretely revealed by the inability of young women to negotiate sexual relations with men. Another key finding, across all study countries, was the rapidly changing expectations and practices of sex among young people as a result of modernization and rapid urban growth. In this regard, the study noted that young people in the study have their own meanings and expression of sexuality – in spite of "the rules", traditions and dangers. The practical implication is that program designers must consider young peoples' meanings, as they are effectively departing from traditional sexual norms, translating these changes into different sexual practices. In part, this new behavior coincides with the longer period of adolescence, before full adult status, during which young people have been expected to be abstinent. In all seven countries, young people are challenging this tradition, with the report concluding that "exhortations to abstinence or delayed sexual activity are resisted by many young people and seen for what they are – moral agendas dressed up as health promotion."<sup>31</sup>

The gender issue has many dimensions and manifestations, including the critical issue of whether adolescent girls have voluntary sex (which is typically assumed). The prevalence of coerced sexual activity is more widespread than has been commonly recognized.<sup>31,27</sup> Closely related is commercial sex,

which is sometimes involuntary and, if not, nearly always “chosen” because of the desperate economic straits of the young people, usually females, involved. The lack of voluntary sex, combined with the limits to negotiating more consensual sex, needs too be better recognized by program designers in the future.<sup>32,27</sup>

Another concern about social context, especially if data are derived from the US antecedent analysis, is the role of parents and family. Whereas parental guidance and “connectedness” may correlate with lower risk-taking (and be thus viewed positively) in the US setting, conditions are quite different for many girls in developing countries. In these settings, the home is often the base of parental control, in which girls are “virtually entrapped in the domestic sphere ... where they undergo their apprenticeship for adulthood – an intense training for a lifelong role as wife and mother.”<sup>27</sup> The authors of an important study on girls’ passage to adulthood argue, in fact, that the resultant social and economic disadvantages, stemming from gender dynamics deeply rooted in familial systems and societal institutions, are “the driving forces behind early marriage and childbearing.”<sup>27</sup>

Researchers reviewing female genital mutilation (FGM) programs in Africa call the complex and culturally entrenched belief system supporting that practice “the mental map,” complete with strong mechanisms of enforcement and rewards.<sup>11</sup> Another study concludes that it is the persistence of these norms that explains why genital cutting continues.<sup>33</sup> As with FGM (which is fundamentally an issue of gender dynamics), programs must move to better understand -- and dismantle -- this mental map.<sup>11</sup>

Program planners are beginning to translate the need for gender equity into programs that more fundamentally strengthen women’s ability to think and act in ways to protect themselves and enhance their well-being, face the more difficult issues of violence and immobility and address the power dynamic that keeps women unable to achieve their goals, small and large.<sup>23,32</sup> Research studies related to women and AIDS confirmed the reality that women have less control than men over initiation of sex and the nature and conditions of sexual encounters. This fundamental power deficit in sexual decision-making makes women, and especially young women, profoundly vulnerable.<sup>34</sup> It is a sad irony that, based on gender stereotyping, men commonly state that the responsibility for protection should be the woman’s, but also insist that women be passive. Given the need to depend on the male condom to prevent HIV, she is charged with the responsibility but not allowed the power to implement it.<sup>35</sup>

Future programs must underscore psychosocial and relational aspects of sexual interactions. The Women and AIDS Research Program, implemented by The International Center for Research on Women (ICRW), found that a small group discussion format could successfully “challenge the culture of silence” surrounding the discussion of sexuality and gender in many societies. More efforts are needed to translate some of these concerns to the larger community, challenging the prevailing social norms.<sup>34</sup> Assisting young women to negotiate safe sexual practices also means challenging culturally constructed notions of femininity and masculinity.<sup>35</sup> Thus, more focus needs to be placed on the other half of the gender power dynamic, males, addressing their notions of gender and sexual identity through which they understand their experiences.<sup>35</sup> Given the greater openness of young people, it would be practical to begin working more with boys and young men to raise alternative views about male roles in society. An encouraging piece of evidence shows that even in traditionally male-dominant societies, there are identified role models for gender-equitable masculinities. Combined with the institutional opportunities available for working with them, this program emphasis appears important and promising.<sup>36</sup>

Another encouraging program area is the work on FGM. In a recent survey of program efforts in Africa, researchers identified the emergence of large-scale information campaigns, and significant commitment from a large number of agencies, mostly NGOs working in FP/RH, women and youth issues, and human rights, individuals, and donor agencies. Government involvement is increasing and laws are being passed. In a conclusion very similar and salient to ARH, however, FGM messages that are communicated

do not, but must, address the core values, myths and social enforcement mechanisms that support the practice.<sup>11</sup>

#### 4.1.3. Community Mobilization Activities

Community mobilization is a dynamic approach designed to involve broad segments of the community in identification of its needs and strengths and work with an array of stakeholders to plan and implement programmatic responses. Those responses, or activities, can be a combination of the approaches. Key strategic benefits derive from engaging the community to express and act on its own concerns. In this process, community members become social change agents themselves, furthering policy goals and minimizing backlash or opposition. Such approaches can be particularly relevant to traditional settings or those that have not addressed ARH issues, though careful management of the process is essential.

Another advantage, depending on the program's objectives and organizing plans, is that multiple interventions will likely result, which can enhance the program's outcomes. Program activities provided in a diversity of settings and through a number of channels increase the chances of reaching more sub-groups in the adolescent population and mutually reinforce information and services.

The growing investment in community mobilization has been fueled not only by these advantages, but also by several new tools and recent documentation of experience. For example, the Participatory Learning and Action (PLA) is an approach that has been used to involve the community (including a major role for young people) in hands-on assessment of ARH needs and desired responses. There is some limited evaluative evidence of community mobilization efforts and an increasing amount of documentation, with additional studies in progress. Because the process is so time-consuming, it will be important to learn how much value-added is gained by various participatory assessment and planning approaches and to attempt to identify an appropriate balance between planning and intervention (recognizing that, in this approach, planning is intervention). Also, given the labor-intensity of the approach, questions will need to be answered about the feasibility of replication and scaling up without at the same time losing the dynamic interactions so vital to the end results.

Most of the community mobilization efforts in the developing world have not been evaluated, in some cases because they have only recently begun. Therefore, although the settings and approaches are different, it is nevertheless useful to briefly review an evaluated US project that worked with multiple institutions and resources in the community.

Begun in the early 1980s, the School/Community Program for Sexual Risk Reduction Among Teens was a community-wide outreach campaign that incorporated multiple education and service channels, engaging the entire community in preventing pregnancy among unmarried adolescents. Public schools, universities, church groups and civic organizations all served as program sites for training and workshops. Public awareness was a key component, targeted at both adolescents and residents, and using newspapers, TV, radio, communications from schools to parents and phone calls to church representatives. Teachers were trained in FL and sex education; school nurses provided FP education and referrals to public agencies and contraceptive services.

Evaluations, which included comparison sites, showed that there was a sharp reduction in the number of adolescent pregnancies in the target community following full implementation of the program, with the lowest rates corresponding to the years of greatest community involvement. However, once community support and participation declined, rates returned to pre-intervention levels.<sup>37</sup>

Developing country settings, are, of course, much different. Although the subject matter of ARH was relatively sensitive in the US situations, it is considerably more so in many of the countries where

community-based projects are being undertaken. Also, the US projects focused on pulling together existing resources to work for a common goal. The resources are many fewer in the developing world; much of the strength of these projects comes from the process of setting goals and agendas and strengthening the human resources committed to meet them.

Save the Children, for example, bases many of its projects on a community-driven approach, with an emphasis on participatory methods of planning, development and management of projects that involve youth as well as key gatekeepers, such as parents and teachers. In its newly initiated Adolescent Reproductive Health Project, Save is working in communities in Malawi, Bhutan, Nepal and Viet Nam toward available and accessible ARH services, increased individual knowledge, attitudes and behavior, a positive policy environment, and a supportive social context. Activities, which differ in each site according to community need and interest, include training service providers on Youth Friendly (YF) services, training youth as peer educators, holding dialogues with parents, developing informational materials, offering career counseling, economic opportunities and credit schemes.<sup>38</sup>

A collaborative effort between Advocates for Youth and the Pacific Institute for Women's Health, Community Participation for Youth: Sexual and Reproductive Health in Burkina Faso, is investing in a long community involvement and planning process in three different areas to identify effective strategies responsive to community needs within a supportive environment designed to expand young people's access to RH information and services. Working with a local NGO and using a "community autodiagnostic" process, each area (consisting of multiple communities) has recently identified priority ARH needs, for which they will develop activities. Although very traditional communities are involved in this project, the identified themes requiring attention were very forward-looking and progressive, including family planning, STD/HIV, unwanted pregnancy and excision.<sup>39</sup>

In a different kind of community mobilization effort, the Bangladesh Rural Advancement Committee (BRAC), a large, established social development organization working with the rural poor established informal schools for rural youth aged 10-15, 70% of whom are girls, to provide three years of primary schooling for those who have never attended school. After graduation, students can join Grade 5 in the formal school system. Monthly reproductive health sessions are integrated into the curriculum. A major emphasis is building trust with the community by meeting their needs through a credit program. The community is introduced to new ideas, involved in problem-solving and encouraged to take risks. Parents are a special priority for involvement. BRAC has anecdotal evidence that people exposed to this effort, in some way, become agents of change, leading to the changing of community norms. They consider community mobilization as a key element of their success. Considerable expansion and scaling up has occurred: there are 175 informal schools in four districts.<sup>40,41,42</sup>

CEDPA also credits community mobilization as the major factor in its program for adolescent girls in Egypt, New Horizons. Based on Choose a Future, developed as part of its Better Life Options Program in India, the Egypt program is designed to demystify and communicate essential information in the area of basic life skills and reproductive health to young women 9-20, with the goal of empowering young women to make informed choices. New Horizons was developed with the participation of community leaders, health workers, religious leaders and parents. The topics selected are rights-based and bold. CEDPA has also focused on expansion: since 1995, over 100 NGOs have implemented the program in seven governorates.<sup>23</sup>

Friends of Youth, a community-based project being pilot tested in Kenya by the Family Planning Association of Kenya (FPAK), with support of the Population Council, is designed to maximize use of existing infrastructure and resources as well as involvement of the community. The project engages respected and well-known parents in the community, trained on ARH issues and advocacy, to educate both adolescents and parents – and encourage dialogue between them. The "Friends" also work with

local leaders to improve attitudes and the overall community climate on ARH. As part of the plan, FPAK trains local providers to offer youth friendly RH services at a subsidized cost. A baseline survey, part of a quasi-experimental design, was conducted among adolescents 10-24 and their parents/guardians in the experimental and comparison sites.<sup>43</sup>

#### 4.1.4. Advocacy and Policy Initiatives

A supportive environment is critical to the initiation and successful continuation of ARH programs. While specific policies and laws sometimes follow demonstrated advantages of ARH programming, advocacy must precede any efforts to ensure adequate receptivity and support. Increasingly, advocacy is carried out through participatory approaches, working with and mobilizing the community. Collaborating initially with existing allies, a broader range of key shareholders can become involved and supportive. Communities have demonstrated a greater willingness to take risks if involved in this way, though the process is long and labor-intensive. Both mass media and localized communications play necessary roles in placing the issues in the public forum, in framing the rationale for program interventions, and in publicizing project activities and successes. Young people themselves appear to play an effective role in identifying and advocating for their own needs.

Advocacy and policy initiatives also help address social norms, which can comprise significant barriers to ARH programs. Although research attention is increasingly paid to the cultural and social context of young people's lives and risk-taking behavior, more programmatic formulations need to be designed and implemented. This is especially important on the fundamental issues of gender dynamics and inequities, which are often at the heart of program failures to enhance ARH. Some successful activities involving small groups of women, especially in HIV-prevention projects, have been carried out but questions remain about how such efforts can be taken to scale.

