



**FOCUS on Young Adults**

**END OF PROGRAM CONFERENCE**

# **ADVANCING YOUNG ADULT REPRODUCTIVE HEALTH: WHAT FOCUS HAS LEARNED & DIRECTIONS FOR THE FUTURE**

The FOCUS on Young Adults Program addresses priority issues in young adult reproductive health (YARH) and promotes positive health-related behaviors, access to appropriate information and services, and enhanced public and private sector capabilities. This one-day conference will highlight program accomplishments, lessons learned, and promising 'best practices' from Africa, Asia/Near East, and Latin America. Recommendations – 'best bets' – for future YARH initiatives will inform new and ongoing work and contribute to decision-making on YARH resources.



**NOVEMBER 19, 2001**

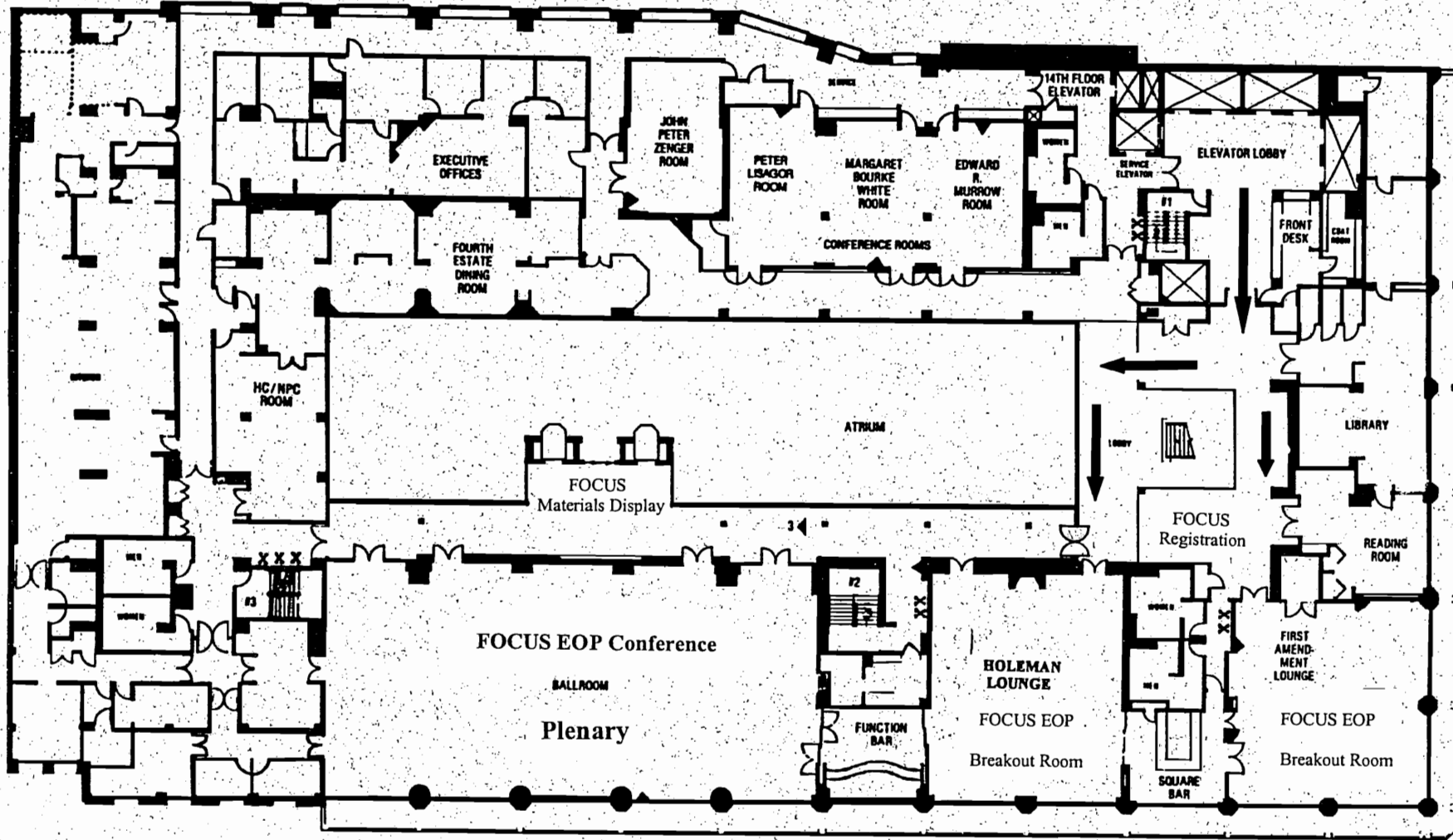
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# Agenda





# FOCUS on Young Adults

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## Advancing Young Adult Reproductive Health (YARH)



November 19, 2001

### AGENDA

#### MORNING SESSIONS

8:30 Coffee and Registration: (Holeman Lounge)

9:00 Opening Session: (Main Ballroom)

*Welcome*

*Welcome and Introductions*

*Introduction of Anne Peterson*

*Shaping the World's Future*

*The Central Role of Youth in*

*Responding to HIV/AIDS*

Judith Senderowitz, FOCUS/Pathfinder

John Dumm, Pathfinder International

Duff Gillespie, USAID

Anne Peterson, USAID

Paul DeLay, USAID

9:45 Program Overview: Lindsay Stewart, FOCUS/The Futures Group International

10:00 Panel I. *Advancing Young Adult Reproductive Health (YARH) Programming through Policy and Advocacy* (Main Ballroom)

1. *Lessons Learned about YARH Policy* - Nancy Murray, FOCUS/The Futures Group International
2. *Implementation of the National Youth Policy in the Dominican Republic: An Emerging Experience* - Remedios Ruiz, ALEPH - *Margaret*
3. *The Role of Policy in YARH Programming: HIV/AIDS and Adolescents in Africa* - Holo Hachonda, JHU/CCP/Zambia - *Unprecessed Unforced*

Discussion Period:

Moderator/Discussant, Karen Hardee, The Futures Group International

11:15 Coffee Break

11:30 Panel II. *Improving YARH Program Planning and Implementation through Evaluation and Research* (Main Ballroom)

1. *Evaluation and Research Findings* - Robert Magnani, FOCUS/Tulane University School of Public Health and Tropical Medicine
2. *Program Implications of Trend Data from YARH Surveys* - Peter Xenos, East West Center
3. *Using Participatory Research to Design Relevant Programming: Experience from Nepal and Burkina Faso* - Anju Malhotra, ICRW

Discussion Period:

Moderator/Discussant, John Townsend, The Population Council/Frontiers Project

AFTERNOON SESSIONS

12:40 Introduction to Afternoon Sessions: Lindsay Stewart, FOCUS/The Futures Group International

12:45 Lunch – (box lunches provided)

1:00-2:00 Lunch Panel III. *A Male Youth Perspective: A Dialogue with Young Men about Reproductive Health*

1. Hylton Grace (Jamaica)
2. Holo Hachonda (Zambia)
3. Christian Naud (Dominican Republic)

Moderator/Discussant: Tijuana James-Traore, FOCUS/Pathfinder International

2:00 Breakout Sessions (concurrent – Holeman Lounge and First Amendment Lounge)

Panel IV. *YARH Strategies and Techniques* (Holeman Lounge)

1. *Training for Young Adult Sexual and Reproductive Health* - Tijuana James-Traore, FOCUS/Pathfinder International
2. *Using Internet Technology to Meet YARH Needs* - David Mariner, Advocates for Youth
3. *Addressing Gender and Power* - Ellen Weiss, ICRW/Horizons
4. *Scaling Up YARH Programs: Lessons from the Peru Experiences* - Milka Dinev, Pathfinder International/Peru

Discussion Period:

Moderator/Discussant, Sharon Rudy, Population Leadership Program

Panel V. *YARH Experiences from the Field* (First Amendment Lounge)

1. *Social Marketing for Youth* - Josselyn Neukom, PSI
2. *Providing YARH Services* - Alejandra Meglioli, IPPF/WHR
3. *Dual Protection for Youth* - Walter Saba, JHU/CCP
4. *Youth Development Approach: Experiences in India and Egypt* - Julie Hanson Swanson, CEDPA

Discussion Period:

Moderator/Discussant, Sam Clark, PATH

3:15 Refreshment Break

3:30 Panel VI. *Future Directions – Perspectives from the Donor Community* (Main Ballroom)

1. Margaret Neuse, USAID
2. Marjorie Macieira, Summit Foundation
3. Susan Rich, Wallace Global Fund
4. Kunio Waki, UNFPA

Discussion Period:

Moderator/Discussant, Phyllis Piotrow, HU/CCP

4:45 *Wrap-up and Presentation of FOCUS Recommendations*: Judith Senderowitz, FOCUS/Pathfinder International

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Presentations

Presentations

# **Program Overview**

**Lindsay Stewart  
Focus/The Futures Group  
International**



## FOCUS ON YOUNG ADULTS: SIX YEARS OF EXPERIENCE: 1995-2001



Lindsay Stewart  
Deputy Director  
November 19, 2001

## FOCUS PARTNERS

- ❖ Pathfinder International
- ❖ Two Sub-contractors:
  - The Futures Group International
  - Tulane University School of Public Health and Tropical Medicine

## FOCUS STRATEGIES

- ❖ Increasing awareness about YARH needs and successful YARH initiatives
- ❖ Improving capability to develop YARH policies and programs
- ❖ Identifying what works by documenting experiences and conducting research and evaluation on promising policies and programs

## FOCUS FUNCTIONAL AREAS


- ❖ POLICY
- ❖ PROGRAM AND TRAINING
- ❖ RESEARCH AND EVALUATION
- ❖ COMMUNICATIONS

## FOCUS AUDIENCE

- ❖ USAID and its Partners (CAs)
- ❖ Other YARH and reproductive health organizations working in the developing world, including:
  - UN Agencies (UNFPA, UNICEF, WHO)
  - Other International and regional NGOs
- ❖ Donors
- ❖ Through these, reach developing country organizations and professionals


## FOCUS FUNDING

- ❖ \$17,600,000 over six years, including from:
  - USAID/Washington
  - USAID/Missions in 10 countries
  - REDSO/East and REDSO/West
  - USAID Regional Bureaus (Africa, Asia and the Near East)
  - From Population, Child Survival and HIV/AIDS
  - Plus joint programming funding with 11 Cooperating Agencies



## FOCUS has worked in 28 countries:

- ❖ 17 Countries in Africa
  - Emphasis Countries: Ghana, Zambia
- ❖ 4 Countries in Asia and the Near East
  - Emphasis Country: Bangladesh
- ❖ 7 Countries in Latin America and the Caribbean
  - Emphasis Countries: Bolivia, D.R., Jamaica, Peru




## FOCUS ACCOMPLISHMENTS (1)

- ❖ Increasing support and expansion of YARH programs
- ❖ Multi-sectoral work to develop and implement national youth and YARH policies
- ❖ Stimulating discussion of evidence on developmental, cultural, health and other factors that contribute to key YARH behaviors



## FOCUS ACCOMPLISHMENTS (2)

- ❖ Synthesizing, sharing and contributing to a body of YARH evaluation and research
- ❖ Improving methods, measurements and indicators for YARH planning, evaluation and research
- ❖ Stimulating State of the Art (SOTA) training, involving both youth and professionals, at the country and regional levels



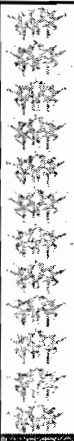
## FOCUS ACCOMPLISHMENTS (3)

- ❖ Increasing awareness
  - Technical expert group exchanges (on policy, communications, training, research and evaluation, social marketing, HIV/AIDS, and other topics)
  - Conferences and workshops examining what works, stimulating creative ideas and relationships, and collaborative YARH efforts
  - Strategic planning and assessments
  - FOCUS Website: [www.pathfind.org/focus.htm](http://www.pathfind.org/focus.htm)



## FOCUS ACCOMPLISHMENTS (4)

- ❖ FOCUS Publications
  - InFOCUS (22 on selected YARH issues)
  - Project Highlights (19 on successes and challenges of YARH projects around the world)
  - Research, Policy and Program Series (6 on current knowledge about YARH)
  - Final FOCUS synthesis document (forthcoming): *Advancing Young Adult Reproductive Health: Actions for the Next Decade*



## FOCUS ACCOMPLISHMENTS (5)

- ❖ FOCUS Publications and Other Tools to Create Awareness (continued)
  - The FOCUS YARH Tool Series: 6 tools developed
    - PLA Guide
    - Youth Friendly Services
    - Scaling Up
    - Developmentally Based Interventions and Strategies
    - Monitoring and Evaluation Guide
    - Bibliography of Training Curricula
  - New Gen computer policy and planning model



