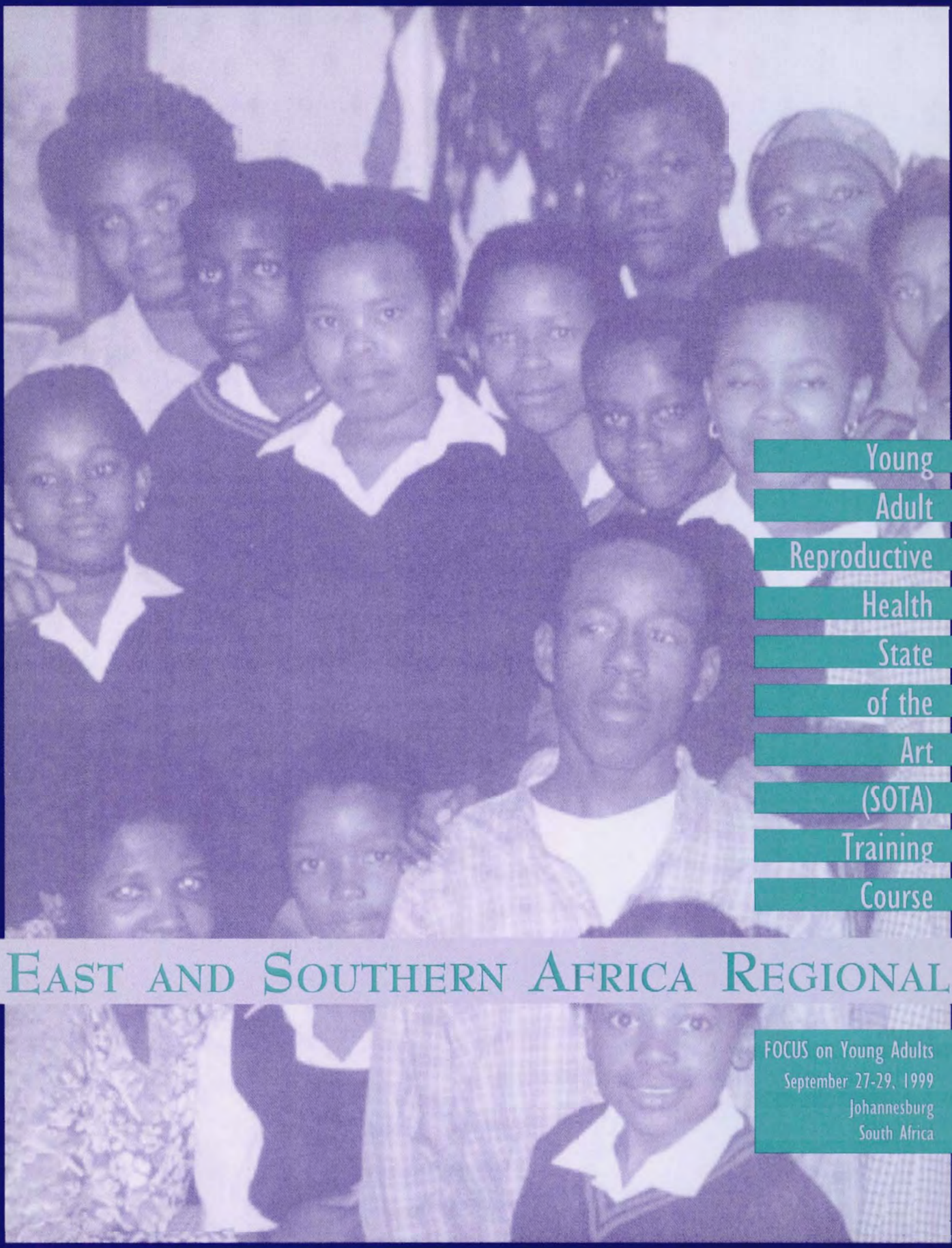

Young Adult Reproductive Health State of the Art (SOTA) Training Course

East and Southern Africa Regional

FOCUS on Young Adults
September 27-29, 1999
Johannesburg
South Africa

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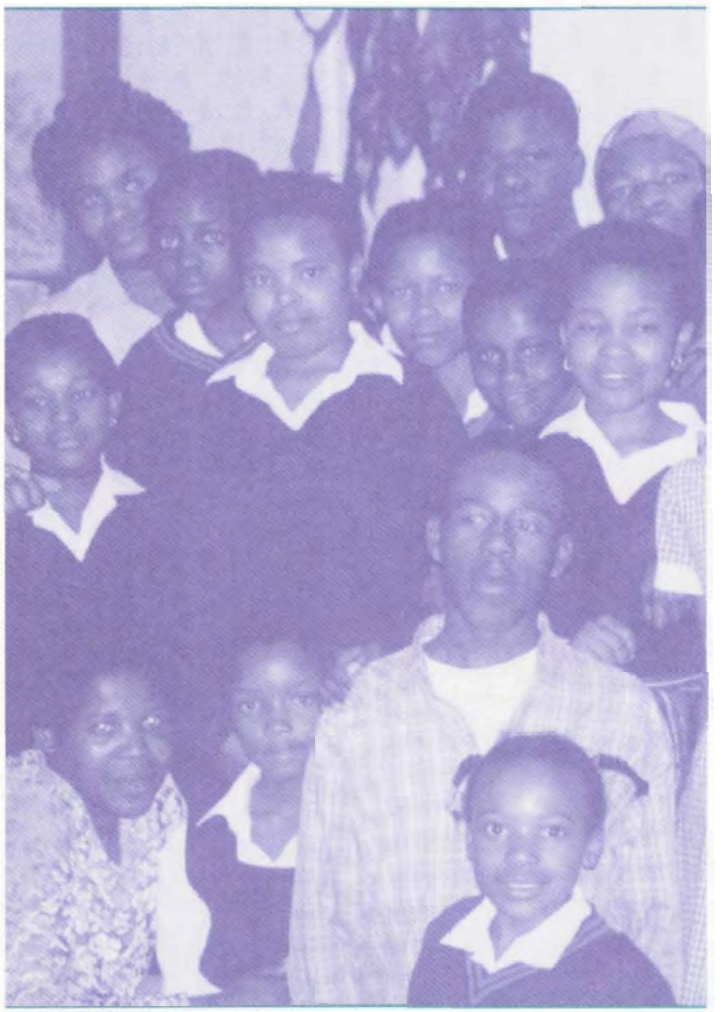
What is FOCUS on Young Adults?



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List of Acronyms

ARH	adolescent reproductive health
BLM	Banja La Mtsogolo
CBD	community-based distribution
CEDPA	Center for Development and Population Activities
CSW	commercial sex worker
DWAF	Department of Water Affairs and Forestry
DHS	Demographic and Health Survey
EARHN	East African Reproductive Health Network
FGM	female genital mutilation
GNP	gross national product
HIV/AIDS	human immunovirus/acquired immune deficiency syndrome
HPN	Health Population and Nutrition
ICPD	International Conference on Population and Development
IEC	information, education, and communication
NAFCI	National Adolescent-Friendly Clinic Initiative
NGO	nongovernmental organization
PALS	Partnership for Adolescent Sexual and Reproductive Health Project
PATH	Program for Appropriate Technology in Health
PLA	Participatory Learning for Action
PPASA	Planned Parenthood Association of South Africa
PRIME	Program for international training in health
PSI	Population Services International
RH	reproductive health
STI	sexually transmitted infection
SOTA	State of the Art Training
TOP	termination of pregnancy
UWESO	Uganda Women's Effort to Save Orphans
WFW	Working for Water
WFS	World Fertility Survey
WHO	World Health Organization
YARH	young adult reproductive health
YFS	youth-friendly services

Executive Summary

FOCUS on Young Adults hosted the East and Southern Africa Regional Young Adult Reproductive Health State of the Art Training (SOTA) Course on September 27–29, 1999, in Johannesburg, South Africa. Attending the course were 97 representatives from local, national, and international agencies in 14 countries in East and Southern Africa. The training was designed to raise awareness of the critical issues related to young adult reproductive health (YARH) among individuals who influence the design and delivery of services to youth in the region. Although the meeting targeted policymakers and administrators, youth were well represented, making up more than 20 percent of the attendees and participating as instructors and agency representatives.