## 4.2. Improving Knowledge, Skills, Attitudes, Self-efficacy

Information about sexuality and the ability to communicate and act responsibly in sexual situations are basic programmatic offerings that must be provided to young people. In order for adolescents to comprehend their physical and emotional development, understand sexual issues, manage relationships and peer pressure, know how to protect themselves and their partners, be able to identify signs of illness and pregnancy and how and where to seek help, they need a fundamental knowledge of sex and reproduction. Ideally, this education and information provides skills for carrying out healthful intentions, such as decision-making, personal communications, negotiating safe sexual practices and an ability to express important concerns.

### 4.2.1. Sex/HIV Education

While most communities would agree that some sexuality education is needed at an appropriate time in young people's lives, considerable disagreement exists over what to teach, at what age, in what setting, by whom, in what manner and to what end. Virtually everywhere in the world battles have been fought over these issues and while there has been a net gain in providing better information to more young people, the road has not been straight. Even a history of the terminology reveals a concern for acceptance and safe packaging. In some countries, a few aspects of sexuality were tucked into the more presentable "population education" or "education for parenthood," the latter viewed as reaching young people who had already strayed. In other places, what started out as "sex education" had to be repackaged as "family life education," with sexual and reproductive issues included if time, teacher or policy allowed.

The quality and extent of sex education available to young people is woefully inadequate.<sup>31</sup> Because sex education is primarily situated in public schools, it is a target for public criticism and action. In addition, because public education often involves more local or decentralized control than other public programs, opponents have a greater power to reconfigure or remove it. Thus, this program area has been difficult to establish and institutionalize.

#### 4.2.1.1. School-based

There are some compelling reasons for placing sex education within schools, especially public ones. First, where enrollments are significant, a large number of young people can be educated through this approach. Such programs can go to scale through Education Ministries' structure, reaching even remote areas within countries. Implementing pre-service courses for new teachers can, over time, institutionalize the process. And importantly, provision of sex education is a key component of public policy for promoting adolescent health.

Getting to the stage of nationwide sex education, however, has been a challenge nearly everywhere, with only a few countries coming close to achieving this goal. Part of the problem has been the prevalence of

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Because of rapid growth and associated high iron requirements, young people are particularly susceptible to anemia. This is exacerbated in developing countries owing to inadequate diet, certain diseases, and poor access to health services.<sup>B1</sup> Adolescence is an important time to address anemia for girls in order to improve iron status before pregnancy.<sup>B2</sup> Intervention channels to reach young people already exist. Settings such as schools and health facilities offer opportunities to integrate nutrition education and actual services to reduce anemia. Other avenues for education and/or services, which can reach non-school going girls, include community outreach, media, and marriage registration systems.<sup>B3</sup>

In several studies conducted by Mother Care/JSI, adolescents were shown to change nutritional behavior, including adherence to iron/folate supplementation and increased consumption of dietary sources of iron and folate. In Indonesia, women counseled through marriage registries to buy and take iron-folic acid (IFA) tablets showed a decrease in the prevalence of anemia; 98% of women had taken at least some IFA tablets.<sup>B4</sup> In a dietary intervention study through community kitchens in Peru, adolescent girls increased their knowledge of anemia and improved their dietary iron intake.<sup>B5</sup>

As with other needed interventions, "creative, large-scale, sustainable avenues and opportunities need to be found for reaching adolescent girls," perhaps as part of RH programs.<sup>B2</sup>

pilot projects, typically initiated by different NGOs using varying curricula and approaches, leaving a patchwork of activities. Often there is a linkage with the MOH, as a logical ally, which helps get the pilot underway, but causes turf problems when the Ministry of Education (MOE) needs to assume the task of scaling up. Ultimately, enabling policy and political commitment are necessary to establish school programs.<sup>14</sup>

There are other implementation issues that often require sorting out, such as whether to implement sex education as a separate course or infuse the material into existing courses, to make it mandatory or optional, examinable or not and, very importantly, who should teach it. Another critical decision involves whether or not to combine sex and HIV education. Given that this newer field has taken a separate track in many countries, there are parallel, and sometimes duplicative, courses being incorporated into already crowded curricula. There is no question that the HIV pandemic has made education on the subject urgent; the challenge is to convert that urgency into quality reproduction health education, including HIV and not excluding the other issues that made sex education important before HIV emerged.

Evaluations in recent years have helped the field to understand what kinds of curricula, content and approach are associated with desired outcomes in knowledge, attitudes and behavioral change. Emphasis is now placed on interactive and experiential learning and skills acquisition. Content, designed to help young people understand the relationship of sexuality and reproduction to other key aspects of their development and lives, is now packaged in a newer generation of life planning and youth development courses.

However, while evaluations will assist planners to choose effective courses that fit their needs, larger questions relate to the readiness of introducing sexual education in particular settings and to strategies for institutionalizing effective and appropriate curricula so that large numbers can be reached. A historical view indicates that timing and opportunity, at the point of readiness (as in Latin America in the past 10 years or so), has allowed sex education to get successfully implanted in various countries.

Most of the research on individual sex education curricula has been conducted in the US.<sup>35</sup> Based on reviewing a number of curricula, Kirby<sup>44</sup> has drawn some conclusions about contributions to effectiveness, including: focus on one or more specific sexual behaviors; base on proven theoretical approaches; give a clear message; provide basic, accurate information on risks of unprotected intercourse and protection methods; address social pressures on sexual behavior; incorporate practice of communication, negotiation and refusal skills; use a variety of participatory teaching methods allowing students to personalize the information; incorporate behavioral goals, teaching methods, and materials appropriate to the age, sexual status and culture of the students; last long enough to complete important activities; and deploy trained teachers or peers committed to the program.<sup>44</sup> Most of these characteristics would likely apply to curricula used in developing country programs, though a similar analysis has not been done.

US reviews have also underscored the fact that sex and AIDS education do not encourage sexual activity. Reviews including US, developed and developing countries confirm this.<sup>35</sup> In a review of 19 studies, researchers reported that: in no study was there evidence of sex education's leading to earlier or increased sexual activity; in six studies sex education led either to a delay in sexual debut or to a decrease in overall sexual activity; two studies showed that access to counseling and contraceptive services did not encourage earlier or increased sexual activity; and, in ten studies, sex education increased adoption of safer practices by sexually active youth.<sup>45</sup>

Some US curricula identified as well-designed and effective include: "Safer Choices" and "Be Proud, Be Responsible". "Safer Choices" is a two-year high school-based curriculum designed to prevent STDs, HIV and pregnancy by reducing sexual activity and increasing condom use. It also included peer activities in the schools, parent education and school-community interaction. Evaluation results show a reduction in unprotected sex and an increase in condom use. "Be Proud, Be Responsible" recruited participants through the schools, but was implemented in eight one-hour modules on two consecutive Saturdays. Evaluation results show reduced frequency of sex, increased condom use and decreased unprotected sex.<sup>44</sup> An adaptation of this curriculum was used for the Prevention Marketing Initiative (see the "Social Marketing" section, below).

Few evaluations have been conducted on individual curricula in developing countries and there are rare examples of countries that have adopted policies on inclusion of sex/HIV education or scaled up to any extent.<sup>46</sup> Mexico is an example of both, however. The course is patterned, to some extent, on a youth development course created by the Center for Population Options (now Advocates for Youth) in 1980, Life Planning. The FLE course developed by the Instituto Mexicano de Investigacion de Familia y Poblacion (IMIFAP) -- Planeando Tu Vida (Planning Your Life) -- was tested for effectiveness and acceptability, with the assistance of the Population Council, in Mexican secondary schools. The studies showed that parents, teachers and students strongly favored including the course in the national secondary curriculum. Experimental group students increased their knowledge on contraception and were no more likely to become sexually active compared to those in the control group. Sexually active students who took the course were more likely to use contraceptives than sexually active control group students. The Ministry of Education contracted IMIFAP to adapt the curriculum for inclusion into existing primary and secondary school curriculum.<sup>46, 47</sup>

The LAC region has moved forward more vigorously on sex education than Africa or Asia, helped in part by more active opportunities for interchange at professional meetings, significant coalition and network activity and more academic interest in the subject matter. Virtually all the countries in the region have had some sex education course, or courses, introduced into the schools. Colombia has a national policy to implement sex education, has adopted the curriculum and intends for the program to be fully institutionalized. However, due to a shortage in funds, only part of the teaching force has been trained thus far.<sup>14</sup>

Family Health International (FHI) has been working with a Jamaican NGO, Ashe, to develop an innovative sex education curriculum "Preparing for the VIBES in the World of Sexuality". VIBES uses drama, music and other active techniques to engage, empower and prepare young people for sexual responsibility.<sup>48</sup> Guidance counselors are being trained in systematic waves designed to considerably scale up the program, with pre-service training to be instituted shortly. A new component will also train parents.<sup>49</sup>

#### 4.2.1.2. Community/NGO-Based

Providing sexual education outside of the schools has become an important task because of low enrolments and dropouts in many countries, but also because this approach is used when introducing formal sex education is too difficult politically or practically. Sometimes it is used as a demonstration that such education has considerable value for young people and the community as well. Such approaches are unquestionably less fraught with public policy barriers, but they also have less potential to reach large numbers of young people. At the same time, programs of this sort are required to reach those at greatest risk and in most need, including such groups as street children, refugees, unemployed youth and other marginalized groups.

Collaboration with NGOs, especially community-based agencies, is an important approach for providing sex education to young people. Working with groups that serve young people to further ARH objectives has considerable strategic potential. A partnership draws on the youth-serving organization's (YSO's) structure and network already established to address youth needs, has a ready-made target audience of youth members or participants, staff trained in youthwork, and either existing physical space or arrangements for conducting activities. Importantly, many YSOs have a tradition of voluntary service by adults to assist staff in carrying out programs. These characteristics enhance an ARH partnership program's potential for cost containment, expansion and sustainability.

At the same time, these NGOs have social objectives and value perspectives that are well established. Depending on what these are – and how well an ARH agenda dovetails – the collaboration can be more or less on a mutually beneficial track. It is important to underscore that a fit in defined objectives and policy does not have to be perfect; some advocacy toward a greater commitment to ARH on the part of the YSO can be part of the program goal. At a minimum, however, the potential YSO partner must have the potential to embrace the ARH issue and undertake mutually rewarding activities. Target group match is also important; the YSO's participant base must coincide with identified audiences of the program objectives. For example, some YSOs organize within the school setting, thus involving primarily school-going youth; this collaboration would not be conducive to reaching out-of-school youth. Thus, selection of a partner is a critical step in program design.

Documentation exists on several partnership programs with a variety of youth-serving organizations ranging from dedicated youth groups (such as the Boy Scouts, YWCA) to youth components of broader organizations and religious institutions. Rigorous evaluations on the results of program implementation are much scarcer. One of the greatest potential outcomes of working with YSOs, expansion through their

existing networks, has been limited thus far although some programs have plans for such scaling up. It will be important to test this expansion in order to assess how well programs can reach large numbers of youth through YSO networks.