## FOCUS ACCOMPLISHMENTS

(6)

- ❖ Improving Capability
  - FOCUS technical assistance to/collaboration with country-level, regional and global organizations on policy, program, training, evaluation and research design and implementation
  - FOCUS-organized regional and country-level SOTA and training of trainers in 5 major workshops in Africa and Asia
  - Implementing FOCUS tools, methodologies and techniques throughout the world
  - Testing/applying NewGen



## FOCUS ACCOMPLISHMENTS

(7)

- ❖ Identifying What Works
  - Program and project site visits/discussions with youth and those who work with youth
  - FOCUS evaluation and research studies in 16 countries
  - Identification, analysis and synthesis of YARH R&E conducted by others
  - Reviewing YARH policy and program documentation to further identify what works
  - Discussions, dialogues with those working in YARH



## FOCUS ACCOMPLISHMENTS

(8)

- ❖ Identifying what works: Developing basic frameworks to:
  - establish parameters for our work
  - and interpret our analysis of YARH policies, strategies, program experience, evaluation and research
    - Factors influencing YARH
    - Key Questions in YARH



## FOCUS ACCOMPLISHMENTS

(9)

- ❖ Defining Young Adults as ages 10-24
- ❖ Defining YARH, based on RH outcomes
  - Postponed or reduced sexual activity
  - Increased contraceptive use
  - Lower adolescent pregnancy/parenthood rates
  - Lower rates of HIV/STI infections among youth
  - Improved nutritional status of young people
- ❖ Developing YARH indicators



## REST OF CONFERENCE


- ❖ Review FOCUS findings and recommendations for the future
- ❖ Give an overview of selected YARH work currently being carried out
- ❖ Give all of you a chance to discuss YARH policies, programs, issues, and opportunities
- ❖ We look forward to a rich experience today and to learning of your future YARH actions
- ❖ Thank you for coming!

**PANEL 1**

**Nancy Murray**  
**FOCUS**




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## Lessons Learned about Young Adult Reproductive Health Policy

Nancy Murray, Policy Advisor  
FOCUS on Young Adults



### What do We Mean by Policy?

- Formal Directives
  - Constitutional Provisions; Legislation; Implementing Rules and Regulations; Judicial Decisions; Executive Orders; Ministerial Level Decrees or Other Regulatory Measures; Expressions of Government Positions (goals, budgets, plans, programs and statements)
- Standards of Practice
  - Formal Standards and Guidelines for Public sector Services; Standards of Practice in Professional Fields Orient Public and Private Providers;
  - De Facto Operational Policies of Health Care Providers
  - Educational Curricula Addressing Reproductive Health

### Why Are Policies Important?

- ◆ Increase availability of programs
- ◆ Signal government and other institutional commitment to YARH (legitimization)
- ◆ Advocate awareness of adolescents' needs and issues
- ◆ Provide a framework for action
- ◆ Facilitate increased multisectoral collaboration

### FOCUS' YARH Policy Mandate (I)

- ◆ Raise Awareness through Dissemination and Advocacy
  - NewGen Demographic Projection Model (Ghana);
  - Special Study: The Effects of Girls' In-School Status on Sexual Debut;
  - Youth Profiles; Strategic Assessments; Inventories of Programmatic Activities (Mali, Zambia, Malawi, Madagascar, Bolivia, Jamaica)
  - In FOCUS: Advocating for ARH: Addressing Cultural Sensitivities

### FOCUS' YARH Policy Mandate (II)

- ◆ Foster Broad Based Organized Political and Technical Support
  - Intersectoral Coalition Building in Bolivia, Jamaica, Dominican Republic
- ◆ Assist in Implementation of National Youth and/or Youth RH Policies
  - Bolivia, Jamaica, Dominican Republic

### FOCUS' YARH Policy Mandate (III)

- ◆ Develop Tools and Conduct Analyses to Advance Sustainability
  - Tool: Getting to Scale in YARH Programs
  - Special Study: Are Adolescents Differentially Affected by User Fees for Reproductive Health Services?
  - Special Study: The Determinants of Adolescents' and Young Adults' Choice of Commercial or Private Sector Providers of Modern Contraception

## The Current State of Young Adult Reproductive Health Policy

- ❖ 153 countries around the world have broad national youth policies, but relatively few specifically address reproductive health
- ❖ Where YARH policies exist, many barriers to implementation remain

## Policy Development: Keys to Success (I)

- ❖ Support from the Top
  - First Lady (Bolivia); Vice-President (Dominican Republic)
- ❖ Intersectoral Coordination
  - Bolivia, Dominican Republic, Jamaica, Ghana
- ❖ A Focal Point
  - Office of Family and Generational Affairs (Bolivia);
  - Direccion General de Promocion de la Juventud (DGPJ) (Dominican Republic)
  - National Centre for Youth Development (Jamaica)

## Policy Development: Keys to Success (II)

- ❖ Youth Involvement
  - National Youth Forum (Dominican Republic);
  - Analysis and Discussion of Policy Implications of National Youth Survey (Bolivia)
- ❖ Involving Civil Society
  - NGO coalitions (Bolivia)
  - Representation on National Multisectoral Committee for National Youth Policy (Dominican Republic)

## Policy Development: Keys to Success (III)

- ❖ Good Information
  - Situation Analysis/Programmatic Inventories (Bolivia, Dominican Republic, Jamaica)
  - Youth Adult Reproductive Health Surveys (Jamaica, The Dominican Republic)
  - NewGen Simulation Results (Ghana)
- ❖ Steady Outside Help
  - PAHO; (Bolivia, Dominican Republic);
  - USAID (Bolivia, Dominican Republic, Jamaica);
  - National Commonwealth, UNICEF (Jamaica)

## Challenges in Developing & Implementing National Youth Policies (I)

- ❖ Political will to focus on both problems and potential of youth;
- ❖ Budgetary and technical support for development, dissemination and implementation of policies to target constituencies;
- ❖ Involvement of all stakeholders (especially youth and youth organizations) in formulating and evaluating national youth policies and programs;
- ❖ Systematic national reviews of the situation of youth and the linkage of this process to the formulation of a national youth policy;

## Challenges in Developing & Implementing National Youth Policies (II)

- ❖ Training opportunities for staff and volunteers from youth-related ministries to deal effectively with the needs and aspirations of youth;
- ❖ Documentation of experiences from which others can learn;
- ❖ Evaluation of policy implementation and its impact on youth in general and YARH outcomes in particular.

**PANEL II**

**Robert Magnani  
Tulane University**

## Major Research Findings Emerging from the FOCUS on Young Adults Program

Robert Magnani and the Tulane  
University Research Team

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## FOCUS Research Mandate

- Improving capability to develop ARH policies and programs
  - M&E Guide
  - Assessing and Planning for YFS
  - PLA Guide
- Identifying “what works”
  - Research on ARH risks and protective factors
  - Research on program effectiveness

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## Programmatic Utility

- Improving Capabilities
  - M&E Guide and YFS Tool
    - Translated into French and Spanish by others
    - Widely utilized by programs
    - High demand for additional copies
  - Technical Assistance
    - M&E capacity enhanced at several partner organizations

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## Programmatic Utility (con't)

- Identifying what works
  - Evaluation findings led to changes in program strategy/design in several locations (e.g. Paraguay, Zambia)
  - Evaluation findings led to doubling of budget for next program cycle (Peru)

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## Research Findings: ARH Risk and Protective Factors

### Background

- Widely recognized that adolescents are influenced by a large number of factors operating at the individual, family, school, community and societal levels;
- These factors are all potential leverage points for intervention, but further information on their relative importance in developing country settings is needed in order to determine intervention priorities.

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## Purpose

- Assess extent to which adolescent sexual and contraceptive behaviors in different settings are influenced in similar ways by selected factors;

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## Methodology

- Data collected via sample surveys in conjunction with program evaluation efforts
- Categories of factors considered:
  - Individual characteristics
  - Peers and sexual partner factors
  - Family characteristics and connections
  - School characteristics and connections
  - Community characteristics and connections

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## FOCUS “Antecedents” Studies

- Brazil (12 Schools, Salvador, Bahia)
- Chile (Community-based, Santiago)
- Ghana (Community-Based, National)
- Jamaica (20 Schools, Kingston)
- Paraguay (Community-Based, 3 Cities)
- Peru (38 Schools, 8 Cities)
- South Africa (Community-Based, Metro Durban & Mtunzini District)
- Togo (Community-Based, Lome)
- Zambia (Community-Based, Lusaka)
- Zimbabwe (Community-Based, Gweru)

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## Analytic Methods

- Bivariate & multivariate methods (logistic, tobit & OLS regression)
- Variables retained for final multivariate models:
  - Significant associations after effects of other factors were controlled
  - Confounders/effect modifiers

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## Limitations

- Different population universes across studies;
- Variables neither uniformly included nor operationalized;
- Direction of causation cannot be determined in some cases.

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## Findings: Factors Associated with Sexual Initiation

- Age and marital status
- Gender (girls start earlier in Africa, boys in LA)
- School attendance (effect stronger for girls)
- SRH knowledge (weak)
- Non-sexual risk behaviors (drugs, alcohol)
- Self-esteem (differential effects by gender in LA)
- Peer behaviors
- Family SES (mixed; effects stronger for girls)
- Not living with two parents (weak)
- Connections with teachers
- Connections with community (girls)

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## Findings: Factors Associated with Condom use at Last Sex

- Gender (boys more likely, but no difference in overall contraceptive use)
- Positive attitudes toward condoms
- Self-efficacy
- Partner/peer communication re: sexuality & contraceptive use

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## Conclusions

- Adolescent sexual & contraceptive behaviors indeed appear to be influenced by multiple factors -- programs that address multiple antecedents may be needed in order to have a substantial, sustained impact on youth behaviors;
- Influences on sexual initiation more easily identifiable than those on condom use -- consistent with hypothesis that it maybe easier to delay sexual debut than influence sexual behaviors once started.

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## Conclusions (cont.)

- Many factors appear to have effects that vary by setting, suggesting that different interventions may be needed in different settings;
- Boys and girls appear to be influenced differentially by a number of factors;
- Further research using panel or retrospective history designs is needed in order to clarify causal directions for several key factors (e.g., SRH knowledge, peer behaviors, self-efficacy).

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## Research Findings: Program Effectiveness

### Background

At the outset of the FOCUS on Young Adults Program in 1995, only weak empirical evidence on the effectiveness of ARH program approaches in developing country settings was available

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## Methodology

- Undertake as rigorous as possible evaluation studies of interventions of different types in collaboration with various partner organizations, and
- Compile and synthesize the findings of studies undertaken by others

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## Materials

- Peer-reviewed and unpublished literature -- 32 "Level 1" studies
- Eight (8) additional (Level 1) studies undertaken by FOCUS
- Numerous "Level 2" studies

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## Outcomes Examined

- RH-related knowledge, attitudes and behaviors (e.g., early sexual initiation, multiple partners, non-use of condoms, etc.)
- Use of RH-related services

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## Limitations

- Limited to programs whose findings have been reported in peer-reviewed journals or in the form of program reports
- Under-represent programs directed to non-RH outcomes that may have had (unmeasured) impacts on ARH
- Majority of the studies were in English

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## Limitations (con't)

- Unable to ascertain in some cases whether programs failed to achieve impact because the program was not well implemented
- Much of the available Level 1 evidence is for small-scale programs implemented over short periods of time; limited evidence on long-term effects on behaviors

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## Findings (General)

- Programs appear to be more effective in influencing knowledge and attitudes than behaviors
- Although not all ARH programs have been effective at influencing behaviors, most models/approaches have been shown to have effects on behaviors in one or another study, although magnitude of effects is often small/modest
- Although the evidence is thin, multi-component programs that target multiple risk/protective factors appear to be more effective than more narrowly focused programs

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## Improving Knowledge, Attitudes, Skills and Behaviors

- School-based ARH interventions appear to be effective in influencing sexual-reproductive health knowledge and attitudes, and roughly 50% have had an impact on short-term behaviors. However, the extent to which they influence long-term behaviors is less certain
- Further research is needed to identify/verify the key elements of effective sexual-reproductive health education programs in school settings in developing countries
- Mass media-based interventions also appear to be able to influence adolescent knowledge and attitudes, but there is less evidence that they influence sexual and contraceptive behaviors

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## Improving Knowledge, Attitudes, Skills and Behaviors (con't)

- Youth development approaches and workplace-based programs appear promising, but more rigorous evaluation in multiple settings is needed before conclusions can be reached
- Community-based peer promotion approaches also appear promising, but a number of key questions require further investigation (i.e., magnitude of effects on peer contacts vs. peer promoters; "reach;" level of training and supervision required; sustainability)

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## Increasing Utilization of Health Services

- "Youth friendly services" initiatives on their own do not appear to be effective at attracting youth (at least in the short-term). Outreach and linkage with efforts to mobilize community support for providing ARH services to youth appear to be necessary
- Youth centers do not appear to increase the use of RH services by adolescents

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**PANEL II**

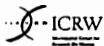
**Anju Malhotra**  
**ICRW**



## **A Participatory Approach to Adolescent Reproductive Health in Nepal**

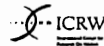
### **ICRW**

In Partnership With  
EngenderHealth  
New ERA  
BP Memorial Health  
Foundation



## **Aim of the Project**

To implement and test the effectiveness of a community-based, client-centered participatory approach to improving adolescent reproductive health in Nepal



## **Participatory Approach**

- **Involve young people and adults**
  - Defining key issues
  - Prioritizing service needs and gaps
  - Program design
  - Implementation
- **Potential for greater**
  - Program Effectiveness
  - Program Sustainability
  - Community ownership



## **Strategy For Integrated Program Design**

- Formative research
- Intervention design & Implementation
- Monitoring and evaluation



## **LOCATION**

- 4 sites
  - 2 Study (rural and urban)
  - 2 Control (rural and urban)

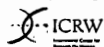
## **TARGET GROUP**

- Male and female youth
- Married and unmarried,
- Ages 14 - 24 years.