Together, participants and instructors examined a host of issues related to sexual and reproductive behaviors during the young adult stage of life. Early initiation of sexual activity, within and outside of marriage, was linked to many direct risks such as early births, poor maternal and infant health outcomes, abortion, exposure to sexually transmitted infections (STIs), and a larger overall family size.

The youth in the region also face critical contextual circumstances that have an impact on their reproductive health. Age and stages of physical, mental, emotional, and spiritual development can put them at risk. Maturing young bodies are more

vulnerable not only to some diseases, but also to exploitation and abuse. At the same time, immature reasoning skills may lead to poor choices that result in risky behaviors. Poverty, loss of parents to war or disease, lack of opportunity, or homelessness leads some young people to seek money, shelter, and protection in exchange for sex. While often having a beneficial effect, traditional beliefs and practices can also increase risks. Adults play a role through the behaviors they model, the attitudes and beliefs they maintain, and their treatment of young people. Professionals who work with youth must examine their beliefs about the capacity of youth and must determine their willingness to work in partnership with young adults.

Numerous strategies and approaches to YARH concerns are being used within the East and Southern Africa region. Many of the programs presented have their roots in reproductive health service delivery. A few began as full-service youth-development programs and have expanded to address reproductive health. Innovative programs make use of the arts, the media, and youth involvement. Other models have social marketing or other media communication strategies at their core. The range of programs discussed allowed participants to think creatively about the variety of options best suited to their home-country circumstances.

SOTA Course participants examined information on a number of issues and strategies that improve reproductive health outcomes and life options for young adults. Over the three-day course, the participants:

- learned what is currently known about the status of YARH demographics and behavior;
- reviewed the factors that influence positive and negative outcomes;
- examined program models and other strategies to improve outcomes; and
- discussed their personal role in moving the YARH agenda forward, both within their respective countries and throughout the region.

The intergenerational experience of the SOTA Course was particularly powerful. The adults welcomed the opportunity to engage with, and learn directly from, the young participants. Not only did the youth train and learn alongside their adult colleagues, but some also shared personal life stories and experiences while working in YARH. This exchange added depth and emotion to the proceedings.

One immediate outcome of the training was participant commitments to improve YARH within their families and professional environments. Collaborations and informal networks were established and strengthened. Adults observed, firsthand, the capacity and potential of youth, and the adults acknowledged the value and importance of youth involvement at all levels.

Participants recognized the need for a greater emphasis on capacity-building in any follow-up activities. They are eager to participate in programs that offer:

- in-depth training that allows participants to learn about new strategies, and to practice the skills and approaches required to implement those strategies;
- on-site interaction with programs, through either study tours or professional exchange programs and youth participation, plus greater interaction between youth and adult professionals.

I Introduction and Course Overview

A. Purpose

FOCUS on Young Adults (FOCUS) designed the Young Adult Reproductive Health State of the Art Training Course (SOTA) for individuals who influence the design and delivery of young adult reproductive health (YARH) programs. The SOTA Course targeted USAID Health Population and Nutrition (HPN) staff, USAID-associated cooperating agencies, other donors, and other international organizations working in East and Southern Africa. It provided an opportunity for those professionals to gain a deeper understanding of factors that influence YARH and issues involved in delivering quality reproductive health (RH) information and services to youth.

In so doing, the SOTA Course sought to raise awareness of issues and opportunities related to YARH in East and Southern Africa and to increase the capacity of those who influence YARH program design and funding so they can make better, more informed decisions.