Early efforts to work through YSOs met with limited or mixed success. A predecessor organization to Advocates for Youth attempted to establish sexuality education programs with 18 US YSOs in the mid-1970s, with only two engaging as full partners (another was well into its own programming, not needing TA). In the early 1990s, a program based in the 29-country Africa Region Boy Scout Association attempted to raise awareness and responsibility on gender issues among participating young men through training seminars, development of a handbook and the awarding of a family life education (FLE) merit badge. Unfortunately, within the Kenya project (one of 8), the timing of this program's initiation caused interrelated problems at both the organizational level and in the wider society. The difficulty of getting a traditional, male youth group to be comfortable with and motivated by reproductive health issues was underestimated. At the same time, a major battle developed in Kenya over the content of the manual, which the scout organization was not prepared for.<sup>50</sup>

Greater understanding and interest in ARH issues have developed since the early 1990s, along with more sensitive techniques for needs assessments, community mobilization and collaboration, which contribute to better prospects for a YSO partnership approach. In fact, CEDPA, which began youth programs in 1987 but intensified its efforts in the early 1990s, builds many of its program efforts on NGO collaborations, often with YSOs. As part of these partnerships, CEDPA conducts training and capacity-building workshops, builds advocacy skills, fosters involvement with youth and with the wider community and develops linkages with key activities affecting women's lives. Although empowering women has been a central objective, and gender concerns part of every program, actions are now undertaken for young men as well based on the need to assist young men to better understand gender inequities and problems. Based on these factors, CEDPA has worked successfully in with the YM and YWCA in Ghana and South Africa, with projects beginning to expand through these organizations networks.<sup>23</sup>

Another project with the Kenya Scout Association fared better when implemented in 1995 in collaboration with PATH. The two-year pilot tested whether or not scouting could effectively reach out-of-school youth with a family life skills curriculum that would positively affect their sexual and reproductive health decision-making. Although Scouts often attract in-school youth (although open to both), one site, a rehabilitation center for street children, was selected to attract non-school going youth. The pilot successful demonstrated the possibility of reaching both in- and out-of-schools youth and confirmed a potential for scaling up.<sup>51</sup>

FHI collaborated with the World Association of Girl Guides and Girl Scout (WAGGS) in the Health of Adolescent Refugees Project (HARP) designed to provide education and links to clinical services for adolescents living in refugee situations in Egypt, Uganda and Zambia. Although the curriculum used took a broad approach to health, an emphasis was placed on reproductive health. The project built on the Girl Guide structure to develop Guide units, work with volunteer trainers and establish new groups of Guides totaling 900 participants, who, in turn, were expected to reach another 25 peers each. Linkages were forged between local clinicians and the Girl Guides to promote greater clinic use.

A qualitative evaluation showed that, more than the one-on-one interactions, the Guides' greater reach involved the larger community – to which it brought songs, poems and role plays, in schools and at village gatherings. In this way, many adults were reached along with the adolescent target group. The pilot project was too brief to allow evaluation of the peer education impact. The linkages with health providers were more challenging than expected, given different organizational ties and lack of resources to meet increased demand. At the same time, the service providers valued their training to work better

with adolescents and indicated a desire for more. Overall, the girls exhibited increased knowledge, understanding, and self-confidence. Researchers concluded that contact with caring adult females met an important need for these girls. FHI and WAGGS are now initiating a similar project in India, for non-refugee Girl Guides, and including Boy Scouts.<sup>52</sup>

While organizational federations provide the potential for expanding ideas and projects through their networks of affiliates, coalitions of YSOs (or NGOs, more broadly, with similar interests) can speed up and increase activities among an array of individual agencies. For example, REDESS Jovenes- the National Network of Education, Sexual Health and Development for Youth in Peru promotes policies, strategies and actions among their participating organizations and professionals. This structure facilitates cooperation among private and public agencies as well as intersectoral actions.<sup>53</sup> In Botswana, Population Council's Africa OR/TA Project assisted the government's effort to enhance the role of NGOs in health and social service by supporting the development of, and strengthening a formal network of eleven NGOs concerned with ARH. Armed with the study results, the NGOs are now addressing factors that limited their effectiveness. For example, based on the findings of one of the OR studies on condom use and safe sex, the Botswana Scouts Association is beginning work on developing a scouts' curriculum on RH education for youth.<sup>54</sup>

#### 4.2.2. Youth Development Projects

There is considerable interest now in youth development approaches, though these curricula have been used since the early 1980s. Such curricula address key interrelated aspects of young people's lives, including sexuality, life options, educational aspirations and employment considerations – and how they interact. This more holistic approach aims to promote overall adolescent well-being by promoting resilience and competencies for meeting needs and facing challenges.<sup>6</sup> The U.S.-developed Teen Outreach Program (TOP) falls into this category. It has two major components: classroom or small-group sessions on key topics such as values, decision-making and communication skills, human growth and development, life options and volunteer experiences. The second component is very experiential: volunteer service in the school or community. TOP has been implemented in many locations in the US, usually in schools. Evaluation results show enhanced academic achievement, lowered dropout rates and lowered incidence of teen pregnancy, by factors as great as 40% when compared to non-TOP youth.<sup>55</sup> TOP is increasingly being implemented in community settings.<sup>56</sup>

Youth development projects (with widely diverse components based on different antecedent analysis) provide a strong, positive approach to adolescent programming. However, given that many program evaluations and proposed activities are based on U.S. data, care must be given when applying these formulations to developing countries.<sup>35</sup> Furthermore, U.S. programs often target at-risk groups of limited size, at a scale very different from what is needed in other areas. Developing countries require culturally relevant and sensitive adaptations evaluated for their acceptability and effectiveness. An even larger challenge -- once a curriculum is identified -- is mapping out the strategy for ensuring that it reaches, not just an "experimental group," but the broader youth population.

CEDPA has focused on a youth development approach because of the organization's emphasis on women's empowerment and the need to address gender roles early in young people's lives. In India in 1987 CEDPA launched Better Life Options (BLO), a non-formal education program to address gender inequity as well as the urgent education and health problems of girls. Beginning with programs for girls 12–20, the program focused on building self-esteem, opportunities and vocational potential through FLE, ARH education and services, public awareness and advocacy. The culturally sensitive and participatory curriculum covers a wide range of topics, including RH, nutrition, and self-protection from violence and abuse. In a study designed to identify ways to improve the project, CEDPA found that following the

program, 80% of the participants played a role in decision-making regarding age of marriage, education, food and employment compared to less than 20% before the BLO program. More recently, CEDPA has begun working with young men, emphasizing gender roles, male RH and other relevant topics.<sup>23</sup>

#### 4.2.3. Peer Programs

Peer education builds on the reality that people tend to congregate and talk with other people similar to themselves. Peer education programs are those which train and deploy as educators people similar in age, place of residence, occupation or interest area to those who are targeted to receive the designated education. This approach has particular salience for young people and sexual/reproductive health education as peers are commonly identified as one of the primary sources of such information. Peer programs in ARH, therefore, ensure that a cadre of young people is armed with accurate information to pass on to their peers within the program's catchment area.

Although most "peer programs" are based on the same strategic considerations, they vary considerably in objectives and operations. The array of names used to designate such programs suggests the range of activities: peer educators, peer counselors, peer helpers, peer promoters, peer distributors. In fact, all peer programs provide education, many also provide counseling and referral and some distribute contraceptives and other reproductive health commodities. Peer projects can be implemented as discrete activities or comprise a component of a larger program, such as part of a formal school sex education program, a clinic program (both as outreach agents and educators/counselors within the clinic) or as part of a social marketing effort.

Peer programs represent a very popular activity, implemented in some variation in virtually every country that addresses ARH in any way. A great advantage that peer programs offer is the direct and meaningful involvement of young people in the program. Adolescents can not only reach and effectively communicate with their peers, but they can provide the program with regular feedback about what does – and doesn't – work with the target audience.

There has been an array of evaluations on peer programs addressing ARH, varying in quality and in results. As might be expected, most studies show a much greater effect on the peer educators themselves than on their intended target audience. Other design and operational issues also need to be better understood for future application, including effective recruitment and selection, turnover, supervision and training, and compensation. The last item is particularly challenging for most programs and of great concern to the peer educators.<sup>1,57,58</sup>

#### ***Preventing the Second Birth: Providing Adolescent Girls with Greater Opportunities***

The Jamaica Women's Centre has pioneered an approach to help girls who become pregnant while in school to reenter the system after giving birth, delay the second pregnancy, and increase their employment potential. Founded in 1978, the program provides academic instruction to those who could return to school and skills training and vocational counseling to those past school age. The program has expanded to seven other main centers and six outreach stations. Recently, activities intended to delay the first pregnancy have been added, including after-school academic assistance and family planning counseling for nonpregnant teens.

This project has been evaluated in various ways over the years. Results showed that 55 percent (Kingston) and 73 percent (Mandeville) of recent Center graduates had returned to school, compared to only 15 percent in the control group. Compared to a repeat pregnancy rate among control group women of 39 percent, 15 percent of Kingston graduates and only eight percent of Mandeville graduates experienced a subsequent pregnancy within three years.<sup>B6</sup>

An FHI case study of the Centre reported that program participants credited this program with helping them to realize they could control their fertility and that they have a clear responsibility for what happens to them as sexually active women. Program staff confirm that this is taken seriously: over the years the pregnancy rate of participants through completion of secondary school has fallen to 1.3-1.4 percent annually.<sup>B7</sup> The Centre has broad coverage: 1997 figures show that the program reached 52% of the 3,016 young women under 16 who gave birth islandwide. Importantly, the Centre helped change policy that now allows mothers to return to school.<sup>B8</sup>

In the Jamaica Red Cross Together We Can Project, peer educators reported significant gains in knowledge about HIV transmission and about where young people can go to find help with STDs. Most of the peer educators also intended to delay their first or subsequent sexual encounters and to use condoms when sexually active.<sup>59</sup> A major study of 21 AIDSCAP projects found that 95% of peer educators had made changes in their own life and behavior, 31% were practicing safer sex and/or were using condoms, 20% had reduced their number of sexual partners and 19% had changed their own attitudes.<sup>60</sup>

Other studies show effects on the intended target audience. The West African Youth Initiative in Nigeria and Ghana used peers to provide reproductive health and sexuality information and counseling to young males and females aged 12-24 in community group settings. Evaluation indicates significant positive effects on program participants' knowledge, perceived self-efficacy, and behavior. A post-intervention survey found that after about 18 months of program activities, the target population showed increases in knowledge and in the use of modern contraceptive methods, when compared to the baseline survey. Compared to a control group, the experimental group showed greater feelings of confidence in saying "no" to sex, in asking a partner to use condoms, and in buying contraceptives. More young people in the experimental group than in a control group reported that they had taken protective measures against STDs/HIV. These included abstinence, limiting the number of sexual partners, and the use of condoms.<sup>61</sup>

The flexibility of peer programs allows their use in a variety of settings, based on selecting educators who resemble and relate to the target audience. In a Thai factory-based setting, single female adolescent workers involved in a peer-led education program demonstrated the most significant improvements in both knowledge and enabling skills when compared to their counterparts reached by either adult health educator-led sessions or by sessions employing materials only. The program participants improved their skills in being able to discuss contraception with their partner, as well as their ability to assume responsibility for practicing contraception. The peer-led group also exhibited the most pronounced increase in perceiving themselves as potentially vulnerable to contracting the HIV infection, but had the lowest level of fear because they had learned how to protect themselves.<sup>62</sup>

In similar ways, peer programs have been set up in university settings, among gang members, in brothels and among hard-to-reach and marginalized sub-populations. For example, the peer education program at Kenyatta University in Kenya in collaboration with Pathfinder International trains students to reach their peers one-to-one and in group settings, distribute condoms, and refer students to depot holders and the health center. Program statistics report a 50% decrease in the rate of unplanned pregnancies on campus.<sup>63</sup> A program in El Salvador, Homies Unidos, is a peer education program led and implemented by gang members to reduce violence, promote educational and employment opportunities, and foster a healthier lifestyle, including STD/HIV prevention.<sup>64,65</sup> In Thailand, Lifenet targets young people at risk through peer educators at discos, bars and other nightspots where they congregate. Based on social network analysis, the project has focused on key leaders to help build support systems among their peers.<sup>66</sup> Also in Thailand, peer education activities, as part of a larger effort involving condom use in brothels, resulted in a sex worker refusal rate to have sex without condom use of 92% compared to a pre-intervention rate of 42%.<sup>67</sup> The Indonesia Planned Parenthood Federation began peer education outreach efforts with marginalized groups at risk of STDs and AIDS, such as transvestite sex workers, and increasingly focuses on mainstream youth.<sup>68</sup>

In a recent study project on HIV/AIDS peer education programs coordinated by UNAIDS and the Horizons Project, a review of programs was conducted by an international consultation of experts based on their experiences and a literature review. In addition to identifying ongoing unresolved issues, the report drew some key conclusions. Among these was the observation that peer education is not only useful in fostering changes at the individual behavior level, but also may be used to create change at the group or societal level by altering norms and encouraging community action that influence programs and

policies. Also, the group recognized that services related to STD/HIV prevention, testing and management must be in place, as peer programs stimulate a demand for them<sup>1</sup>.