## **FORMATIVE RESEARCH Triangulated Methodology**

- **EXPLORATORY QUALITATIVE (4 sites)**
  - Focus Groups, Key Informant Interviews
- **QUANTITATIVE BASELINE (4 sites)**
  - Household, Adult, Adolescent Surveys (N=965, 752, 724)
  - Service Provider Survey (N=40)
- **PARTICIPATORY TOOLS (2 sites)**
  - 9 Group activities with adolescents, adults, service providers



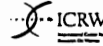
## Substantive Findings

- Reproductive Health issues specific to youth
- Issues beyond Youth & beyond RH



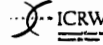
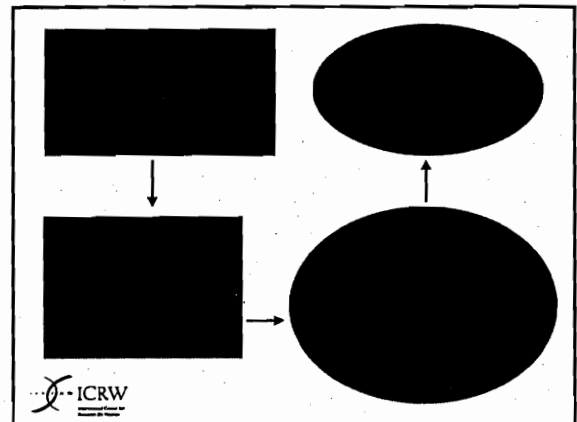
## RH Issues Specific to Youth

- Youth knowledge, attitudes and behaviors on Reproductive Health
- Service provider perspectives
- Parental attitudes



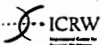
## Issues beyond RH and Youth *Norms and Institutions* *Ideals and Aspirations*

- Gendered Construction of Adolescence
- Centrality of Early Marriage, Childbearing
- Gendered Construction of Sexuality
- Centrality of Economics for adolescent futures
- Ideals and aspirations similar among youth and adults



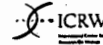
## Linkage confirmed by the community

- Community members clearly articulated these pathways
- Paradox between individual ideals and social norms



## Translating Research to Action – Action Planning Process

- Share and discuss finding with community members
- Create task forces to develop interventions
- Review and prioritize interventions based on acceptability, equity, feasibility, and resource availability
- Develop integrated plan



## **2 Key Intervention Strategies**

- Direct Reproductive Health interventions
- Interventions beyond Reproductive Health



## **Direct RH interventions Using participatory techniques**

- Youth Friendly Services
- Peer Education
- Information Education & Communication



**PANEL IV**

**Tijuana James-Traore**  
**FOCUS**



## Training for Young Adult Sexual and Reproductive Health

Tijuana A. James-Traore, MSW  
Program & Training Advisor  
FOCUS on Young Adults

### The training strategy assumes that:

- ✦ Youth are different from adults and therefore have differing needs, requiring different approaches.
- ✦ Staff, volunteers and others benefit from a better understanding of these needs.
- ✦ Personal values and beliefs related to adolescent sexuality influence how policies and programs are designed and implemented.

### The training strategy is designed to:

- ✦ Respond to the needs of missions, CAs, and others.
- ✦ Meet the needs of diverse groups of people who work with youth.
- ✦ Provide an orientation to YARH issues, including HIV/AIDS, sexual behavior & decision making, and contraceptive use.
- ✦ Increase institutional & individual capacity.
- ✦ Orient or train professionals to apply FOCUS tools.

### Training activities have targeted:



- ✦ Policy makers
- ✦ Program managers
- ✦ Service providers
- ✦ Youth
- ✦ USAID
- ✦ Donors
- ✦ Public sector
- ✦ Private sector
- ✦ NGOs
- ✦ Government

### Types of training and professional exchanges:

- ✦ State of the Art (SOTA) training courses
- ✦ Skills building courses in Monitoring and Evaluation, Youth Friendly Services and Advocacy
- ✦ Working groups
- ✦ Partner dialogues
- ✦ Technical Assistance


### Training materials developed:

- ✦ Reproductive Health of Young Adults: Contraception, Pregnancy and Sexually Transmitted Diseases (with FHI)
- ✦ Improving Interpersonal Skills for Counseling Adolescents on Sexual and Reproductive Health (Latin America)
- ✦ Assessing and Planning for Youth-Friendly Services training manual



### Training materials developed:

- ❖ Monitoring and Evaluating Adolescent Reproductive Health Programs manual
- ❖ Youth to Youth Peer Education Training of Trainers (TOT) Manual (with CAFS)
- ❖ Reproductive Health: A Practical Pocket Guide for Providers (with Pathfinder Mozambique)




### Training materials developed:

- ❖ Self-directed Learning Program Guide (with INTRAH)
- ❖ Developmentally-based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents
- ❖ Annotated Bibliography of Training Curricula for YARH Programs



### Lesson learned:

- ❖ There is a tremendous need for training in areas related to YARH, especially among NGOs and GOs.
- ❖ Training alone is not sufficient. Organizational commitment and supports are also needed.
- ❖ More follow-up and technical assistance is needed after training is conducted to assist in applying newly acquired knowledge.




### Lessons learned:

- ❖ Training efforts and information exchanges must be culturally specific and take into account the resources and limitations within which people are working.
- ❖ The attitudes of service providers greatly impact service provision. Accurate information and training can help change attitudes and improve interactions with adolescent clients.



### Lessons learned:

- ❖ Fostering partnerships is an important way to integrate YARH and broaden our reach.
- ❖ The capacity that lies within developing countries is an underutilized resource.
- ❖ Creative ways of sustaining training efforts should be employed. For example, technical assistance, mentoring, and list serves.
- ❖ There is a need to clarify terms and test assumptions.



### Lessons learned:

- ❖ Site visits, the involvement of youth, and other hands-on, participatory training techniques help maximize participant learning.

**PANEL IV**

**Milka Dinev**  
**PATHFINDER/PERU**



**Pathfinder**  
INTERNATIONAL

**FOCUS on Young Adults**


**End of Project Presentation**  
**September 24th 2001**

**Keys to Scale-Up Adolescent Programs**  
**Peru Case Study**  
**Milka Dinev**  
**Dorina Vereau**

**FOCUS on Young Adults**

**FOCUS on Young Adults**





**FOCUS Strategy for Improving Youth Initiatives in Peru**


↓



**Program and Training Evaluation Dissemination**

**Same Staff, Tools and IEC material**



<b>Both Public Sector</b>			<b>Both are Preventive Promotional Programs</b>
	Transfer skills and tech resources related to YARH evaluation	Transfer skills and tech resources related to YARH program and training	

**FOCUS on Young Adults**




 <b>1997 - 6 sites</b> <b>1998 - 8 sites</b> <b>1999 - 21 sites</b> <b>2000 - 41 sites</b> <b>By year 2000...</b> <b>56 exclusive staff</b> <b>508 schools or institutes</b> <b>26,710 leaders</b> <b>7,054 parents</b> <b>5,996 teachers</b> <b>600,000 contacts</b>	 <b>1997 - 5 sites</b> <b>1998 - 5 sites</b> <b>1999 - 6 sites</b> <b>2000 - 6 sites</b> <b>By year 2000...</b> <b>800 health professionals trained in counseling services</b> <b>300 professionals trained in service organizations</b> <b>20 integrated health centers established</b>
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**FOCUS on Young Adults**

**FOCUS on Young Adults**



**Keys to Scale-Up Adolescent Programs**

- Politics
- Management
- Commitment





## Politics



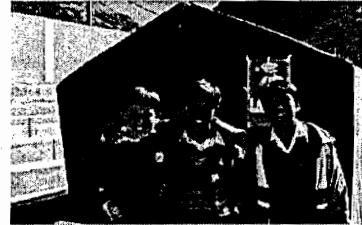
- Strong commitment from decision-makers
- Own financial resources invested
- TA understood and institutionalized (i.e. hiring MIS consultant provided by FOCUS/Pathfinder)
- Authorities only committed for PR purposes - no serious efforts made
- Program Budget is the lowest among MOH budget - but adolescent population is 22% of total Peru population
- Huge turn over of staff: 4 directors in less than 4 years



## Politics



- TA provided at central level flowed to regions: cascade training really worked
- Permanent evaluation
- Staff with exclusive dedication to program
- Difficult to work smoothly with central level authorities - TA focused on regions
- Fear/rejection of evaluations
- Staff not permanent nor exclusive to program. Staff in charge of various programs



## Management



- Long term strategic vision: future citizens
- Strategy based on cost/benefit analysis
- Staff chosen by merit/attitude
- Human development vision - adolescents participate from design
- Short term vision
- No analysis
- Assigned staff - no attitude evaluation
- Top to bottom design - very little value given to adolescents



## Management



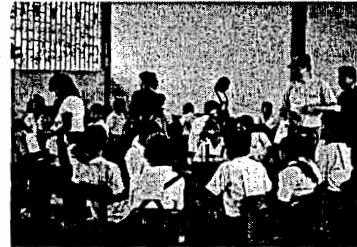
- Effective management skills and programming
- Extensive use of management information system for decision making. Tulane University assistance
- Better targeting: focus on school based adolescents peer promotion
- Evaluation culture program and staff performance
- Improvisation
- Decisions made on personal assumptions. Weak MIS
- Dispersion, no targeting
- Fear evaluation



## Management



- Clear program and activities, focused in peer promoters, parents and teachers
- Clear and defined methodology and strategy: understood by all program staff
- Institution organized as private corporation
- Activities are not focused/ disarticulated
- No articulated set of strategies, no holistic approach, no defined methodology
- Traditional public sector bureaucratic Institution



## Commitment



- Committed staff
- Open to learn and receive TA and share knowledge
- More Impact achieved by conjugating own resources, TA, staff and synergies with other interventions
- Strong and permanent knowledgeable leadership
- Demoralized staff
- Bureaucratic barriers to receive TA - too many decision layers
- Less Impact achieved, no commitment to create synergies in spite of external investment
- Weak leaders. No nationwide knowledge

**PANEL V**

**Walter Saba  
JHU/CCP**

### Dual Protection for Youth: Results from Nicaragua, Zambia and Uganda

SAFER SEX OR AID?  
WAIT  
OR  
USE A CONDOM  
THE CHOICE IS IN  
YOUR HANDS

**Body  
Guard**

**HEXRT**  
Helping Each other  
Act Responsibly  
Together

### Juntos Decidimos/Bodyguard

JUNTOS DECIDIMOS COAHUILA

**Body  
Guard**

### Marketing Condoms for Dual protection in Nicaragua

USAID  
USAID/Nicaragua

### One Brand for Dual Protection

JHU/PCS collaborates with PROFAMILIA to build capacity within the Division of Marketing and Communication in:

- Marketing of Services
- Behavior Change Communication
- Monitoring and Evaluation
- Social Marketing Products

### Juntos Decidimos/Bodyguard

- Built upon successful youth campaign
- "Bodyguard" for dual protection
- Supported by the Interagency Commission for RH (15+ organizations working in RH)

### Bodyguard and Protection

PROFAMILIA's first socially marketed condom "Bodyguard":

- Positioned as protection:  
Primarily - unwanted pregnancy  
Secondarily - STDs/HIV/AIDS

Audience understood "protection" to mean both unwanted pregnancy and STDs/HIV/AIDS

- Positioned as a "modern & cool" brand

### Youth Behavior

- High teenage unwanted pregnancy rate
- High percentage of no method use with first sexual relation
- Low awareness of the risks of pregnancy at first relation
- Misinformation on HIV/AIDS

Acetico Solo Siempre

## Linking Brand Sell and Demand Generation

Multi-Media campaign to:

- Position new condom in the market
- Stimulate demand for dual protection
- Tailor safe sex messages for youth/young adults

JOHNS HOPKINS  
Center for Communications Programs

## Behavior Change Objectives:

- Increase self perception of risks of unprotected sex & consequences of unwanted pregnancies
- Increase individual perceptions of self efficacy to discuss, negotiate and take actions with partner to prevent unwanted pregnancy
- Increase use of condom to prevent unwanted pregnancies and to protect against HIV/AIDS

JOHNS HOPKINS  
Center for Communications Programs

## Marketing Objectives

- Position "Bodyguard" as a symbol of protection
- Associate "Bodyguard" with modern and "cool" behaviors
- Increase sale of condoms



JOHNS HOPKINS  
Center for Communications Programs

## Reaching Youth

Campaign intended for m/f 15-24 years of age

TV and Radio – 70% - 84% exposure (seen or heard) in earlier youth campaign

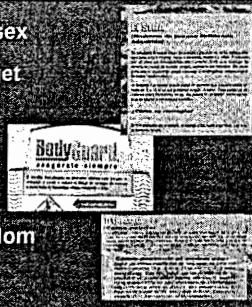
Print media (brochures, bus advertising, etc)

Promotional items (t-shirts, hats, etc)

JOHNS HOPKINS  
Center for Communications Programs

## Messages

- Safe sex: no condom no sex
- It only takes one time to get pregnant and interrupt life plans
- AIDS has no face and no cure; protect yourself
- "Bodyguard": a new condom



JOHNS HOPKINS  
Center for Communications Programs

## Interim Results: Increased Access

- 2.3 million condoms sold
- Non-traditional outlets major emphasis of project (motels, discos, markets, etc.) and account for a third of sales
- Condoms now available in more than 2,500 outlets that have never sold condoms before

JOHNS HOPKINS  
Center for Communications Programs



## One Brand for Dual Protection

Dual protection can be:

- integrated throughout all communication materials - not always together
- positioned as an added value: can sell more
- positioned as a "lifestyle" behavior (protection)

JOHN HOPKINS

## ZAMBIA The HEART Campaign

"Helping Each other Act Responsibly Together"



JOHN HOPKINS

## Objectives

Campaign designed for youth by youth to:

- Inform young people on HIV/AIDS
- Discuss ways to protect oneself from HIV/AIDS
- Promote abstinence and condom use

JOHN HOPKINS

## Program Elements

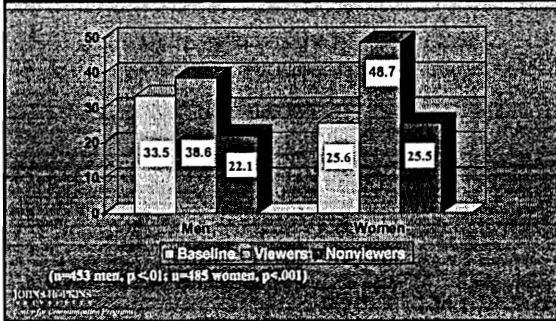
Design team - Communication specialists including young people

Youth Advisory Group - 35 young people from 11 youth organizations

Phase 1 - Radio and TV - promoting condom use or abstinence

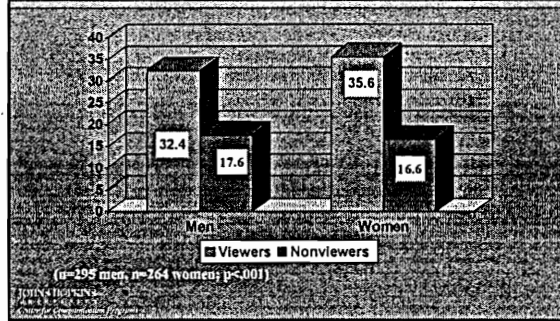
JOHN HOPKINS

## Results Condom Use by Campaign Viewership



JOHN HOPKINS

## Results - Condom Use during Last Sex by Campaign Viewership



JOHN HOPKINS

## Results

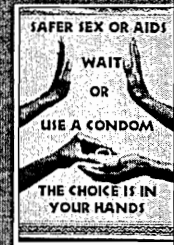
- Perceived efficacy to use condoms was positively and significantly correlated to viewership
- 81% of viewers vs. 72% of non-viewers could name a source where condoms could be purchased
- Although there was a decrease between baseline and impact of perceived risk - sexually active youth still severely underestimate their risk of HIV -

JOHNS HOPKINS  
AIDS EDUCATION & PROMOTION PROGRAM

## UGANDA - Safer Sex Campaign

Addressed adolescent boys (15-19) and secondary girls (12-19)

- delaying sexual activity
- using condoms
- resisting peer pressure
- reducing number of sexual partners
- discussing protection/safe sex w/ partners



JOHNS HOPKINS  
AIDS EDUCATION & PROMOTION PROGRAM

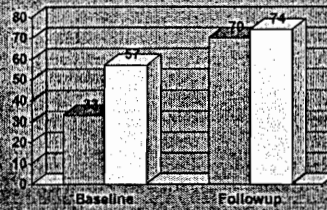
## Components

- Radio spots & jingle
- Radio programs
- Newsletters
- Hits for Hope music contest and Group Africa tour
- A Matter of Fact quiz
- Poster
- More Time Video
- District level activities



JOHNS HOPKINS  
AIDS EDUCATION & PROMOTION PROGRAM

## Results

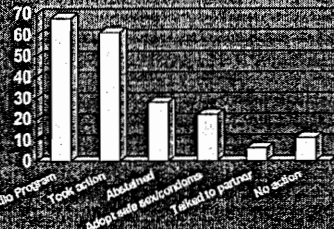


% of sexually active reporting use of condom

JOHNS HOPKINS  
AIDS EDUCATION & PROMOTION PROGRAM

## Results

Actions taken as a result of exposure to any of the three radio programs



JOHNS HOPKINS  
AIDS EDUCATION & PROMOTION PROGRAM

**PANEL VI**

**Marjorie Macieira  
SUMMIT FOUNDATION**



**DONOR INVESTMENTS AND PERSPECTIVES  
IN INTERNATIONAL ADOLESCENT  
SEXUAL AND REPRODUCTIVE HEALTH**

Survey by The Summit Foundation

FOCUS End of Program Conference  
Washington, DC  
September 24, 2001

**ASRH Donor Funding**

- In 1970's:
  - Very limited
  - Politically constrained
- In 1990's:  
ICPD + Beijing + HIV + Strong US economy =  
Increased Investments

**Survey of Select Donors  
in the US and in Europe**

- To clarify funding landscape
- Included nineteen donors:
  - Ten private US foundations
  - USAID
  - Five multilateral organizations
  - Three European government development agencies

**Donors and Agencies  
Surveyed by  
The Summit Foundation**

- |                                  |                             |
|----------------------------------|-----------------------------|
| • DANIDA                         | • The Summit Foundation     |
| • GTZ                            | • SIDA                      |
| • The Gates Foundation           | • Turner Foundation, Inc.   |
| • International Youth Foundation | • UNICEF                    |
| • The MacArthur Foundation       | • United Nations Foundation |
| • The Moriah Fund                | • UNFPA                     |
| • The Packard Foundation         | • USAID                     |
| • PAHO                           | • Wallace Global Fund       |
| • The Rockefeller Foundation     | • The World Bank            |
|                                  | • WHO                       |

**Donors Prioritized**

- Youth access to quality ASRH education, information and services
- Advocacy and public policymaking
- Youth participation in all ASRH policy and program aspects

**Funding Experiences**

- Moving from project to program funding approach
- Private money and smaller grants support controversial or risky projects
- Facilitation of collaboration between public and private sectors

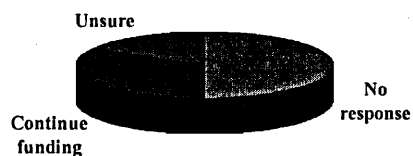
## Future Directions

- Many donors unclear about their future funding directions
- Need for greater assessment of ASRH movement direction

## Identified Gaps/Weaknesses

- Commonality of vision within the ASRH community
- Research
- Evaluation
- Level of funding devoted to ASRH
- Linkages between the reproductive health sector and other sectors
- Attitudes towards both youth and their adult gatekeepers

## Funding Direction Next Five Years



## Future Funding Priority Areas

- Services
- Research and advocacy
- Resources and sustainability

## Service-Related Priorities

- Provision of youth-friendly services, beyond clinics
- Getting private sector involved
- Safe abortion
- Quality of care assurance
- HIV/AIDS prevention
- Increased contraceptive supplies and security
- Modification of medical personnel attitudes
- Taking on Cairo agenda
- Challenging who really is and isn't being reached

## Research Priorities

- Documentation and distribution of models/best practices
- Disaggregated data collection
- Debunking myths
- Evaluation

### Advocacy Priority

- Self-help culture among youth
- Improving exchanges among all ASRH players

### Resource and Sustainability Priorities

- Greater resources for ASRH
- Better small grant-making process
- Strengthening organizational and civil society

### Conclusions

- Insufficient meaningful ASRH information exchange among donors
- Strong call for well-managed discussions@ rather than conferences or meetings

**FOCUS on Young Adults**

**End of Program Conference**

**YARH Briefs**

YARH Briefs

- 1. PARENT/CHILD COMMUNICATION ABOUT SEX: MORALS, VALUES, AND PARENTING SKILLS**
- 2. LIFE SKILLS APPROACHES TO IMPROVE YOUNG ADULT REPRODUCTIVE HEALTH**
- 3. YOUTH AS ASSETS: BUILDING EFFECTIVE YOUTH-ADULT PARTNERSHIPS**
- 4. POSTPONING FIRST AND SECOND BIRTHS AMONG YOUNG MARRIEDS**
- 5. POSTABORTION CARE (PAC) PROGRAMS FOR ADOLESCENTS**
- 6. MEASURING THE EFFECTIVENESS OF DUAL PROTECTION INITIATIVES FOR YOUTH**
- 7. MAKING CONDOM USE AN ACCEPTED SOCIAL BEHAVIOR FOR YOUNG PEOPLE IN DEVELOPING COUNTRIES**

## PARENT/CHILD COMMUNICATION ABOUT SEX: MORALS, VALUES, AND PARENTING SKILLS

Shirley Oliver-Miller, Margaret Sanger Center International

**H**aving worked as a reproductive health professional for more than two decades in cross-cultural settings in Africa, Asia, the South Pacific, the Caribbean, and Central America, I find it disturbing and sobering that many sexuality educators are still uncomfortable with encouraging family discussions about sexuality within culturally defined roles.

Parents and other caregiving adults face formidable challenges in parenting. Even those who are well informed find it difficult to know what and how much information to give to young people about sexuality and at what age to give it. Their task is made that much more difficult by the influence of the media and popular culture, from which young people take their cues about “acceptable” sexual behavior:

While reproductive health professionals promote efforts to make sexuality education more widely available, we often overlook flaws within our own programs that contribute to the dilemma parents confront when trying to educate their children about sex. One might argue that most sexuality education curricula address morals and family values and feature them prominently in the programs; in practice, however, many educators are reluctant to facilitate discussions of these issues. This, in turn, restrains the free flow of ideas and precludes honest discussion.

Though not always obvious to laypersons, this problem is painfully clear to those educators in the field who struggle with the conflict between providing factual information about sexuality and ensuring that values are clarified in line with personal, family, and community norms and attitudes. Discussion of religious beliefs and moral codes, which help govern behavior and decision making, strengthens sexuality education programs by increasing the weight of the factual information provided.

There is also a growing awareness in the young adult reproductive health field that parents and other adults raising young people need basic parenting skills to help them tackle an array of child-rearing issues and that having good parenting skills is essential for providing sexuality education in the home. In one workshop, for example, a single mother of four teenaged girls expressed her concerns for her daughters this way: “I wish my daughters would delay having sex until they’re older. But I can’t compete with the rest of the world when I have to worry about keeping a roof over our heads, so I just tell them to make sure they use a condom.”

It is clear from this parent’s response that her personal values are at odds with the advice she gave her daughters. And, while the recommendation to use a condom was certainly positive, the underlying



economic pressures had a more serious impact on the message.