#### 4.2.4. Mass Media

A mass media approach is important in the ARH arena because it can introduce words, ideas and discussions that need greater public consideration. TV, dubbed “the great legitimizer,” helps people to begin dealing with formerly unspoken or taboos subjects, both responding to and influencing the public debate. A great advantage of mass communications is its ability to incorporate information within entertaining formats, holding the audience’s attention for important message transmission. It can provide actual role models and “scripts” for good interpersonal communication, for example, by showing adults talking with children and sexual partners discussing protection before deciding on sex.

Media programs are thus critical at early stages of ARH program development, but play other roles at other stages. Various media program designs often have elements intended to promote behavioral change by encouraging specific actions, such as calling a hotline or going to a clinic. Other media activities are components of larger efforts, for example, promotion of youth friendly services and social marketing campaigns. A major challenge for this approach is cost; high quality media has a high price tag. Some additional assessment needs to compare cost and result as well as other factors related to targeting the adolescent population most effectively.

Evaluating media efforts designed to provide information, change attitudes and foster certain behaviors has presented a significant challenge to researchers. Whereas commercial companies use market research to measure changes in product sales as a result of advertising, and determine what price to pay for these campaigns, it is not so easy to measure discussability or acquisition of new ideas. For example, when the Center for Population Options’ Media Project finally got the word “condom” on prime time television in the mid-1980s (after having the word “responsible” censored in 1978 because it suggested condom use), setting the stage for additional discussion of these issues, can we measure what changes resulted in institutional and personal behavior?

Evaluations are now being used to measure a new generation of media activities in developing countries, pioneered largely by the Center for Communication Programs/Johns Hopkins University (CCP/JHU). These efforts combine education on RH with entertainment formats to attract and engage the audience while important information is communicated. “Enter-educate,” as it’s called, works particularly well with young people, who have their own entertainment idols and favored formats.

CCP/JHU’s Philippine Multi Media Campaign for Young People built on their experiences with popular singers Tatiana and Johnny in Latin America. A major addition in the Philippine campaign was an advertised telephone hotline (Dial-a-Friend) linking young people to counseling and health services. The project was designed to reach young people 12-24 (with an emphasis on 15-19) from middle and lower socioeconomic groups in the Metro Manila area. The primary objectives included increasing awareness of the problems of early pregnancy and pregnancy before marriage and promoting the concept of sexual responsibility. The campaign was carried out using a popular group and an up-and-coming singer, Lea Salonga, selecting appropriate songs to record and perform, arranging wide coverage for the songs, conducting related essay and art contests and promoting the hotline.

The evaluation included a baseline, mid-project and final survey, and monitoring of the hotline calls. Results showed that 92% of young people questioned in the second survey, when one of the songs was at its peak of popularity, recalled the song, with 70% able to interpret the message correctly. Of those recalling the song, 51% said it had influenced their behavior. Forty-four percent had talked with friends and parents and 25% said they had sought information about contraceptives as a result. Although not all

calls were able to get through, Dial-a-Friend received over 8,000 calls in the first seven months of operation. Most callers were single, female, between 15-24 and calling from home. Their priority concerns included boy-girl relationships (including pressure to have sex), problems with parents, self-concept, problems with peers, and sexuality matters (including unwanted pregnancy, family planning). Although Dial-a-Friend made referrals to counseling and health services, a weakness of the evaluation was the failure to adequately monitor referrals at the service sites<sup>9</sup>.

CCP/JHU carried out a broader media program -- the Kenya Youth Initiatives Project -- collaborating with 26 youth-serving organizations on both policy and education for youth on RH. The education component included two radio programs, the *Youth Variety Show*, a weekly interactive hour-long show in English, and *Dau La Ujana*, a weekly 15-minute drama in Kiswahili. Both programs were designed to provide information, in an entertaining way, identified as needed by youth; youth were also invited to provide feedback for upcoming episodes.

Evaluation results indicated that over half the youth (and 40% of adults) interviewed in a nationwide survey had listened to the *Youth Variety Show*, and about 40% of youth and adults listened to the drama. Importantly, radio was cited by 56% of the youth as the main source of referral to youth-serving sentinel sites after four months of project operations compared to only 23% at the inception of the program. The evaluation showed that the shows were able to appeal to younger as well as older youth, covering an array of issues of concern to different interests<sup>22</sup>.

In Paraguay, PSI, in collaboration with FOCUS, implemented the Arte y Parte Project, a communications project using tailored media products and peer education to increase RH knowledge, communication and negotiation skills and to promote responsible sexual behavior. An evaluation using a pre- and post-survey of adolescents, one-time surveys of school principals and adult/parents and program records showed that, overall, the communication efforts succeeded in reaching a significant number of youth. About 44% of the youth in the follow-up survey had been reached by one of the activities, with radio the most successful, reaching 39%. Although youth of lower socioeconomic status and out-of-school were not reached as successfully, probable owing to the emphasis of school workshops over street drama during the project's second year, there was some evidence that they were more responsive to the messages. There was an increase in knowledge of selected sexual/reproductive health indicators (for example, that condoms prevent STDs) and in certain attitudes/beliefs (for example, that both partners are responsible for protection). However, this latter finding was offset by an increase in those who disagree that girls who protect themselves are responsible. Lessons learned include the demonstrated potential of mass media to reach large numbers of adolescents at modest cost, the need for market segmentation, and that counseling and services must be available as part of a communications effort on ARH<sup>17</sup>.

Communications programs often form essential parts of larger programs. In Uganda, for example, behavior change communications campaigns were integrated into the Delivery of Improved Services for Health (DISH) Project, which contributed to increases in contraceptive prevalence, condom use to prevent STDs and an increase in clients attending health facilities. A targeted campaign within the project was designed for 15-19 year olds, Safer Sex or AIDS, encouraging young people to wait until marriage to have sex or to use condoms to prevent HIV/AIDS.<sup>69</sup> The campaign reached a large number of the intended audience and contributed to an increase in knowledge and in condom use among sexually active respondents from 46% to 70%.<sup>70</sup> Similarly, a newspaper prepared by youth for a youth audience, *Straight Talk/Sema Wazi Wazi*, is part of the Tanzania AIDS Project and is designed specifically for the target group's information and behavior change communication needs. Part of its distribution involves placement in over 350 secondary schools nationwide and insertion into regional newspapers and a popular sports paper.<sup>71</sup> Another youth-to-youth newspaper, *Trendsetters*, is widely popular in Zambia, where there is some evidence that ads for private physicians have generated new clients.<sup>72</sup>

#### 4.2.5. Linkages with Employment and Livelihood Programs

Although high unemployment is a significant problem for both young men and young women, there are special issues related to female work and reproductive health. To the extent that females are in the labor force, it is probably most often as domestic servants, though this work is largely undocumented and undervalued – and too often exploitative. In contrast, wage-earning, more adequately compensated and under good working conditions, could have benefits for girls' health and socioeconomic well-being.<sup>27</sup>

A trend to hire young women in the textile industry appears to be increasing in several developing countries, especially in Asia and Latin America.<sup>27</sup> While many of these young women clearly face substandard working conditions, they also gain, in addition to income, increased self-respect and independence. One specific social effect that has been identified is delayed age of marriage. Such positive variations from strict gender stereotypes may help not just the young employed women to pursue a more self-determined future, but may also help change social norms for the larger society.<sup>27</sup>

Workplace settings also provide a channel for provision of RH education, and in some locations, actual services. In northern Thailand, a peer education program focused on HIV prevention for young factory workers was tested as part of an ICRW program. Evaluation results show improvements in respondents' understanding of risk-reduction and the importance of communicating with partners about HIV/AIDS and safer sex; there was also a reported increase in actual communication among partners as well as efforts to educate family and community members about sexual health.<sup>73</sup>

A more recent project in Cambodia aims to reduce barriers to sexual health services for out-of-school youth. Based on the need to challenge social and attitudinal norms that create gender inequalities, the research phase began with a participatory approach to explore the social and economic context of sexual decision-making and behavior among young garment factory workers. Findings include concern about health, cost and confidentiality barriers to seeking health care, inaccurate RH knowledge and negative views about condoms in an established relationship.<sup>74</sup>

In countries or areas with less developed economies, efforts are beginning to link adolescent RH and livelihood components. CEDPA, for example, places an emphasis on economic opportunities in its partnership programs, linking with income generating and microenterprise activities.<sup>23</sup> In India, the Population Council's Frontiers Project plans to test an add-on livelihoods component for unmarried adolescents to an ongoing CARE India RH care program for urban slum dwellers. The new component will include peer vocational counseling, vocational training, follow-up supportive counseling and group savings formation. RH services will be extended to adolescents.<sup>75</sup> IRCW will also be investigating linkages between RH and livelihood projects for adolescent girls.

#### 4.2.6. Use of New Information Technologies

Computer technology is developing quickly and, while it remains unavailable to much of the developing world, it is making significant inroads. Using computers is especially appealing to young people. Because programming can be interactive, educating with computers more directly involves the user than passive methods; such programming can also be made fun and entertaining – and confidential.

Some computer-based learning is already being used and tested. In a new initiative, IPPF/WHR is exploring what its affiliates are doing with computer technology while working on sexual and reproductive health with youth. Early findings suggest that the affiliates in Chile, Costa Rica, El Salvador and Peru are already using computers in their youth programs to some extent and most affiliates intend to do something with computer technology in the near future. Examples include:

- In Peru, INPPARES and JHU/PCS set up an interactive, computer-based instruction program Isabel: our Electronic Counselor" to increase knowledge about sex, sexuality, unplanned pregnancy, contraception, and gender to encourage family planning use and avoidance of risky behaviors among adolescents and young adults. The touch-screen computer is set up in the clinic waiting room; a clinic "hostess" invites and directs young people and couples to try it out. The evaluation, conducted by the Population Council in Peru, along with IPPARES and JHU/PCS, found the typical user to be a woman (67%) between the ages of 13 and 24 (42.9%). Topics most frequently consulted were benefits of family planning, first sexual relation, machismo, hygiene, and abortion prevention. In a survey of users, clients liked the program and mentioned that it helped them avoid the embarrassment of having to ask strangers about issues of sex and sexuality.<sup>76</sup>
- MEXFAM, collaborating with the Population Council, tested the use of interactive touch screen kiosks as a means to increase clinic clients by providing information on RH services. Based on the assessment results, clinic directors concluded that, while using such kiosks was not a good strategy for generating new clients, it is an excellent medium for providing RH education, especially to hard-to-reach audiences such as adolescents and males.<sup>77</sup>
- APROFA in Chile is planning to use interactive computer technology with adolescent males as part of a new initiative on understanding the influence of gender and gender roles related to sexual and RH.<sup>78</sup>
- ADS in El Salvador has a Cyber Center that provides Internet access at a low cost to youth.<sup>71</sup>
- Advocates for Youth has an Internet resource and referral service for gay, lesbian, bisexual and transgender youth, which gets about 1,900 visitors each month. Plans are underway to collaborate with IPPF to establish a site for peer educators throughout the world, enabling them to report on new developments, exchange ideas and interact to problem-solve and improve their performance.<sup>79</sup>

#### 4.2.7. Information and Education

Information about sexuality is a basic need and right – and a necessary but not sufficient part of what young people require for good reproductive health. Although studies, mainly from the U.S., have identified components of a successful sex education curriculum, such criteria may be difficult for developing countries to meet in the short run. Youth development approaches, based on antecedent research and holistic principles, provide a good model for addressing broader youth needs but may be less easy to implement in developing countries, especially on a broad scale, which would require intersectoral coordination at the policy level. A characteristic of successful programs that appears critical to success is an interactive and experiential learning environment where young people can comfortably and safely explore issues and concerns and develop skills to practice safer sexual behavior. New information technologies involving computers offer potential for confidential information and diffusion of new ideas.

Information and education approaches have succeeded in a variety of settings, including schools, youth groups, community locations, and the workplace. Peer projects are often part of these efforts and, although they are very popular and used widely, many questions about their sustainability and the quality of peer communications remain. In all of these educational efforts, ways to go to scale are the big challenge. Media activities can successfully reach a large portion of the population, and result in knowledge and behavioral changes, but these changes do not appear to survive the campaigns. Sustainability and intensity of intervention, not reach, are the challenges with media programs. However, media can introduce new ideas and foster social change, thus contributing to a positive climate for other interventions. With all of these approaches that inform and motivate, it is essential to have RH services in place as increased demand is created.

### 4.3. Improving Health-Seeking and Safer Sex Practices

Although there are differing views about motivations for safer sex and sexual responsibility, there is a strong consensus that methods to prevent pregnancy and sexually transmitted disease must be conveniently accessible in order to achieve good adolescent reproductive health. There are numerous ways in which various reproductive health services can be delivered, through: public health facilities, NGO clinics, teen centers, youth-serving and community-based organizations, CBD and other outreach activities (including peer distributors), private physicians, the commercial sector (especially pharmacies, but also food shops, kiosks and other retail outlets), and social marketing efforts. Some of these strategies are combined within a single program whose primary objective relates to service delivery, while others interrelate with programs that have multiple objectives, such as combining reproductive health education, counseling and health service delivery and/or referral.

A program designed to deliver services in diverse ways and settings has benefits for young people as their needs and preferences for services vary considerably, especially at different stages of adolescence. In an ideal setting, therefore, there would be multiple choices for counseling, preventive care and treatment. While possible, broad options do not usually exist, at least in service models that make young people feel comfortable. Adolescent decisions about where to obtain services place an emphasis on non-judgmental provider attitudes, trust, confidentiality, cost, convenience and confidence in the quality of method or care.

Because most young people consider themselves healthy, they are reluctant to seek preventive care at health facilities more commonly used for curative care. They also prefer obtaining needed methods without running the risk of encountering neighbors or relatives within a clinic setting. Health facilities have developed well-deserved reputations for being unaccommodating to young people. Young people indicate that they'd rather pay for contraception or treatment than run the risk of the nurse's delivering moralistic lectures or telling their parents why they've come to the clinic. In most countries young people prefer going to pharmacies and private doctors, or depending on informal advice and remedies.

#### 4.3.1. Facility-based services

Although young people prefer other sources, there are several good reasons why some attention should be given to health facilities to increase their youth-friendliness and use by young people. First, there are existing and extensive public networks of such facilities in many countries, reaching significant portions of the population; these could be adapted to better attracting and serving youth. Second, in many developed countries, public health facilities have been shown capable of attracting and effectively serving young people for RH needs. NGOs, too, have networks of clinics, albeit more limited, that can adapt policies and activities to serve youth. In fact, such groups, especially FPAs, have pioneered some approaches for this population. Finally, some kinds of care that young people need, such as laboratory tests and STD treatment, lend themselves to a clinical setting.

##### 4.3.1.1. NGO

Significant efforts have been made in developing youth-friendlier services, often with NGOs leading the way. Profamilia, the IPPF affiliate in Colombia, has been in the vanguard of developing effective approaches to ARH. Profamilia provides youth-friendly services in 22 clinics with three different approaches. First, dedicated youth centers were established in three large cities in response to a heavy demand for services by young people. Given the high cost and the difficulty in sustaining such centers, other approaches needed to be implemented. These included physical spaces set aside for young people in existing clinics with personnel exclusively attending to young people, and "Adolescent Services"

provided to young people in regular clinics. Profamilia emphasizes deployment of young professionals capable of empathy and with positive attitudes toward their young clients.<sup>80</sup>

Profamilia's Youth Center in Bogota alone serves 1,000 teens per month. Other centers attract clients, too. Following a three-year intervention addressing unwanted pregnancies and STI/HIV among adolescents in nine small and medium cities, there was an increase in clinic-based service clients from 6,111 the first year to 17,240 the third year at the participating Profamilia Youth Centers. Over 70% of the clients were single women, between the ages of 17-19. The project involved workshops for in- and out-of-school youth and training/deployment of peer promoters.<sup>81,82</sup>

There is considerable youth activity in other FPAs in the LAC region. INPPARES in Peru, Mexfam in Mexico and Profamilia in the Dominican Republic are among others actively addressing ARH issues. IPPF/WHR has assisted the process of sharing ideas and expertise through both South-to-South sharing among the FPAs and the South-North Partnership, in which FPAs from the South are paired with counterparts from the North for mutual assistance.<sup>83</sup>

The FPAs are active in other regions too. For example, in Burkina Faso, the IPPF affiliate, Association Burkinabe pour le Bien-etre Familial (ABBEF), has implemented a project --Youth for Youth -- designed to test and develop a participatory model to help young people protect themselves against unwanted pregnancies, STDs/AIDS and unsafe abortions. Activities include provision of IEC, peer educators (who also distribute condoms) serving both in- and out-of-school youth and youth centers providing education, counseling, some limited games and a range of RH services.

The primarily qualitative review included focus groups and interviews with youth, parents, community leaders and project staff. Youth reported that they learned useful information, had changed their own behavior, had acquired skills to avoid risky behaviors, and were now able to negotiate with their partners. They specifically noted that they know how to avoid unwanted pregnancies, STDs and HIV/AIDS and about different methods to do so. Project service statistics show that 82% of visits to the youth centers are actually visits to the clinics (within the centers) for services or counseling and that 77% of these clients are young women. Over 81% of the visits to use the recreational facilities are by young men. Interviewed clients described the staff as friendly, welcoming and non-judgmental and that they felt comfortable and not embarrassed talking about their problems with them. Very importantly, the government of Burkina Faso considers ABBEF to be a pioneer in the ARH field and is planning to create ten new youth centers based on the Youth for Youth approach.<sup>84</sup>

#### 4.3.1.2. Public

A collaboration between the FPA, the Planned Parenthood Association of South Africa (PPASA) and the government, primarily through the Department of Health, as well as other NGOs and private agencies, is underway in South Africa with the loveLife project. The project's primary goal is to effect positive behavioral change to reduce teenage pregnancy, STDs and HIV/AIDS, and by doing so, improve adolescents' sexual and reproductive health. Four main project action areas include media and entertainment, print and radio, services and institutional support and research and evaluation. An integral component of loveLife is the National Adolescent-Friendly Clinic Initiative (NAFCI), which aims to encourage health facilities to make services more accessible and acceptable to adolescents, with a focus on public sector clinics. Part of the overall plan includes a clinic accreditation process, with qualifying facilities awarded stars depending on their appraisals.<sup>85</sup>

Public health facilities have typically been avoided by young people for their lack of friendliness, especially provider attitudes and concerns of confidentiality. Yet these challenges have been significantly overcome in many developed countries and are showing promising signs in some developing countries,

especially in Latin America. For example, in the US, approximately 63% of young women 15-19 obtain family planning services through a public source<sup>86</sup> and 60% of publicly supported family planning clients are under 25<sup>30</sup>. Several Latin American countries are moving ahead on public service provision to adolescents. For example, a recent study of ARH programs in Argentina, Mexico and Brazil found some promising signs in the public sector, such as highly motivated health teams committed to serving this population and adolescents reporting satisfaction with the health care received. To be sure, some challenges remain, including those related to government policy and implementation and continuing social, cultural and religious barriers. Researchers noted that males do not seek these services and that incorporating young men would require overcoming significant obstacles. Operation problems persist, too, such as long waits, need for more provider training and better systems for monitoring and evaluation.<sup>87</sup>

***Emergency Contraception:  
A new opportunity for young people***

While emergency contraception (EC) is new to much of the developing world, this method offers the potential of averting pregnancy after unprotected intercourse and can help young people begin to use regular contraception.<sup>B9</sup> In a Population Council study in Africa, of the non-contraceptive users who received EC, over 90% eventually chose a routine FP method.<sup>B10</sup>

EC is still relatively unknown. In a study of Nigerian university students with previous clandestine abortions, only 30.1% knew about EC, and only 15.7% had ever used it. However, 63% said they would use EC in the future.<sup>B11</sup> Knowledge and practice figures would likely be much lower among younger adolescents and/or less well-educated youth.

Delivery models will be a challenge in developing countries, especially because of the need for rapid treatment (within 72 hours). Furthermore, a Population Council study in Zambia showed that male and female students were unanimous in wanting to obtain EC only in private circumstances.<sup>B10</sup> A possible solution to the time constraint is to provide EC in advance, to have on hand in case it's needed.<sup>B9</sup>

While scaling-up YFS in developing countries is limited (and analysis even rarer), there are studies in both developed and developing countries that look at specific models, or characteristics of youth friendly services to attract, serve and positively affect adolescents regarding their reproductive health. For example, in a US study, a special adolescent protocol that stresses psychological and social concerns was implemented in six nonmetropolitan family planning clinics. The design included the following elements: one-to-one teen counselors, involvement of male partners, encouragement of parental involvement, additional time for discussion, more frequent follow-up visits, and other refinements. This intervention resulted in greater contraceptive continuation and lower pregnancy rates (within 1 year) among clients in the experimental group compared with the control group.<sup>88</sup>

Several projects to assess the success of a model in developing countries are in progress, with some evaluation results available. For example, in Zambia, the Lusaka Urban Youth-Friendly Health Services Project, is a collaboration of SEATS-JSI and the Lusaka Urban Health Management Team (LUDHMT) to improve and to promote access to and use of quality RH services for youth ages 10 to 24 years. Before establishing the program, a

participatory learning and action (PLA) exercise was undertaken to create awareness and to identify needs. Key design elements to attract and to serve youth included implementation of youth-friendly services and placement of trained peer educators in "Youth Corners" in two clinics; the peer educators also performed community outreach. The evaluation using PLA, focus groups and interviews showed an increase in young clients compared to the control clinics, including client visits to the "Youth Corners" and increased condom distribution. However, most of the clients were either being seen for STIs or were young mothers for ante-natal care and FP counseling and services. Several factors can help explain the apparent limited success thus far of this model. There remains some cultural and social hostility to YFS in the community. Operationally, there were too few peer educators to cover their assigned catchment areas. The service providers were not fully trained as the project got underway, and some continued to have mixed feelings about adolescent sexual activity. Some young people reported that they did not think that their concerns about education and employment were being addressed. Importantly, it was recognized that the LUDHMT did not assume adequate ownership of the program and would need to do so for planned expansion to take place.<sup>89</sup>