If we educators truly want to enhance communication about sexuality among family members, we should reexamine how we approach this subject. We have to ensure that sexuality educators are tolerant and well prepared to facilitate discussions about morals, ethics, and religious and family values even when those values conflict with their own. Educators must understand that effective communication about sexuality or any other subject can operate only within a framework of personal values and good parenting skills.

To accomplish these tasks, funders and program planners must recognize the need for long-term parenting interventions and be willing to provide the necessary support toward this effort. Then we can work to improve overall parenting skills, increase family members' comfort levels when discussing sexuality, and integrate morals and family values into parenting skills.

A resource for helping educators reach this goal, *Christian Family Life Education: A Resource Guide for Facilitators Working in Adolescent Sexuality and Reproductive Health*, has been drafted and is being adapted for training facilitators from religious institutions and parenting organizations in Jamaica.

### RECOMMENDATION:

Support parenting skills workshops. These workshops:

- ❖ help build parents' confidence, address internal and external pressures, and help raise awareness of the

significant role that words play in the decision-making process;

- ❖ give parents—and other adults important to young people—an opportunity to discover their own parenting styles and learn what shapes young people's personalities;
- ❖ help parents learn how to motivate, discipline, and communicate effectively with their children;
- ❖ provide practical time management techniques to help parents cope with life's daily pressures.

Parenting skills programs can be promoted through many different kinds of community groups: social clubs; religious organizations; schools; health centers; social service agencies; and family courts, for example. Flyers, mailings, posters, and recommendations from past participants are all effective methods for advertising workshops.

### RESOURCES:

Oliver-Miller, Shirley. *Christian Family Life Education: A Resource Guide for Facilitators Working in Adolescent Sexuality and Reproductive Health* (forthcoming 2002).

Planned Parenthood of New York City. "Hey, What Do I Say? A Parent-to-Parent Guide on How to Talk with Your Children about Sexuality."

Tugum-Kolma, E. 2000. Pastors preach population, change lives. *Populi*. September 27 (2): 13-15.

For more information on parenting skill workshops, contact Shirley Oliver-Miller by e-mail: [shirmler@aol.com](mailto:shirmler@aol.com).

## LIFE SKILLS APPROACHES TO IMPROVE YOUNG ADULT REPRODUCTIVE HEALTH

Cecilia Moya, Advocates for Youth

### THE LIFE SKILLS APPROACH AND ITS METHODS

The life skills approach is an interactive educational methodology that focuses on acquiring knowledge, attitudes and interpersonal skills. It aims to enhance young people's ability to take greater responsibility for their own lives by making healthy choices, gaining greater resistance to negative pressures, and avoiding risk behaviors.

The World Health Organization (WHO) defines life skills as abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life. According to this definition, the five foundation life skills areas are:

- ❖ Decision making—problem solving
- ❖ Creative thinking—critical thinking
- ❖ Communication—interpersonal skills
- ❖ Self-awareness—empathy
- ❖ Coping with emotions—coping with stress

The teaching methods used by the life skills approach are youth-centered, interactive, and participatory and emphasize experiential learning. The following methods are commonly used: group work and discussions, brainstorming, role-playing, storytelling, debating, and conducting audio-visual activities.

The life skills approach is based on Social Learning Theory (SLT), the dominant theory on interpersonal health behavior. SLT explains human behavior in terms of a three-way, dynamic, reciprocal theory in which personal factors, environmental influences, and behavior continually interact. According to SLT, the following influence behavior change: interactions with the environment; observation; information and skills; self-efficacy; expectations; and responses to one's actions. Life skills take these factors into account by providing youth with the knowledge and skills to better understand themselves and their environment, and to take charge of their lives.

Life skills have played a key role in improving young adult reproductive health (YARH) around the world. For example, married girls who participated in Better Life Options (BLO), a comprehensive life skills development program carried out in India by the Centre for Development and Population Activities (CEDPA), based in Washington, DC, were more likely to have married at age 18 or older and to have influenced the selection of their husbands. These young women also demonstrated increased knowledge of contraceptives and HIV prevention, better communication with their spouses about family planning, and increased contraceptive use. Child survival and health-seeking behavior rates were also higher among the women who participated in the program than among those who did not.



In Zimbabwe, the AIDS Action Programme for Schools, spearheaded by UNICEF and the Zimbabwean Ministry of Education and Culture (MOEC), not only provided information about STIs/HIV/AIDS but also worked to build the life skills that enabled youth to make better decisions for themselves. A curriculum developed for training youth in the schools covered relationships, life skills, human growth and development, and health. Supplementary materials included “Bodytalk in the Age of AIDS,” a page from *The New Generation*, a free monthly newspaper for young people, and plays used in school drama competitions. The program has been successful and well documented. Baseline studies and the 1995 “Flashback and Hindsight” report on the design, implementation and evaluation of the program demonstrate its success and high level of documentation.

## LESSONS LEARNED

When developing and implementing a life skills program:

- ❖ Focus on the main goal—improving YARH. Program objectives should focus on key behaviors and conditions, such as delaying the onset of sexual activity, avoiding unprotected sex, and/or reducing the number of sexual partners.
- ❖ Involve participants, parents and the wider community in all program stages.
- ❖ Deliver programs through well-trained personnel within or attached to schools or in the community.
- ❖ Ensure sequence, progression and continuity in programs over time.

When conducting life skills training:

- ❖ Focus on the risks most likely to occur among participants and recognize what they already know, feel, and can do about them.

- ❖ Adapt program objectives, teaching methods, and materials to the age, gender, sexual experience and culture of the participants.
- ❖ Encourage learning from each other—peer-to-peer, teacher, family, and others in the community.
- ❖ Use a range of participatory learning methods that provide opportunities to use knowledge and practice skills and that have proved effective in changing sexual behaviors.
- ❖ Place sexual and reproductive health education in the context of other related health and social issues that can be useful entry points.
- ❖ Ensure messages and related processes are consistent and coherent across the school environment.
- ❖ Establish early partnerships with key ministries to secure their commitment to the program and to advocate for its inclusion into the national curricula.
- ❖ Evaluate program objectives, processes and outcomes using realistic indicators and allowing enough time for results to be observed.

## RECOMMENDED READING

Advocates for Youth. 1995. rev. “Life Planning Education: A Youth Development Program.”

Bandura, Albert. 1986. “Social Foundations of Thought and Action: A Cognitive Social Theory.” Englewood Cliffs, NJ: Prentice-Hall.

CEDPA’s *Youth Development Program*:  
<http://www.cedpa.org/trainprog/youth/htm>

*Teachers Talking About Learning: Life Skills*:  
<http://www.unicef.org/teachers>

## YOUTH AS ASSETS: BUILDING EFFECTIVE YOUTH-ADULT PARTNERSHIPS

Jane Norman and Kent Klindera, Advocates for Youth

In the adolescent sexual reproductive health (ASRH) field, youth are too often viewed as problems that need fixing. There is an assumption that most youth are actively making wrong choices that lead to adverse public health outcomes (e.g., unwanted pregnancy and sexually transmitted infections [STIs], including HIV/AIDS). Although these negative stereotypes persist, increasing numbers of youth-serving organizations and professionals actively promote and incorporate the concept of meaningful youth involvement in program and policy development to help youth become part of the solution to the problems many ASRH program implementers and policy advocates face. Youth involvement itself is viewed as an effective ASRH intervention. The essence of youth involvement is forging effective youth-adult partnerships.

### WHAT IS A YOUTH-ADULT PARTNERSHIP?

In a true partnership, both parties have the support and opportunity to make suggestions and decisions, and the contributions of both are recognized. In the context of ASRH, youth-adult partnerships can develop while conducting a needs assessment, fundraising, designing a program, training new staff, in service delivery, in implementing ideas and projects, in overseeing a youth program, in collecting data and evaluating or, most beneficially, in all these contexts.

Of course, being willing to share power with youth requires that adults respect and have confidence in the young people who help make decisions. They must be prepared to modify their ideas about what will or won't work. Youth must believe that adults respect their insights and other contributions and understand some of the limitations and realities of developing, running, and evaluating a program or organization.

Often, tokenism appears in the guise of youth involvement and can take many forms. Simply having young people around without any clear role—other than to make adults feel good or to be seen in media reports or advertisements—can leave young people feeling used rather than empowered. The key to avoiding tokenism is to be prepared to share decision-making power with young people.

### WHY YOUTH-ADULT PARTNERSHIPS?

There is evidence that partnering with youth and respecting their ability to make positive contributions can help provide important protective factors for young people. A study conducted by the Innovation Center for Community and Youth Development, a division of the U.S.-based National 4-H Council, concluded that involving young people in decision making provides them with the essential opportunities and supports (i.e., challenge, relevancy, voice, cause-based action, skills-building, adult structure, and affirmation) that are consistently



shown to help young people achieve mastery, compassion, and health.

Many factors influence health behaviors, including knowledge; attitudes; perceived risk, consequences, and social norms; and self-efficacy. Unfortunately, there have been few explicit linkages between the resiliency research and the youth-adult partnership movement. However, many of the factors that research has found to help young people resist stress and negative situations are produced in, and facilitated by, effective youth-adult partnerships. Behavior-change theories and research on resiliency suggests that while the kinds of activities offered by successful youth development programs vary, the emphasis lies in providing opportunities for active participation and real challenges. Few things can more convincingly and concretely demonstrate the belief in young people's capabilities than trusted adults sharing decision-making power with them.

Resiliency research has identified the following protective factors that seem to account for the difference between young people who emerge from high-risk situations with positive results and those who do not become healthy and happy adults. These factors include *Social Competence* (responsiveness, flexibility, empathy, communication skills, a sense of humor); *Problem-Solving Skills* (ability to think abstractly and to arrive at alternative solutions for problems); *Autonomy* (individual identity and ability to act independently); *Sense of Purpose and Future* (healthy expectations, goals, success orientation, educational aspirations, and hopefulness).

Along with a caring and supportive environment and high expectations, opportunities for meaningful involvement and participation are the most important factors that seem to contribute to resilient children. The development of an internal locus of control, or the ability to have an impact on the environment or on others, is a key protective factor found in resilient young people.

## What Are Important Elements of Effective Youth-Adult Partnerships?

- ❖ Establish clear goals. Youth and adults must understand what their roles and responsibilities will be and enter into the partnership of their own free will.
- ❖ Be prepared to share power in order to avoid tokenizing youth.
- ❖ Try to elicit "buy-in" or a commitment from the highest levels of the organization.
- ❖ Be selective. Not all adults can or want to work with youth; similarly, not all youth can or want to work with adults in a given capacity. Being clear about the goals and roles in the partnership can attract young people who are committed, reliable, and effective. Adult leaders should believe that young people are assets and be willing to advocate for them in the face of negative stereotyping.
- ❖ Include training and skills-building to maximize the contributions of youth and adults.
- ❖ Resolve conflicts about communication and expectations by asking questions and keeping in mind the common goals.
- ❖ Have high expectations of youth, and hold them accountable for their responsibilities.
- ❖ Value adult participation. Adults frequently have more knowledge, experience, and access to resources. Guard against discounting the potential of other adult allies or assuming that all adults believe the negative stereotypes about young people.

Include room for growth—what are the next steps? Peer education programs are often great vehicles for empowering young people and helping them develop important skills. Often, however, they do not include stages of advancement that allow room for more experienced young people to assume more responsibility.

## POSTPONING FIRST AND SECOND BIRTHS AMONG YOUNG MARRIEDS

Ubaidur Rob, Population Council, and Nancy Piet-Pelon

Marriage is recognized primarily as a civil or religious union, marking the beginning of socially acceptable sexual relations and family formation. In most countries, childbearing is socially acceptable only within marriage. Therefore, families and society expect first pregnancies to occur soon after marriage. Since in many, if not most, societies, children and parenthood are highly valued, newly married young couples are expected to have their first child within the first year of their union. Among developing countries, the proportion of young married girls who bear a child before age 20 varies widely from one place to another. In some of these countries, the proportion may reach as high as two-thirds, whereas in others it may be as low as one in five girls giving birth before age 20. In Bangladesh, for example, the median age of marriage for girls is 17, and approximately 50 percent of young women have children by age 19. Married adolescent girls are usually married to men who are much older than they. In some cases, married adolescent girls delay childbearing in order to complete their education or to remain employed. The most important factor for postponing first and second birth among young marrieds is related to the adverse effects of early pregnancy on mother's health. In addition, in countries where fertility is high, postponing births among young marrieds significantly reduces the size of the total population. Findings from operations research studies suggest that behavior-change communication interventions had motivated young marrieds to delay the first pregnancy.