In Zimbabwe, a collaboration between SEATS and the Gweru City Council sought to create a more favorable climate for the provision of ARH information and services and to increase utilization of available RH services by youth. The design included mobilization of community leaders and parents, training service providers, training peer educators and establishing a youth corner in the youth center. The center was renovated; indoor and outdoor recreational activities were added to attract youth. Quantitative baseline and endline surveys of unmarried youth 12-24 living in selected areas of Gweru showed that more youth were attracted, but, similar to the FPA youth centers reviewed below, most were male and most came for the recreational activities (80.5%). Only 2.5% of clients were attracted by the RH services.<sup>90</sup> In a related study of service providers, 75% indicated that they were not adequately trained to serve youth, with one-half saying they are not comfortable discussing sexual and reproductive health issues with 12-14 year olds.<sup>91</sup>

#### 4.3.1.3. Youth Centers

Several FPAs in Africa have also developed projects for young people, including youth centers whose primary concern is ARH, but which provide expanded educational, vocational and recreational activities in a youth-friendly setting. This approach was used earlier in the LAC region, and largely discontinued or reconfigured because of cost and sustainability problems.<sup>92</sup> Evaluations of youth centers in three African countries (Kenya, Zimbabwe and Ghana) also found that the high costs of maintaining the centers in view of clients served, compared to costs of supporting the outreach/peer promoters component, were not justified given assessed results. In Kenya, attendance at the two centers was low, especially for RH services. (No clients came for contraceptive services during the two-week data collection period.) Males outnumbered females by 2-1 and the vast majority came for recreational activities. Eighty-six percent of the clientele was over age 20.<sup>93</sup>

Very similar results were found in Zimbabwe and Ghana. In Zimbabwe, clients' average age was 21 and in Ghana 18. Those using clinical services were even older: 45% in Zimbabwe and 43% in Ghana were over 24. RH use is also low in these centers: only 4% of clients during the collection period in Zimbabwe and only 12% in Ghana reported to have ever come for this purpose.<sup>94,95</sup> Many of the added activities are used to both sanitize RH services and create reasons for young people to attend. Given that these centers intended to provide young clients with RH counseling and services, they failed to achieve their goals.<sup>87,94</sup> At the same time, there were problems with design and implementation. Youth felt uncomfortable going to centers run by family planning associations. Once there, providers were often judgmental and many young people surveyed did not trust that their concerns would be kept confidential.<sup>93,94,95,96</sup>

Although neither have had rigorous evaluations, two health center programs appear to attract a healthy mix of both young men and women who use the RH clinical facilities. The Action Health Incorporated (AHI) Youth Centre outside Lagos, Nigeria, provides RH education, life-planning skills and services free of charge to young people. The Centre sponsors many other activities, including entertaining education sessions on relevant topics and on special occasions such as International Women's Day and Valentine's Day, as well as publishing a teen-friendly quarterly magazine filled with advice and information.<sup>97,98</sup>

FOSREF (Foundation pour la Santé Reproductrice et de l'Education Familiale – Foundation for RH and Family Education), an NGO in Haiti, operates two youth centers in Port-au-Prince and will soon open five more in other locations. FOSREF offers a wide range of services, FLE programs and activities (such as clubs and RH contests), which are all well-attended. A mid-term evaluation identified a large number of contraceptive acceptors, but also noted considerable discontinuation. Information sessions and counseling, provided by peers, were well-utilized.<sup>99</sup> Although both the Nigerian and Haitian programs appear successful in attracting both girls and boys to clinical services, clearer results must await more

systematic evaluations. An important difference between these and other centers is that most of these activities seem focused squarely on RH issues – albeit many offered in fun and engaging ways.

#### 4.3.2. School/Clinic Linkages

Several projects have tested the linkage of school activities with clinics. A successful three-year intervention was implemented in the US, the Self Center. A partnership between junior and senior high schools and a neighboring clinic, the program combined school-based presentations, discussions and counseling linked with services provided by a team of nurses and social workers who divided their time between the schools and the clinic. At the clinic, in addition to providing RH services and counseling, staff encouraged other educational activities and discussion. Evaluation results showed that students in program schools, in contrast to those at comparable schools, showed reduced levels of sexual activity, more effective use of contraception and lower pregnancy rates (a decrease of 37% compared to an increase in non-program schools of 58%). Those students abstinent at baseline who attended all three years of the course postponed intercourse for an average of seven months.<sup>37</sup>

In Chile, the Integrated Adolescent Development Program for Urban Teenagers was patterned after the Self Center. The replication and adaptation were undertaken by the Center for the Reproductive Health of Adolescents (CEMERA), a University of Chile affiliated center that provides clinical services, research and training in ARH. Most design elements were very similar, with a few alterations. In addition to a very different cultural setting, the curriculum took a broader adolescent development approach and the referral clinic was not as accessible. Also, CEMERA staff were available in the school for only the first two years. The evaluation used a quasi-experimental design, with control schools, and found for the program school students: substantial increases in knowledge, postponement of first intercourse for boys participating for three years and modest increases in the use of contraception at last sex, especially for girls.<sup>100</sup>

In Brazil, the Strengthening Public Sector ARH Project addressing policy, training, and services, was designed to establish an effective linkage between schools and health clinics. On the basis of some earlier efforts on incorporating sexuality education into secondary school curricula and on the consequent increased use of clinics by adolescents for family planning services, the project emphasized preparing health providers to work with adolescents. In addition, project components included a coordinated approach to policy revision, the training of student educators, the inclusion of sex education into different disciplines by trained teachers, and the establishment of cross-referral systems. The purpose of this pilot demonstration project was to identify a replicable model for referral between health clinics and nearby secondary schools that would improve the RH of adolescents attending those schools.

A multi-method evaluation (including baseline and follow-up surveys) showed a modest, though significant, increase in students citing health center staff as potential sources of RH and sexuality information after an academic year of intervention. Twice as many students knew about referral clinics and, of those, 51% could correctly name the clinic, compared to 12% at baseline. However, only 10% had been to a referral clinic. This compares to the 24.3% who had attended any public health clinic in the previous six months. Although the project failed to develop and confirm a cross-referral system, the data do show that adolescents use public-sector clinics for FP purposes. Information about obtaining a FP method was the key motivating factor cited in those going to clinics.<sup>101</sup>

### 4.3.3. Outreach/Non-Facility Provision

It is impractical to think that clinical services could – or should – carry the bulk of adolescent reproductive health service provision.<sup>102</sup> Given young people’s documented preferences, more programmatic attention (and evaluation) should be directed to the potential of private physicians and the commercial sector to meet ARH needs.

#### 4.3.3.1. Community-based Distribution and Services

In the Youth Project of the Zimbabwe National Family Planning Council (ZNFPC) in collaboration with the Population Council, existing community-based outreach workers such as CBDs, TBAs, village health workers and agricultural extension workers have been trained to give RH information and referrals to youth. An evaluation is in progress.<sup>103</sup> Preliminary findings suggest that young girls quickly learn which individual can be approached for assistance in their area.<sup>102</sup> In Kenya’s Friends of Youth project, most of the service providers trained to give judgment-free services at a subsidized cost are private physicians.<sup>103</sup>

In developed countries, youth also patronize pharmacies and private physicians. Campaigns in the Netherlands, Germany and France, for example, target these professionals for information on ARH. In the Netherlands, family physicians receive regular training to improve communication with youth patients, viewing their sexual and reproductive health as a major responsibility.<sup>30</sup>

In countries where marriage occurs early in adolescence, any program to delay the first birth and/or promote reproductive healthcare must reach out to young married women. In Bangladesh, Pathfinder International has worked with NGOs for over a decade to reach younger, low parity couples with RH information and services before they begin childbearing. In most couples, the newlywed wife is under 19 years old. In participating areas, all newly married couples are registered and visited by a field worker establishing a relationship with the couple and their in-laws, while providing information on family planning. The field worker, when appropriate, provides family planning services and referrals for maternal and child health care. Orientation meetings are also held. Given recent changes in the contraceptive delivery system in Bangladesh, women now get their contraceptive services (along with other reproductive and general health care) at health clinics. Some home visits are still made, however, by the newly created “contraceptive depot holders” who sell contraceptives for a small commission on the sale. A major advantage of the program is the confidence that young women have in the depot holders, who are women from the community well known to them. Program findings indicate that overall contraceptive use has increased: the contraceptive prevalence rate of newlywed adolescents (aged 15-19) in the targeted areas increased from 19% in 1993 to 39% in 1997.<sup>104,40</sup>

#### ***Condom Use by Adolescents: fostering a behavioral norm***

Several studies conducted by PSI on condom use by African adolescents shed light on challenges to be faced in increasing safe sexual practices. Findings suggest that while sources are well-known, and ever-use relatively high, condom use is very irregular: more common with casual partners and less so with regular ones.<sup>B12, B13</sup>

Young men are significantly more likely to purchase condoms; obtaining them is a major challenge for young women who are fearful of their reputation.<sup>B12, B14</sup> Young women also have difficulty negotiating condom use.<sup>B12</sup>

Another gender difference involves motivation for use: males are more likely to use condoms to prevent STDs whereas females are more focused on pregnancy prevention.<sup>B12, B13</sup>

The majority of condom users in a Botswana study purchased condoms from retail outlets, with only one in two adolescents obtaining them from health facilities even though these are free.<sup>B14</sup> Adolescents find that service providers sometimes intimidate or lecture them whereas retailers are seen to view them only as customers. The study concluded that young people would be happy to get condoms from clinics if service provider attitudes were more positive.<sup>B14</sup> Other barriers to condom use include perception of unnaturalness, sense of reduced pleasure and fear that condoms could break or spread disease.<sup>B12</sup>

Condoms need to be destigmatized, access made easier, and provider attitudes toward young users more open and helpful.<sup>B14</sup> For programmers, “encouraging condom use by young people cannot be other than a first priority.”<sup>B15</sup>

#### 4.3.3.2. Social Marketing

Social marketing combines principles of social and behavioral change with business operations. The approach uses mass media and advertising to publicize the designated issues and product brands while identifying, through market research, promising outlets for selling commodities, usually at a subsidized price. This activity is well suited to an adolescent audience, which is easily attracted by media and advertising, especially as messages and images can be tailored to youthful tastes.

Most social marketing activities, intended for a young adult audience, feature condoms as the primary product. Condoms, highly recommended for young people because they doubly protect against pregnancy and STDs, are a practical product for social marketing purposes, easily placed for sale in a wide variety of outlets. Given that adolescents have specialized and favored places for socializing and recreation, outlets can be chosen that correspond closely to adolescent-frequented settings. This targeted placement also dovetails well with peer education backup to mass media and sales, a program component considered critical to successful social marketing to adolescents.

Targeted social marketing to adolescents and/or young adults has intensified in recent years, both as separate programs for this age or as targeted programs within a larger social marketing effort. Evaluations are promising, though questions remain, especially related to broad coverage, if peer education is a necessary component, and to sustainability.

PSI's Social Marketing for Health (SMASH) Program incorporated an adolescent-focused social marketing initiative into four existing, broader programs in Botswana, Guinea, South Africa and Cameroon. The effort, using mass media along with peer educators reinforcing messages interpersonally, aimed to raise awareness of sexual and RH issues and encourage young people to take protective action by practicing safe sex, including use of contraception. The projects each developed brand names associated with their activities and made socially marketed products widely available through peer educator distribution and youth-friendly service outlets. Sponsored events, such as concerts and soccer games were used for additional awareness-raising. Country projects ranged in length of intervention at the time of the evaluations from eight to 13 months, and varied by type of site selection, and by coverage of program components.