Young adults (ages 10-24) represent approximately one-third of the total population in developing countries and are at high risk for unintended pregnancy, sexually transmitted infections (STIs) and HIV/AIDS. Findings suggest that delayed childbearing by adolescents significantly reduces maternal and infant deaths, especially in countries where anemia and malnutrition are common.<sup>1</sup> Health problems that can be commonly experienced by young pregnant women are damage to the reproductive health tract, delayed or obstructed labor, ruptures in the birth canal, and elevated risks of maternal and infant mortality. The vast majority of newly married adolescents know little about STIs and are less likely than older women to take appropriate steps to protect themselves from them. This in turn may lead to serious health consequences for the expectant mother and the baby. For example, in Bangladesh 19 percent of newborns are exposed to a high risk of death because the mother is underage.

Factors that accelerate or lead to married adolescent girls' entering into early motherhood include the widespread belief that contraceptives are inappropriate for young people to use before a first birth and family expectations that young marrieds should have children as soon as possible. Many family planning programs do not help young people, and especially young marrieds, acquire the knowledge

1 Rob, U., and N. Piet-Pelon. 1998. "Adolescents and Reproductive Health." *Policy Dialogue* No.8. Population Council, Bangladesh.



and skills needed to postpone first and second births. And in some cultures it is considered socially unacceptable for young married women to leave their homes to receive family planning services.

Contraceptive use early in marriage can have a positive effect on future reproductive health. It appears that a growing number of young women use contraceptives prior to the birth of their first child. In Bangladesh, approximately one-third of married adolescents ages 15-19 report using contraceptives prior to childbearing (Bangladesh Demographic and Health Survey, 1999 - 2000). The use of menstrual regulation, abortion and the reported desire to delay childbearing among married adolescents underscore the need for contraception earlier in marriage than is usually assumed. Appropriate family planning programs could greatly enhance young women's reproductive health by intensifying efforts to reach newlyweds.

Several interventions have been designed to help young married women delay their first births, including encouraging smaller families, providing information about birth spacing, and prenatal care. These types of programs try to reach young women in their homes and communities, recognizing that young married women usually have less mobility than older women. One example of a successful program to reach young married women is conducted by Pathfinder International in Bangladesh.<sup>2</sup> There, field workers were trained to work with young married women, contacting them through home visits and promoting and selling contraceptives to them. Field workers consult with the newly married women on arranging and scheduling the orientation meetings, including how best to involve their in-laws. Findings suggest the program has increased contraceptive use and delayed first pregnancy among newly married young women. Although males show an interest in the program, their attendance in the orientation meetings is poor compared to that of the young women.

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<sup>2</sup> Barkat et al. 1999. *Newlywed Strategy: Results of a Program Assessment*. Pathfinder International.

Because young women are often protected by their families, have less mobility, and frequently cannot go to a clinic, it is critical that field workers visit them at their homes. These workers should be able to conduct examinations and screen for potential problems related to pregnancy. The worker should also be able to motivate the family decision makers to call her when labor begins and prepare to transport the woman if necessary.

In Bangladesh, there is an emerging trend of contraceptive use prior to the first birth. Service providers should give special emphasis to reaching these couples. Special events such as village fairs or street dramas for newlyweds can be organized at clinic and community levels where adolescent reproductive health should be the theme.

Young married women's underutilization of health services must be examined and effective methods devised to encourage young women to use these services. Where reproductive health (RH) programs are managed by nongovernmental organizations, innovative methods can be employed to ensure that these programs incorporate income-generation and skills-building activities as part of their program plans. For instance, RH programs may help newly married women with micro-credit and informal education that may help reinforce young couples' willingness to postpone first and second births.

Research findings suggest that socioeconomic and educational factors affect the timing of first and second births among young married women. Therefore, health-service policies and programs should be designed and especially targeted to married adolescents. Interventions should include programs that support or reinforce their self-esteem; help them take care of their reproductive health needs; and encourage and assist young couples to continue their education, which may strengthen their economic prospects as well. Married and soon-to-be married young people are a priority segment of the population that must be reached and addressed through effective health programs immediately.



## POSTABORTION CARE (PAC) PROGRAMS FOR ADOLESCENTS

Jeannine Herrick, Ipas\*

Unsafe abortion endangers the health and lives of many female adolescents worldwide. The World Health Organization (WHO) estimates that as many as 4.4 million adolescent girls resort to abortion annually, the majority unsafe. These abortions result from a special vulnerability, lack of information and resources, and fears of many adolescents. In addition, adolescents often delay seeking care and therefore experience disproportionately high rates of abortion-related complications. According to a 1998 study by Initiatives, Inc., about one-third of abortion complications worldwide are in women under age 20.

The needs and life situations of female adolescents seeking postabortion care (PAC) and contraceptive counseling vary greatly depending on their age, marital status, and the circumstances of their pregnancies.

For all young women who have had an abortion, making postabortion contraceptive services available is critical for preventing repeat abortions. Following care for abortion complications, providers should ask the young woman about her reproductive intentions and life situation, then

provide information and counseling about a quick return to fertility, contraceptive methods available, and the risk of HIV/AIDS and other sexually transmitted infections (STIs). Among other things, the circumstances of the pregnancy, history of complications such as infection, severe vaginal hemorrhage, vaginal/cervical trauma, and intra-abdominal injury may need to be considered in the choice of method.

Few adolescent-specific postabortion care programs exist anywhere in the world. Below, two of the first such programs are described.

Since 1990, Pathfinder International has supported a hospital-based adolescent PAC project at Kenyatta National Hospital in Nairobi, Kenya. The hospital treats an average of 20-25 women for abortion complications each day, one-third of whom are under age 25. A High Risk Clinic (HRC) was established at the hospital to help young women prevent future unintended pregnancies after having had an unsafe abortion or a delivery.

At the clinic, adolescents receive reproductive health, HIV/STI, and contraceptive counseling and are provided with contraception, including emergency contraceptive pills (EC). The clinic has established referral links in schools and communities and with a telephone hotline to make follow-up care and contraceptives more easily accessible to youth. Similar projects based on this

\*Ipas is an international nongovernmental organization that works globally to promote women's reproductive health and rights.

model have been established in smaller hospitals and clinics in Kenya.

An evaluation of this program reveals that while approximately half the clients accepted a contraceptive method at a first visit, there was a sharp fall in contraceptive use between the first and second months after the visit. The 20 percent of clients who continued to use contraceptives did so for an average of seven to eight months. Thus, it is clear that more effective follow-up and community-based services are needed.

In Fortaleza, Brazil, after adolescent women receive PAC services in the emergency department at Escola Assis Chateaubriand Maternity, they are referred to the hospital's Adolescent Center for an appointment. There, young women are counseled on reproductive health, both in groups and individually. Counselors and PAC providers are trained by Ipas to be sensitive to adolescents' needs and life situations.

At this same hospital, the Adolescent Center, with support from the Women's Studies Project at Family Health International (FHI), conducted a longitudinal study comparing adolescents who induced their abortions and those who did not. At one year postabortion, 43 percent of the spontaneous abortion group (n=51) and 56 percent of the induced abortion group (n=94) were using contraception.

Despite the large numbers of adolescents seeking abortions, PAC programs have greatly neglected adolescent-specific services, and few initiatives have been community-based, which is necessary to work effectively with adolescents. Conversely, many adolescent programs that focus on the reproductive health needs of youth have neglected to address the special needs of those who have had abortions.

## RECOMMENDATIONS

- ❖ Clarify policies and consent laws that may prevent adolescents from seeking or obtaining reproductive health services, including PAC.
- ❖ With youth participation, ensure that PAC programs develop and invest in adolescent-focused services, with special attention to postabortion contraceptive counseling.
- ❖ Develop training for PAC providers and counselors that encourages empathy, sensitive interpersonal communication methods, and nonpunitive, nonjudgmental attitudes toward adolescents.
- ❖ Routinely include condoms and EC in PAC services for adolescents, as these methods may be particularly well suited to their needs. A dual-method approach is recommended for adolescent women, particularly those who have multiple partners, are engaged in commercial sex work, or are in relationships that are violent or that limit their decisionmaking autonomy to prevent the transmission of HIV and STIs.
- ❖ Conduct research, including longitudinal studies, to look at the reasons for the continued use or discontinuation of postabortion contraceptive methods.
- ❖ Increase and enhance linkages between PAC facilities serving young women and youth-friendly reproductive health services, as well as community-based youth development programs. These linkages should ensure that modern methods of contraception, sexuality education, and other reproductive health information and services are made accessible and affordable to adolescents in a sensitive and confidential manner. This approach will facilitate sustained use of contraception.



## MEASURING THE EFFECTIVENESS OF DUAL PROTECTION INITIATIVES FOR YOUTH

Theresa Hatzell, Family Health International

One of FOCUS' key objectives has been to identify programs and policies that have proved effective in reducing risks faced by youth. Promoting condom use by sexually active adolescents is now accepted as an important "dual protection" intervention for preventing both undesired pregnancy and transmission of HIV and other sexually transmitted infections (STIs). As interventions are developed for encouraging correct and consistent condom use among youth, practical research techniques must be applied to measure effectiveness. Objective evidence must be gathered to answer the following questions concerning the condom promotion intervention:

1. Did it produce a decrease in the number of unprotected high-risk sex acts?
2. Did it produce a decrease in the incidence of unplanned pregnancies?
3. Did it lead to a decrease in the incidence of STIs?

Answering the first question requires collection and analysis of *behavioral* data. The answers to questions 2 and 3 are obtained through assessment of *biologic* measures. Today the most accurate assessments of condom promotion interventions rely on a combination of behavioral and biologic measures. Both have their strengths and limitations in measuring dual protection program effectiveness. For example, a typical biologic indicator is assessing changes in the proportion of targeted youth testing positive for an STI before and after the introduction of a condom promotion intervention. This is an attractive outcome measure because it directly reflects one of the ultimate objectives of dual

protection initiatives: driving down STI rates. Investigators can use validated biochemical tests that produce findings of known accuracy.

At the same time, STI testing has its limitations and challenges, particularly when dealing with an adolescent population. In some settings, parental consent may be required for examining or treating minors, and communication of STI test results may not necessarily be confidential between the provider and the young person. Adolescents may be reluctant to undergo testing, particularly if an invasive procedure such as a pelvic exam is involved. Finally, there can be difficulties in documenting decreases in disease rates if the infections that are detected and treated prior to the introduction of the condom promotion program are never actually cleared up as expected. Participants' failure to comply with full treatment regimens often contributes to this problem.

Behavioral measures of condom promotion effectiveness also have their strengths and limitations. Consider, for example, estimating changes in the proportion of protected sex acts in youth before and after the introduction of a condom promotion intervention. Program evaluators are naturally interested in this measure since increasing the consistency of condom use is an immediate objective of dual protection programs. In some situations it may be far easier and cheaper to assess behaviors than to conduct STI testing; the only essential requirements are a reliable questionnaire and interviewers trained in its use. Nonetheless, it can be difficult to obtain accurate behavioral data. Since ethical considerations obviously preclude



direct observation of sexual activity, investigators must rely on self-reported behaviors to assess condom-use practices. Youth may be especially inclined to underreport their sexual activity or exaggerate their use of condoms to avoid embarrassment or reprisals. This tendency to give socially desirable responses may only increase as condom promotion campaigns, with their expected “right” answers, intensify. Furthermore, no “gold-standard” method exists for obtaining precise condom use data. Consequently, each time a new survey technique is developed, there is no way of knowing for certain that the condom use data derived from it are accurate. This uncertainty generates skepticism about the validity and value of data on self-reported condom-use behaviors.

Relying on a combination of behavioral and biologic data is an effective means of drawing on the unique advantages of both sets of techniques, while compensating for the limitations of each. Combining condom-use data with information on pregnancy and STI rates can help create a full picture of how an intervention is working in a community. In some cases, a documented change in behavior may fail to achieve the anticipated public health impact. For example, if a condom promotion campaign leads to increases in dual protection use primarily among the most responsible youth who are in mutually monogamous relationships and already using contraception, then the initiative will fail to achieve substantial decreases in STI transmission and pregnancies. In such a case, program evaluators who have access to both behavioral and biologic outcome data might correctly discern that the condom promotion program is not completely ineffective, but that it should be targeted more directly toward youth at highest risk.