The evaluation study used a quasi-experimental design, obtaining data from pre- and post-intervention surveys in experimental and control sites. In general, the results indicated that the projects succeeded in raising knowledge, and also increased awareness of the benefits of sexual responsibility and in decreasing barriers to condom use in two or more sites. However, impacts varied considerably among the country projects.<sup>105</sup>

Cameroon experienced the most successful outcomes. Both young men and women became more aware of the benefits of sexual protection, and experienced reduced barriers to safer sex and increased self-efficacy. Young men reported fewer sexual partners and young women a lower likelihood of having sex by age 15. Greater use of abstinence, certain contraceptive methods, and ever-use of condoms among women were also reported – for pregnancy, but not for STD prevention.<sup>106</sup> In Botswana, the program had a positive impact on young women's perceived susceptibility to sexual risk, perceived benefits of prevention and perceived barriers to safer sex.<sup>107</sup> The South African intervention resulted in increased awareness of the benefits of sexual protection among young women and an increase in ever-use of condoms,<sup>108</sup> whereas the Guinea intervention appeared to have no impact on project indicators.<sup>109</sup>

Researchers attribute some of the different impacts to variations in program design and coverage. In Cameroon, where the strongest outcomes occurred, there was also the lengthiest and widest coverage, with mass media and peer communication reaching a substantial portion of the population over a period

of 13 months. Peer educators were able to reach a significant percentage of the target populations in Cameroon and Botswana because of the relatively small intervention sites, whereas, because of larger targeted populations in Guinea and South Africa, coverage was less complete. Also, in South Africa, the campaign emphasis determined by the youth was on pregnancy prevention, which undoubtedly affected indicators related to HIV/AIDS prevention<sup>108</sup>. Because of design considerations, Guinea did not use mass media, but relied primarily on sponsored events, thus reaching fewer adolescents. Given the disproportionately positive effects on women, researchers also conclude that a greater understanding of young men's sexual health concerns will benefit future projects.<sup>105</sup>

A study of an earlier social marketing effort also concluded that pregnancy prevention, and not disease prevention, was the major reason for condom use among the young adult target group in Ghana. Sponsored by the MOH, with implementation by a local advertising group and technical support from AIDSCOM, a multimedia campaign was used to increase AIDS awareness and promote AIDS prevention. Radio and television advertisements, as well as school outreach activities, were designed to inform about the disease and underscore behavioral changes needed to prevent its spread, including delayed sexual initiation, reduced number of partners and condom use. Pre and post KAP surveys indicated increased awareness and knowledge as well as behavioral change. In particular, fewer 15 year olds were sexually active at the end of the campaign than at the beginning (27% compared to 44%) and more young people reported condom use at last sex, particularly those who were unmarried or had a partner outside of marriage.<sup>110</sup>

Some interesting insights can be gained from a project in the US, the Prevention Marketing Initiative (PMI), a CDC-sponsored pilot project with technical support from AED, conducted in five local sites to reduce the risk of young people under 25. PMI stressed the involvement of the community in design and implementation while retaining the framework and business principles of social marketing. This investment resulted in extended planning time, so that only by the end of the fourth year were all five sites implementing activities. While site activities differed, all sites provided adolescents with repeated exposure to prevention messages through multi-session, skill-building workshops and reached a broader community audience with activities and creative products.<sup>111</sup>

In the two sites that were able to use a pre/post randomized experimental design to assess the workshops, reduced risk behavior (condom use at last intercourse) and knowledge, intentions, attitudes, self-efficacy beliefs and skills related to safer behavior were identified as project results. Results in the other three sites, with weaker evaluation designs, were consistent with these. Random sample telephone surveys in one site showed a significant association between level of exposure and condom use at last intercourse with one's main partner.<sup>111</sup> Given the good outcomes, but in view of the time and TA-intensive design, it was important to consider how these projects could be replicated with lower costs. AED concluded that replication strategies must consider two major areas. The first is selection of grantees based on existing capacity and with an identified target group. The second involves providing the most important TA, including working within a basic framework and building upon past experiences.<sup>112</sup>

#### 4.3.4. Voluntary Counseling & Testing (VCT)

A service area that holds promise for reaching young people is voluntary counseling and testing for HIV. As previously shown with adults, observational reports from Zambia, Zimbabwe and Malawi suggest that strong positive behavioral change is occurring among those young people who have been tested. These services are being provided at drop-in centers, where rapid testing and low prices make the process more appealing.<sup>72</sup> Formative research by the Horizons Project in Kenya and Uganda confirms the interest of youth in VCT. Findings indicate that significant numbers of young people in these countries find out about VCT from their peers, and among those who were tested in Kenya, for example, about one-quarter spoke with their peers before receiving the service. The advice and information aspect of VCT is

important for young people: of youth who participated in VCT, 39% in Kenya and 68% in Uganda reported that they liked this service component the best.<sup>113</sup>

Services for counseling and method provision for safer sex need to be available to young people and in ways that are responsive to their needs for privacy and confidentiality. Given young people's preference for retail purchase of condoms and private physicians for RH methods and care, more programmatic attention should be given to these approaches, as well as to other avenues such as CBD agents and community health workers. Social marketing programs have demonstrated that a combination of media, peer education and youth-relevant sales outlets can succeed in increased condom acceptability and use – if coverage of these components is great enough. Challenges remain in fostering more regular condom use, however, especially related to use with regular partners, and purchase and negotiation by young women.

While more emphasis should be placed on non-clinical services, some attention should be directed to making existing clinical services more youth friendly, especially because of the far-reaching networks of public health facilities and, in some countries, NGOs. The major challenge in these settings is negative provider attitudes, which can be addressed through better pre-service training in the long run and remedial adjustments in the short run. Use of public health facilities by young people for RH has been shown to be viable in developed countries and in Latin America. Experience to date with youth centers offering a broader array of recreational and vocational activities has proven costly and ineffective in attracting youth for RH services. Some promising efforts seem able to draw youth to RH services, but these conduct focused, but entertaining, activities around RH more directly. VCT efforts have succeeded in attracting young people, though perhaps more for information and advice.

## 5.0. SUMMARY OF CONCLUSIONS

Although scattered and sometimes isolated, there are many ARH activities underway in every region of the world. Several of these approaches have been evaluated and shown to have positive results; others are new and promising initiatives. In sum, we know a great deal about “what works”. But also we face barriers, challenges, and the need to better understand adolescents, adolescent reproductive health, and adolescent reproductive health programs. Important among these factors is a political will and commitment to seriously address ARH programs. Following are the major conclusions for future consideration:

- Programs should be conceptualized and designed to move from the current “project mentality” of scattered, one-time efforts into a more sustainable and comprehensive program framework using multiple interventions.
  - programs should be designed to effect changes at the individual, relational, community and structural levels;
  - whenever possible, programs should use multiple interventions to address ARH, with an array of message channels and diverse service delivery points;
  - program design should include mechanisms to expand and replicate, including cost analyses;
  - in order to reach large numbers of the target population, projects should be selected that can feasibly be scaled up at affordable costs; and
  - programs should be planned so they can operate for longer periods than currently occurs.
- Program planners must undertake preparatory actions to foster an enabling environment before introducing an ARH intervention and select designs appropriate to the community’s readiness to support these activities.
  - implementers should collect data, identify needs and develop a supporting rationale for interventions within their planned program areas;
  - communications at the personal and community level should be used to introduce issues and surface topics for public discussion;
  - participatory research and community mobilization help identify the most urgent issues, develop a shared solution and foster support for ARH programs;
  - selection of projects should match needs and stage of adolescent program development; and
  - when drawing on proven models from developed countries, program planners must make careful adaptations to meet the specific conditions of the host country.

- The choice of partner agencies and the selection and training of staff are critical to achieving ARH program objectives.
  - partner organizations should be chosen, at a minimum, according to their commitment and ability to promote and implement ARH programs;
  - organizations' membership or participant base must be considered in terms of a planned program's desired target audience;
  - if expansion is a planned or possible action for projects, partner agencies should be identified according to their networking potential, either within their own federation or structure, or through external affiliations;
  - selection of trainees to work with youth should be based on attitude, interests and capabilities and not on seniority or reward; and
  - as possible, young staff should be selected to work with adolescents.
- Youth should be viewed as assets within ARH programs, which should serve them early in adolescence, be responsive to their needs and seek their active involvement.
  - while some RH "problems" need addressing in direct, short-term fashion, programmers should also seek program frameworks that address positive youth development as a longer term goal;
  - to create responsive programs, youth must be involved and encouraged to openly present their views, upon which forthright programming should be designed;
  - involvement of youth in program design helps assure program relevance, ownership and participation; and
  - programming on ARH should be increased on ARH for the 10-14 age group.
- Given the significance of gender dynamics for young women's ability to practice safe sex and establish good reproductive health, program options need to be devised, and successful approaches expanded.
  - greater attention must be given to gender equity programming at the individual and structural levels to empower women to protect their health and to reduce barriers to gender equity;
  - creative linkages and channels for ARH programming should be explored, such as microenterprise, livelihood projects, and alternative educational programs;
  - more programmatic attention should be given to married adolescent girls who are often isolated and in need of RH care;
  - increased attention should be focused on programs addressing gender issues for young men; and

- ARH programs should not feel obligated to attract larger numbers of young men to clinics, but rather provide other, more suitable, approaches to attract their involvement, meet their needs, and encourage gender equity.
- Mass media and informal communications can be selectively used at all levels of program readiness and development, and can help programs achieve the three major program objectives related to a supportive environment, enhanced information and skills and improved health services.
  - mass media can help break taboos on sensitive topics and promote the discussability of ARH issues;
  - mass media can assist in the process of changing social norms;
  - mass media can reach large numbers at a modest cost and disseminate practical information;
  - In entertainment formats, it is possible to reach several market segments by including an array of topics appealing to a diversity of ages and situations; and
  - every program approach can benefit from a carefully constructed communications component to publicize activities, improve interpersonal communications, and inform policy makers and donors of project achievements.
- Both formal and informal sex/HIV education programs should be increased, going to scale where possible, and, in addition, identifying youth-popular venues for reaching young people with needed information.
  - sex education is a basic need and right but remains inadequate as young people, in many countries, remain ill-informed on important and practical RH topics;
  - emphasis should be placed on helping youth to develop skills and abilities to be sexually responsible;
  - sex educators should be well trained, non-judgmental and open to young people's concerns;
  - program planners should try to identify an appropriate and effective sex education curriculum for institutionalizing within the country's formal school system, working with the MOE as early as possible to ensure ownership; and
  - nutritional information to improve RH can be effectively incorporated into ARH education and outreach programs.
- Young people should have access to a variety of commercial, private, NGO and public health services, where they can receive respectful and confidential treatment for their RH needs.
  - more program attention should be applied to the role of non-clinic service providers, including private physicians, CBD agents, traditional health workers, commercial outlets and social marketing activities;

- greater efforts should be made to integrate education and method promotion for pregnancy and STD/HIV prevention;
  - because of existing networks of facilities, and because some young people use these sources, efforts should be made to make current clinics and health centers youth friendly;
  - training of service provider staff should include all staff as each one has some contact with adolescent clients;
  - a careful balance should be made in using recreational activities to attract clients for RH services to prevent diversion from, and underutilization of, the RH services;
  - when using peer education and mass media to motivate use of methods and services, programs must assure that these services are in place;
  - condoms should be encouraged as the social norm for sexually active adolescents; and
  - emergency contraception should be publicized and made available to adolescents;
- Considerable research is needed to better understand determinants of adolescent risk-taking in developing countries, the potential for alternate venues to provide ARH education and services, ways in which programs can be expanded and scaled up and more effective ways to conduct research with young people and assess ARH programs. Possible actions include:
    - refine an approach to undertaking cost studies as part of operations research to better enable comparisons of program approaches;
    - assess acceptability, appropriateness and effectiveness of adapted youth development curricula for developing country use;
    - identify through case studies, or other means, key elements, needs and conditions for institutionalizing sex education within a formal school system;
    - assess characteristics of peer education projects related to recruitment, training, supervision and mentoring, incentives and compensation, and turnover;
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    - assess projects to strengthen pharmacies' role in providing methods to adolescents;
    - assess the role of private sector physicians in providing YFS;
    - assess ways to expand programs for women to explore issues of gender dynamics;
    - identify young men's sexual health concerns for social marketing and gender equity programs;
    - test expansion/scaling up of projects through YSO networks;
    - assess the value-added of using PLA to program outcomes;

- assess the potential for expansion/scaling up of community mobilization projects; and
- conduct impact evaluations of antecedent-based programs to identify relevant determinants and effective program designs.