This example shows that combining basic information on condom use frequency with STI test results may still not be enough for understanding fully the effectiveness of dual protection interventions. Ideally, program evaluators will complement surveys and STI testing that measure outcomes in terms of counts or percentages—quantitative indicators—with qualitative investigations that delve more into *why* and *how* programs

succeed. Qualitative methods, such as focus-group discussions and in-depth interviews, allow youth to share their thoughts and experiences in greater depth and in their own words. They allow the investigator to build rapport, probe, and explore. Youth may offer information that is more accurate and complete than that provided by short responses to a structured questionnaire. Evaluation of dual protection programs would be well served by qualitative examinations that explore issues such as the following:

- ❖ young people’s perception of risk and their level of motivation to protect themselves from disease and pregnancy;
- ❖ obstacles they face in using condoms consistently;
- ❖ their knowledge, skills, and confidence level related to correct condom use;
- ❖ their condom use patterns in different circumstances, with different types of partners;
- ❖ problems they have in using condoms and things they like about them;
- ❖ their impressions of the existing dual protection program intervention and their ideas for program improvement.

A qualitative investigation exploring such issues will produce findings that can be combined with quantitative outcome measures on pregnancy, STI rates, and condom-use behaviors to arrive at a complete understanding of how well the dual protection program works, how it can be strengthened, and what lessons learned can be transferred to other sites.

### RECOMMENDED READING:

- Fishbein, M., and B. Jarvis. 2000. Failure to find a behavioral surrogate for STD incidence—what does it really mean? *Sexually Transmitted Diseases*. 27: 452-5.
- Morgan, D.L. 1998. Practical strategies for combining qualitative and quantitative methods: applications to health research. *Qualitative Health Research*, 8: 362-76.



## MAKING CONDOM USE AN ACCEPTED SOCIAL BEHAVIOR FOR YOUNG PEOPLE IN DEVELOPING COUNTRIES

Robert Ainslie, Johns Hopkins University Center for Communications Programs

Complications associated with pregnancy, childbirth and unsafe abortion are the major causes of death for women ages 15-19, and half of all new HIV/AIDS cases are estimated to be among 15- to 24-year-olds. Consistent use of condoms is an effective strategy for preventing unwanted pregnancies, sexually transmitted infections (STIs) and HIV/AIDS.

Youth surveys and research show some alarming data about youth's sexual behavior. For example, a 1998 survey of 1,500 youth in Nicaragua showed that 67.5 percent of males and 32.2 percent of females engaged in premarital sex, but only 15.5 percent used any contraception the first time they had sex. Their reasons? Sex was not anticipated (39.5 percent), lack of knowledge that one needs to use contraception (32 percent), not necessary (17 percent), or lacked information on contraception (15 percent). In Zambia (Zambia Sexual Behavior Survey 1998), of those young people who had engaged in sex, 84 percent did not use condoms the last time they had sex. The 1996 Zambia Demographic and Health Survey showed that 64 percent of girls and 70 percent of boys think they are not at risk of contracting HIV. These data suggest that while many young adults are engaging in sexual activity, a large percentage do not believe they are at risk of pregnancy or disease, or need to protect themselves.

What is the solution? There is no easy answer. Results from projects in the developing world demonstrate the need to promote condoms for sexually active youth. Although there has been some success, more work needs to be done to break down access and psychosocial barriers of getting youth to use condoms consistently and correctly and to make condom use an acceptable social behavior. To overcome these obstacles, these issues must be addressed:

- ❖ **Self-efficacy.** For individuals to adopt preventive behaviors, they must believe they can put the behavior into practice without fail, feel it is accepted by their peers, and need models to emulate.
- ❖ **Negotiation skills.** Before engaging in sexual activity, both young women and young men must discuss with their partners the use of preventive methods such as condoms.
- ❖ **Access.** Access includes having convenient, youth-welcoming places to get condoms, range of condom distribution outlets, paying affordable prices, and obtaining correct information on use.
- ❖ **Reproductive health information.** Youth need correct information on fertility, STIs/HIV/AIDS, and contraception. Lack of knowledge about the need for protection against unwanted pregnancy and disease explains why many youth do not use contraception when they begin sexual relations.
- ❖ **Prevalent social and cultural norms.** Youth are confronted with social and cultural norms that praise males for sexual prowess and punish females for premarital sex, while rejecting preventive measures. Both boys and girls must be empowered to promote and practice safer sexual behaviors.
- ❖ **Perceptions about condoms.** In many countries, condoms are perceived as leading to promiscuity among unmarried youth. Many young people also cling to negative ideas about condoms.

More promotion and better access to condoms are not enough to bring about positive social norms for condom use. Programs designed to increase youth's adoption of safer sexual behaviors need to address more than supply-and-demand issues. To be more successful, programs must integrate different approaches, including behavior-change communication, social mar-



keting, counseling, clinical services, and peer outreach. Multifaceted programs incorporating psychosocial and access issues will help change social norms on sexuality and using preventive measures (condoms). Many programs have successfully increased condom use and changed attitudes about them, using the following strategies and approaches:

**Behavior-change communication.** Effective communication strategies have changed behaviors with intended audiences. In Uganda, the DISH (Delivery of Improved Services for Health) “Safer Sex or AIDS” communication campaign contributed to increasing knowledge, changing attitudes, promoting responsible sexual behavior, and persuading youth to adopt safer sex measures. Using an entertainment-education approach with such components as radio spots and programs, newsletters, concerts, song contests and print materials, the campaign demonstrated an increase from 46 to 70 percent of reported condom use among sexually active respondents. Of the 68 percent who listened to the radio programs, 61 percent reported taking action such as abstaining from sex, adopting safer sex practices, or talking to someone about sex. To be effective, communication programs should be theory driven; be research based; segment audiences (male, female, age-groups, primary and secondary audiences); provide a good media mix (e.g., TV, radio, networks/interpersonal, community mobilization); have youth participation; and use formats that youth like and are comfortable with (e.g., music, drama, video).

**Social marketing:** Social marketing has been successful in increasing availability and use of condoms in many countries. Social marketing needs to promote condoms by engaging people, reaching them emotionally, and persuading them that condom use is important, easily accessible, and a social norm. As Population Services International’s (PSI) SMASH (Social Marketing for Adolescent Sexual Health) program in Africa demonstrated, social marketing programs that integrate a mix of media and interpersonal communication (radio programs, peer counseling) with increased access to condoms through “youth-friendly” outlets (pharmacies and clinics), reach is expanded, and youth participation in the program is guaranteed. Program results also showed increased youth awareness of the benefits of protecting themselves against AIDS and unwanted pregnancy and in reducing barriers to condom use.

**Providers and clinics:** Youth should feel they can access reproductive health services and products without being judged or condescended to. If programs promoting condom use are to be effective, health providers must offer a space for adolescents to talk and get

information, products, and services in a nonjudgmental way, i.e., become “youth friendly.” PSI research conducted in Africa found that youth feel providers lecture or intimidate them, whereas retailers treat them as customers. While youth may be able to get condoms more readily in retail outlets, health providers may miss opportunities to offer counseling and more information on pregnancy, STIs, HIV/AIDS, etc. In Zimbabwe, the National Family Planning Committee and JHU/CCP’s “Promotion of Youth Responsibility Project,” a multimedia campaign to increase young people’s knowledge of reproductive health issues and encourage healthy sexual behaviors, designated 26 clinics “youth friendly.” Staff were trained to communicate with and counsel youth effectively, and drama groups and peer counselors referred youth to these clinics. Results showed that 33.5 percent of sexually experienced youth with high exposure to the campaign sought services, as compared to 9 percent of those with low exposure.

**Peer educators:** Peer education can be an effective way to reach youth. When youth see that people like themselves have the same questions, fears, anxieties, and needs, they feel less isolated and more like others. Peer education programs in Nigeria and Ghana (West African Youth Initiative) showed an increase in participant attitudes and knowledge as well as in safer sex behavior. A post-intervention survey showed significant positive differences in knowledge and behaviors—including abstinence, number of sexual partners, and condom use—between participants and control group.

**Dual protection.** Condoms are the only method that protects against both STIs/HIV/AIDS and unintended pregnancies. Promoting dual protection can help position condoms as a method of protection for couples. In Nicaragua, JHU/PCS and PROFAMILIA marketed the BodyGuard condom to young people with dual protection messages. BodyGuard was positioned as a cool and modern contraceptive method. The dual protection messages were disseminated through TV and radio spots and print materials. PROFAMILIA sold 1.5 million condoms the first year of the campaign.

**National-level policies.** One way to help make condom use become socially acceptable is to ensure that national-level policies help promote, rather than hinder, access to condoms by youth. Some countries apply import duties to condom shipments, taxes on domestic manufacturers, and licensing requirements on condom sales. Policies promoting condoms must be supported. In many countries, condoms can be freely advertised in the media; however, government and media outlet restrictions still exist.

FOCUS on Young Adults

End of Program Conference

Participants

Participants

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FOCUS on Young Adults

End of Program Conference

EOP Report

# Executive Summary



**FOCUS on Young Adults**



**Advancing Young Adult  
Reproductive Health:  
ACTIONS FOR THE NEXT DECADE**

**END OF PROGRAM REPORT  
EXECUTIVE SUMMARY**

**WASHINGTON, DC  
2001**



# EXECUTIVE SUMMARY



Over the past six years, the FOCUS on Young Adults program has worked on young adult reproductive health (YARH) issues, policies, and programs in all regions of the developing world. This report summarizes what we have learned. Chapter 1 describes the most critical YARH issues and identifies important factors that influence YARH knowledge, attitudes, perceptions, skills, and behaviors. Chapters 2 through 5 summarize what we know about the effectiveness of YARH policies and programs. Chapter 6 describes key operational factors that influence program effectiveness. Chapter 7 presents recommendations to improve YARH programs, fill gaps in our knowledge of effective programs, and—ultimately—extend access to YARH services.

## MAIN FINDINGS AND RECOMMENDATIONS

### CHAPTER 1: THE CONTEXT OF YOUNG PEOPLE'S LIVES

Adolescence is a period of dynamic change representing the transition from childhood to adulthood and is experienced differently in every society. Most young people start having sex before age 20, and many consequently become pregnant and have children or undergo abortion as adolescents. Relatively few youth use reliable contraception. Young people are better educated than ever, but many either never enter school or drop out before completing primary or secondary education. Many eventually enter the labor force, but even those who work remain poor for the most part.

Adolescence is generally a healthy time, but many youth face risks from unwanted pregnancies as well as HIV/AIDS and other sexually transmitted infections (STIs). Approximately half of all new HIV/AIDS infections occur in young people under age 25, the majority of them young women. Young people are at high risk of contracting HIV and other STIs because they often have multiple, short-term sexual relationships and do not consistently use condoms. They also tend to lack sufficient information and understanding of HIV/AIDS, which affects their vulnerability to it, their attempts (if any) to prevent it, and their levels self-confidence to protect themselves from it. In a few countries, including Uganda for example, HIV infection rates in young people have declined significantly. These data are important because they show that behavior change for youth is possible at a societal level.

A wide range of individual, social, and cultural factors—also known as “risk and protective factors”—influence the reproductive health behaviors of young people. Peers, families, institutions, and communities all may have an impact—positive or negative—on young people’s decisions and actions. Understanding these factors and their relative importance is critical in designing effective YARH policies and programs. Although the risk and protective factors model is a potentially powerful tool in program design, knowledge of the important factors is still very limited, our methods to analyze these factors are too crude, and findings are often too contradictory to draw clear conclusions. Thus, further study of risk and protective factors is needed.

## **CHAPTERS 2 THROUGH 5: WHAT WORKS TO PROMOTE YOUNG ADULT REPRODUCTIVE HEALTH**

Many different policy and program approaches attempt to help youth practice healthier sexual and reproductive behaviors. To determine what works, FOCUS reviewed the best available research and evaluation and came to the following conclusions.

**Only a small proportion of YARH interventions have included a relatively strong impact evaluation component and, thus, some promising approaches have yet to be rigorously evaluated.** Only a few of the strong evaluation studies reviewed by FOCUS assessed effects on the use of health services, and none examined the impact on behaviors of creating a supportive environment. Of those studies looking at impacts on knowledge, attitudes, and practices, most look at just one type of program—school interventions. Furthermore, much of the available evidence from strong studies is for small-scale programs that are carried out over short periods of time, and little evidence is available on long-term effects on behaviors.

**Although not all YARH programs have been effective at influencing reproductive health behaviors, all of the approaches examined—with the exception of those attempting to increase the use of clinical services—have been effective in at least one study.** It is impossible to say, however, that certain models are more effective than others because the period of observation and the behaviors that were influenced varied by study. Moreover, further replications in multiple settings are necessary to provide a basis for identifying the key features or elements of successful interventions.

**Programs appear to be more effective in influencing knowledge and attitudes than behaviors.** Almost all rigorously evaluated programs reviewed by FOCUS improved reproductive health knowledge and selected attitudes. A smaller but still encouraging percentage of programs significantly changed at least one important adolescent reproductive health behavior. Often, however, programs tried and failed to improve many important behaviors, and the magnitude of effects was modest in many cases. This finding likely reflects the difficulty of changing behaviors that are influenced by a large number of factors, factors that go beyond knowledge and attitudes related to reproductive health alone.



## CHAPTER 6: KEY OPERATIONAL ISSUES RELATED TO YARH POLICY AND PROGRAM EFFECTIVENESS

Three key operational issues cut across regional and cultural boundaries: (1) capacity building, (2) scaling up and sustainability, and (3) youth participation and involvement in YARH policy and programming. These issues hold significant implications for all policy and program initiatives.

**Capacity Building.** The needs of young people, their access to information and services, and their abilities to think and act are different by virtue of their age. Those working with youth thus need to acquire specialized skills to effectively provide reproductive health care. Four important areas where such capacities need strengthening follow:

- ◆ *National strategic assessments and planning.* Reproductive health groups generally know little about the special characteristics of youth. Assessment and planning thus play a key role in the many countries where YARH programs are new and have not yet become routine elements of a country's reproductive health and youth efforts. Although FOCUS and other organizations have developed a variety of assessment and planning techniques, more needs to be done to evaluate their effectiveness in developing and implementing realistic policies and strategic plans.
- ◆ *Performance improvement.* Values and beliefs affect those working in YARH programs to a greater extent than they affect professionals in other fields of work. As a result, YARH training has needed to go beyond imparting the standard technical knowledge and abilities that may be sufficient in other areas of work and, instead, has needed to help institutions and individuals become more effective by coming to terms with their personal feelings and potential biases. In its work, FOCUS has found a tremendous need for YARH training. Particular emphasis should be placed on follow-up and technical assistance after training to assist program staff in making changes and applying newly acquired knowledge.
- ◆ *Information exchange and sharing.* Many developing country professionals and young people themselves desire to exchange (rather than merely receive) information on YARH programs and to explore opportunities to adapt approaches through interaction with others involved in YARH. Moreover, field programs want practical, "how-to" information and descriptions of successful program approaches in other countries and settings.
- ◆ *Monitoring and evaluation.* Monitoring and evaluation offer program managers, decision makers, funders, and others the means to determine whether programs are working or not. Unfortunately, monitoring and evaluation often are not built into YARH programs from the very beginning. Funding agencies must ensure that money is set aside not only for monitoring and evaluation efforts but also for the dissemination of results, both positive and negative.

**Scaling up and sustainability.** With key support such as leadership, staff, funding sources, and advocates, programs can move beyond local origins to operate at scale. To be sustainable,

programs need to adapt to changing circumstances and changing resources. Moreover, sustainability, especially in a time of health-sector reform in many countries, requires cooperation and collaboration among different levels of government and among different organizations.

**Youth participation and involvement in YARH policy and programming.** Clearly, many YARH programs recognize the value of youth involvement and participation, and they have incorporated youth in several ways. Peer-education programs—an important type of youth involvement—can successfully improve youth knowledge, attitudes, and behavior related to prevention of pregnancy and STIs. However, few other means of youth involvement, for example, governance, program design, and evaluation, have been rigorously evaluated for their impact on sexual and reproductive behaviors.

## **CHAPTER 7: RECOMMENDATIONS FOR IMPROVING AND EXPANDING YARH INITIATIVES**

With resources still limited and political will to support YARH efforts still weak in many countries, countries must choose their YARH actions judiciously according to the best available knowledge of effective policies and programs. They must also be willing to adopt a flexible approach that takes into account local needs.

To support these efforts, FOCUS offers three sets of recommendations. The first summarizes findings on effective YARH policy and program approaches, based on the review of research and evaluation presented in this report. The second set articulates important principles critical to the expansion of effective YARH policies and programs. The third recommends future priority actions to improve programs and fill important gaps in our current knowledge.

### **RECOMMENDATIONS FOR EFFECTIVE YARH POLICIES AND PROGRAMS**

- 1. Carry out continuous and broad-based advocacy to support YARH efforts.** Advocacy efforts are key to building multisectoral support for policies that promote YARH programs. Advocacy groups that widely involve adolescents and the community and that speak on behalf of the needs of adolescents are particularly effective in desensitizing YARH issues and in pushing for positive change. Funding and technical assistance are required to improve monitoring and evaluation of policy efforts, to disseminate policies, and to allow for effective follow-up.
- 2. Carry out well-designed reproductive health education in schools.** Well-designed school-based programs appear to be almost universally effective in improving young peoples' knowledge of sexual and reproductive health, including contraception and HIV/AIDS prevention, and often are effective in promoting positive YARH behavior changes. Where school enrollment is fairly high, a comprehensive approach should include schoolwide reproductive health education to reach large numbers of young people. Ideally, governments should scale up these efforts to be national in



scope; should begin them, with age-appropriate information, in primary school; and should adequately train and support teachers to impart reproductive health education. Further research is needed to determine how to strengthen connections among school programs and commercial sources as well as among other nonclinical sources of reproductive health care.

- 3. Promote condom use through social marketing programs and mass media.** Condom use is effective for pregnancy prevention as well as for prevention of HIV/AIDS and other STIs. Social marketing approaches directed at youth appear to hold significant promise for promoting condom use on a relatively large scale and for making regular condom use more socially acceptable. Media promotion efforts should be coordinated with pharmacies and other private sector outlets that young people prefer for reasons of confidentiality and convenience and should be combined with training to make these service sites more youth friendly.
- 4. Carry out broad-based community initiatives.** Community programs influence youth at multiple levels and can reach the many youth who are not in school. A broad range of these programs—including youth development, peer promotion, mobilization of youth and adults, and community-based distribution of contraceptives—have been successful in improving youth reproductive health behaviors. Further research is needed on the effectiveness of outreach programs for referring youth to clinics; the type of community service delivery that is most appealing to different groups of young people; and the impact of broader youth development approaches on reproductive health.
- 5. Build on the promise of youth-friendly services.** Evidence from the relatively rigorous studies discussed in chapters 4 and 5 did not show conclusively that a youth-friendly approach is more effective in attracting young people to clinical services. Nonetheless, combined with the evidence from supportive studies, the youth-friendly approach is clearly a promising one, particularly when such programs also actively work to build broad support within communities for providing information and services to young people. Youth-friendly services in community, social, recreational, and commercial settings also represent a promising—though largely untested—approach to improving young adult reproductive health.

The idea of youth centers—which were intended to offer reproductive health as one of many recreational and other services—was and is still very appealing. However, several evaluations have found that youth centers are a relatively expensive and ineffective way to provide reproductive health care to young people.

- 6. Enhance peer programs.** Peer programs are culturally appropriate initiatives that can help change community norms and individual reproductive health behavior in diverse settings. Peer networks and network mobilization strategies also show promise in promoting positive and protective reproductive health behaviors. Despite the promise of peer programs, a number of important questions remain about their effectiveness, including how to address high turnover, how to improve

supervision and training, and what impact incentives have on peer educator effectiveness and continuation. More information is also needed about effective ways to reach hard-to-reach youth populations such as HIV-positive youth, refugees, street children, and commercial sex workers.

## RECOMMENDED PRINCIPLES FOR EFFECTIVE POLICIES AND PROGRAMS

The following principles of program design, delivery, and evaluation are grounded in the experience that FOCUS and others have gained in carrying out YARH programs in the developing world. Although, in most cases, their impact on YARH outcomes has not been rigorously measured, many evaluations have shown that programs adhering to these principles are more likely to succeed

### **1. Involve young adults in meaningful ways in YARH policy dialogue and programming.**

Involving young people in designing, carrying out, and evaluating YARH policies and programs enhances the relevance of these efforts and increases the sense of “ownership” that young people feel toward the program. In whatever capacity it occurs, youth participation must be real, meaningful, and sustained rather than token.

### **2. For HIV/AIDS and pregnancy prevention, emphasize condom use and other means of dual protection.**

An emphasis on dual protection, condom use, and abstinence—especially for unmarried youth—is an effective way to address the twin risks of unwanted pregnancy and HIV/AIDS. Mass media and social marketing strategies have shown some success in reducing the stigma of condom use, but more of these efforts are needed because many adolescents continue to view condom use negatively.

### **3. Explicitly address gender inequality.**

Gender inequality increases the vulnerability of girls and young women to coerced sexual intercourse, unwanted pregnancy, as well as HIV/AIDS and other STIs. Policy and program efforts need to help change prevailing social norms when they are harmful to girls and young women. Accomplishing this kind of change also requires an increased focus on changing the attitudes and behaviors of boys and young men.

### **4. Identify the policy and program mix best suited to the target population.**

The context in which youth mature varies considerably within and across countries. Regardless of the setting, assessment that is based on good information should precede any program effort. This assessment is necessary to understand this cultural context and to identify the program mix best suited to the target population. Programs need to use their limited resources, first, to provide services to those youth in greatest need and, then, to use different strategies that take into account differences in age, sex, and marital status.

### **5. Design comprehensive programs that address multiple youth needs.**

Comprehensive, multicomponent programs, by simultaneously addressing the different categories of risk and



protective factors that influence young people, may be more effective than narrowly focused programs in improving reproductive health. An example of a multicomponent program is one that works in both schools and communities, includes a clinical services component, and uses mass media to promote positive YARH messages.

- 6. Design projects with expansion in mind.** To meet the needs of the large and growing youth population, the YARH community must move from small pilot projects to larger-scale YARH programming. Efforts to scale up should be based on knowledge about effective YARH policy and programs and should take into account information on cost and financial feasibility
- 7. Incorporate monitoring and evaluation from the start.** Programs should establish clearly defined indicators and costing mechanisms to measure achievement of program goals and cost-effectiveness and to better understand project dynamics to ensure necessary midcourse corrections. Programs must also try to better measure changes in behavior, using experimental research designs or other, less-rigorous methods.

## RECOMMENDED FUTURE ACTIONS

The following list identifies key future directions for the YARH community that have been determined after considering the FOCUS experience of the last six years

- 1. Pursue additional research.** Additional research is needed on critical influences and factors affecting reproductive health behaviors that are actionable through policy and programmatic interventions.
- 2. Assess programs to alter social norms.** Better assessment is needed of programs that influence attitudes and practices with respect to gender roles and equity, women's status and opportunities, as well as sexual behaviors and responsibility.
- 3. Document the nexus between policy and effective YARH programming.** In particular, efforts to identify these connections should study how policy can be influenced and changed to result in greater acceptance of and support for YARH programming
- 4. Through policy action, address the contextual factors that influence young adult reproductive health.** YARH advocates can help show policymakers the importance of connections among young adult reproductive health, education, income levels, and job opportunities and can encourage policies that address allocation of resources for youth programs outside the health sector
- 5. Identify the most important linkages between YARH programs and other youth activities, and study practical and effective strategies to achieve these linkages.** Effective links must be established with efforts that have goals related to YARH programs, including general youth

development activities, programs such as micro-enterprise and job training that try to improve youth livelihoods, and efforts to expand educational opportunities.

- 6. Develop cost-benefit analysis methodology for YARH programs.** This methodology should be used to identify and select project activities, especially in resource-poor settings, and to guide decisions with respect to scaling up YARH projects.
- 7. Leverage the private and commercial sector for greater participation in and contributions to YARH programming, including workplace programs and private health care delivery.** The added participation and contributions would raise the level of available financial resources and create broader reach to clients and consumers.
- 8. Undertake studies of the effects of scaling up proven projects.** At a minimum, this effort should include in-school reproductive health education and social marketing.
- 9. Set realistic goals for sustainability.** These goals should not handicap the survival of emerging YARH programs. Donors should define sustainability in a way that supports YARH program objectives and that takes into account young people's limited ability to pay for reproductive health care relative to adults.
- 10. Assess how existing public health structures can be made more youth friendly and become more effectively used by youth.** In particular, assessments can begin studying these efforts in many developed countries and, increasingly, in Latin America. It is critical to build on these extensive existing networks to reach large numbers of youth.
- 11. Establish more effective and sustainable mechanisms to provide technical assistance, training, and other capacity-building measures to organizations that are planning to reach youth with reproductive health programming.** A top priority is to strengthen host country organizations that can carry out this needed work.
- 12. Conduct operations research in different national contexts to identify a minimum package of YARH interventions.** Research should compare the effectiveness and cost of different combinations of intervention components in different contexts. At the same time, research should continue to explore new and innovative approaches to meeting YARH needs.
- 13. Expand investment in young adult reproductive health.** To reach even a modest proportion of the developing world's youth with effective YARH programs requires a much greater investment on the part of governments, donors, and communities. Moreover, improving the effectiveness of YARH programs requires longer-term donor support, better coordination among donors, and the creation of more flexible funding mechanisms to encourage effective partnerships and linkages among groups working in education, employment, young adult reproductive health, and youth development