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**ANNEX A**  
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## ANNEX C

### **New Tools and Approaches to Evaluating ARH**

Based on the increased activity directed to ARH programming and the need to better evaluate projects, more evaluation is being conducted. Some of this work involves new approaches and/or the use of new tools. FOCUS on Young Adults has developed some of these new resources, including the forthcoming **Monitoring and Evaluation Guide**, a compendium of how-to's and methodological information and suggestions.<sup>1</sup> Some new developments on specific areas and approaches follow.

- **Participatory Assessments**

Involving the community in assessing and identifying their needs has been used, in the form of rapid rural appraisal (RRA) and participatory rural appraisal (PRA) primarily as an information gathering strategy. An adaptation of that methodology, Participatory Learning and Action (PLA) is being applied to ARH programs, not only in the needs assessment and design phases, but continuing throughout the project for monitoring, revising plans and evaluation, as well. The approach lends itself to the special situation of research with adolescents on sensitive issues. Not only does PLA involve them in the program development process so that their needs can be accurately identified, but it uses experiential techniques that allow the deeper and more guarded – but essential – views on ARH to emerge within a safe situation.

FOCUS has produced a tool, **Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents**, which provides step-by-step information on designing a participatory appraisal with adolescents using PLA techniques.<sup>2</sup> It is based on the experience from the **Partnership for Adolescent Sexual and Reproductive Health (PALS)** project being implemented by CARE in Zambia.<sup>3</sup> It has been used successfully in other settings also. For example, researchers used it for their study, **Access to Reproductive Health Services: Participatory Research with Ugandan Adolescents**, in order to enhance their understanding of the context in which adolescent sexual behavior and practices occur. In particular, the study showed that adolescents are capable and effective in discussing those issues of greatest interest and concern to them. This methodology allowed adolescents to problem-solve among themselves, and in the process, enable researchers to “address gaps between adolescents knowledge of HIV/AIDS prevention and their actual practice.”<sup>4</sup> In Cambodia, CARE researchers, collaborating with Cambodian NGOs, concluded that PLA tools enabled implementers of a project assessing the sexual health needs of Cambodia's young garment workers to gain capacity and confidence by experiential learning, while challenging safe and easier program choices.<sup>5</sup>

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<sup>1</sup> **Monitoring and Evaluation Guide**. FOCUS on Young Adults Project. Forthcoming Spring 2000.

<sup>2</sup> Shah, Meera Kaul, Rose Zambezi, and Mary Simaskiu. “Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents.” *FOCUS Tool Series* #1, June, 1999.

<sup>3</sup> Celantano, David D., Katherine Bond, Cynthia M. Lyles, Sakol Eiumtrakul, Vivian F.-L. Go, Chris Beyrer, Chainarong na Chiangmai, Kendrad E. Nelson, Chirasak Khamboonruang, and Chayan Vaddhanaphuti. “Preventive Intervention to Reduce Sexually Transmitted Infections: A Field Trial in the Royal Thai Army.” *Arch Intern Med*, 160: 535-540, February 28, 2000.

<sup>4</sup> Bohmer, Lisa and Edward Kirumira. “Access to Reproductive Health Services: Participatory Research with Ugandan Adolescents.” Makerere University Child Health and Development Centre, December 1997.

<sup>5</sup> Forder, Julie A. “PLA Tools in Action: Lessons Learnt During a Sexual Health Needs Assessment with Cambodia's Young Garment Workers.” CARE International in Cambodia, September 1999.

The International HIV/AIDS Alliance's partners have used and improved the process of participatory community assessment, concluding that the process helps to develop a "richer picture of the contexts within people live and a better analysis of HIV, and its prevention, in relation to those contexts".<sup>6</sup> While the approach appears logically beneficial, it is also costly, and as yet there is little evidence to show conclusively how much this process contributes to program outcomes. To add some insights to this matter, ICRW and AVSC conducted a study, **Adolescent Reproductive Health and Sexuality in Nepal: Combining Quantitative and Participatory Methodologies**. They concluded that combining these methods for intervention research is a strategy with enormous payback, but requiring substantial investments of time, planning and expertise in conducting research.<sup>7</sup>

- **Youth Friendly Services Assessments**

Program managers in existing clinics in the public and private sectors, as well as those working in other service delivery areas, have become interested in making these services more appealing to, and effective for, young people. A FOCUS review of this field, **Making Reproductive Health Services Youth Friendly**, identifies the characteristics related to improved ARH services.<sup>8</sup> IPPF/WHR has developed a tool, **Self-Assessment Module: Sexual and RH Programs for Youth**, designed to help agencies improve the planning, implementation and evaluation of youth programs in developing countries. The approach is participatory, can be completed in one-week and results in an action plan for the agency.<sup>9</sup> FOCUS has a newly developed tool, **Assessing and Planning for Youth-Friendly RH Services**, to help program managers assess the extent to which their facility is already reaching youth, what characteristics discourage young people from accessing services; it will also help to prioritize services and programs and tailor them to local needs.<sup>10</sup>

AVSC will soon publish **Adolescent COPE: Self-Assessment Guides for Adolescent RH Services**, an adaptation, for adolescents, of their quality improvement tool.<sup>11</sup>

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<sup>6</sup> Greig, Alan (lead author). "Beyond Awareness Raising: Community Lessons About Improving Responses to HIV/AIDS." International HIV/AIDS Alliance and Gaxo Wellcome Positive Action, N.d.

<sup>7</sup> Malhotra, Anju, Sanyukta Mathur, Manisha Mehta, Pushpa Lal Moktan, and Rajendra Bhadra. "Adolescent Reproductive Health and Sexuality in Nepal: Combining Quantitative and Participatory Methodologies." Paper presented at the Annual Meeting of the Population Association of America, Los Angeles, March 23-25, 2000.

<sup>8</sup> Senderowitz, Judith. "Making Reproductive Health Services Youth Friendly." Research, Program and Policy Series. FOCUS on Young Adults, Washington, D.C., February 1999.

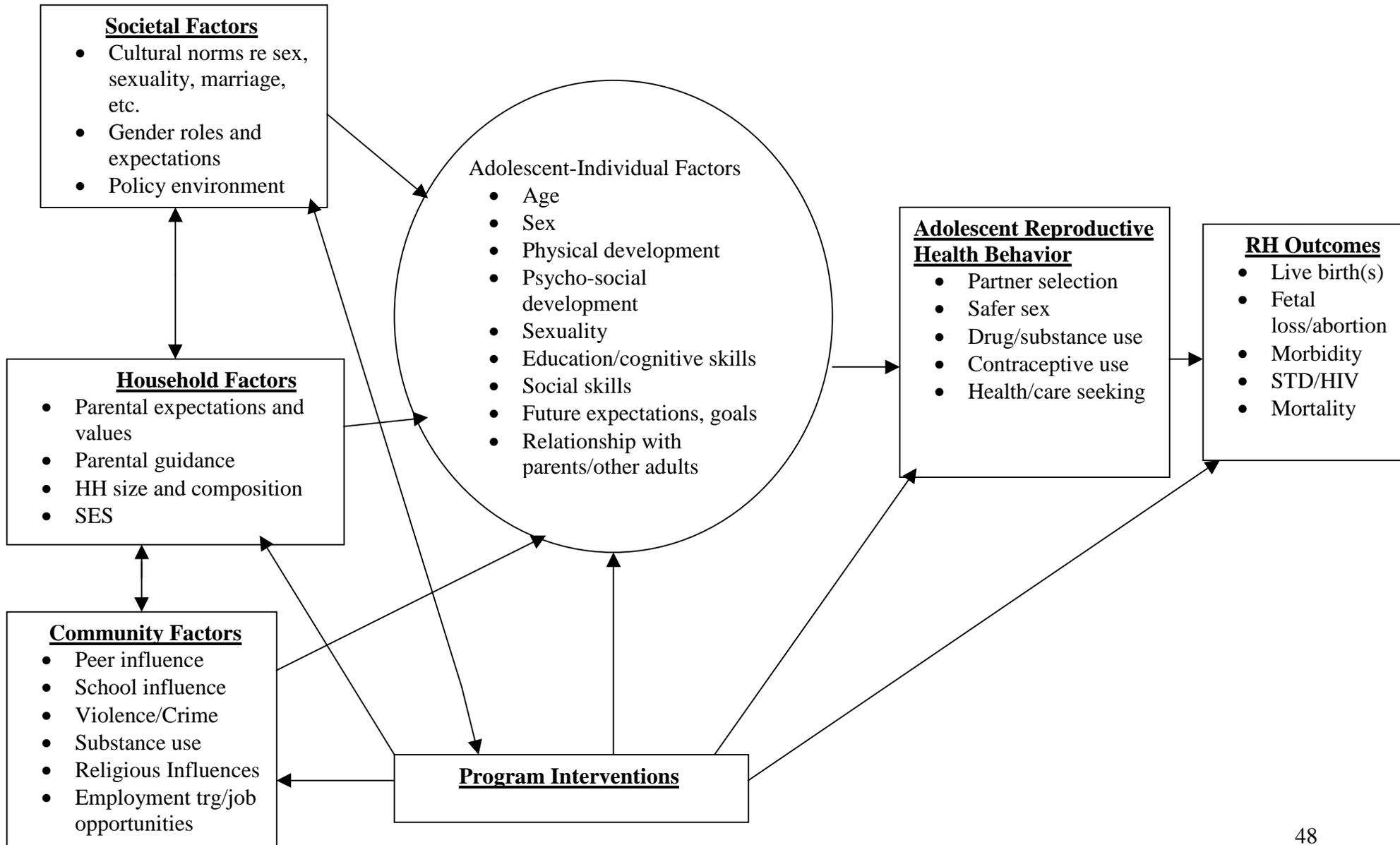
<sup>9</sup> Self-Assessment Module. Sexual and Reproductive Health Programs for Youth. IPPF/WHR, 1999.

<sup>10</sup> Nelson, Kristin, Laurel MacLaren, and Robert Magnani. "Assessing and Planning for Youth-Friendly Reproductive Services, workbooks 1-4." FOCUS Tool Series #2, FOCUS on Youth Adults, Washington, D.C., January 2000.

<sup>11</sup> "Adolescent COPE: Self-Assessment Guides for Adolescent Reproductive Health Services." AVSC International, 1999. (Draft)



**Conceptual Framework – Adolescent Reproductive Health**



## Flow Chart of Youth Reproductive Health Outcomes and Service Needs