B. Objectives

The course was designed to increase the capacity of participants by enhancing their ability to:

- define the adolescent development process and its impact on sexual and RH behavior;
- assess the nature and scope of health and health-related issues facing young adults in the region, including HIV/AIDS, contraceptive use, and sexual attitudes and behaviors;
- identify cultural, societal, and familial factors that influence the transition from childhood to adulthood;
- identify program and policy strategies that can increase, enhance, and sustain services to young adults;
- identify what is known about effective strategies to reach and serve underserved young adult populations, and identify how to adapt those strategies, policies, and programs for ongoing or new YARH programming in the region;
- identify special issues in working with young adults, tailoring programs to their needs and interests, and ensuring their involvement; and
- offer advice and assistance to help participants make more informed decisions about using scarce population and health funding to address the needs of young adults.

C. Course design

The SOTA Course provided three days of interactive presentations and discussions led by international and East and Southern Africa regional program planners, managers, policymakers, service providers, researchers, donors, youth program employees, paid or volunteer peer educators, and young adult program participants. This discussion was complemented by visits to community- and clinic-based service delivery sites that are frequented by young adults in and around Johannesburg.

The first day of the meeting was devoted to assessing the current state of YARH. This assessment was the foundation upon which the rest of the course was built. The second day focused on program innovations and best practices in the region. On the final day, participants explored how existing programs could be adapted, what the various research techniques are that can be used to gather information, and how that information can enhance programs and advocacy for YARH programs and resources.

Youth involvement was a highlighted feature of the entire SOTA Course. Young adults participated in all aspects of the training course: presenting sessions, participating in small-group and regional discussions, and sharing moderator responsibilities. Some peer educators

shared their personal stories, giving life to the issues presented. Others shared stories of their peer education work. The youth also led interactive exercises between sessions and provided feedback as the meeting progressed.

Throughout the course, participants met in small groups to discuss key issues, share perspectives, and gain additional insight into the program strategies that were presented. Country-specific groups allowed participants to plan strategies for continued work, collaboration, and follow-up. Each individual made personal commitments to YARH needs and issues as each outlined steps that would be taken to improve the RH environment for young people in East and Southern Africa. FOCUS agreed to return to participants their commitment statements six months after the workshop, as a reminder of their commitments, as well as to get feedback on their activities since the SOTA Course.

D. Report organization

This report is organized by the key questions used to design the course and to structure the course sessions. Each question, or set of questions, is followed by a summary, which is drawn from the primary SOTA sessions, small-group discussions and interaction among participants. Where appropriate, supporting research and documents also informed the summary sections. Case studies of program innovations and site visits are also used. A list of key points, recommendations, findings, and additional issues follow each summary. Where additional or more recent data are provided, the sources are referenced. All other information comes directly from course presentations as outlined in the Course Agenda

The report appendices provide a complete summary of program models with contact information and a summary of lessons learned from the site visits. The Course Agenda and Participant List are also located in the appendices.

II The State of the Art: Young Adult Reproductive Health in East and Southern Africa

A. Key Questions:

What are the latest demographic data and research results related to young adults, including population, pregnancy, birth and abortion rates, age of onset of puberty/menarche, and age at first sex/marriage? What are the latest demographic data and research results on STIs, including HIV/AIDS, and youth?

Demographic information on the reproductive health behavior, circumstances, and experiences of young adults living in East and Southern Africa is limited. The information is either not available or insufficiently addresses the young adult experience. Data that are available focus primarily on women. Data quality varies as well. The summary information below reflects specific data on East and Southern African youth by country, region, or group, as they have become available. Where specific data are not available, information for sub-Saharan Africa is provided.

Population Demographics

- Sub-Saharan Africa has a young population: 46 percent of East Africans and 35 percent of Southern Africans are under 15 years of age.[1] Among the

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populations of ten East and Southern African countries,* 23 to 25 percent are between ages 10 and 19.[2]

- The population is growing quickly: East African women have, on average, 6.0 children and Southern African women have 3.5 children (total fertility rates). The East African population is expected to grow 1.5 times between now and 2025—from 235 million to around 408 million.[1]
- Birth rates across the region range from 27 per thousand in South Africa to 43 per thousand in Ethiopia.[1]

Demographics of Reproductive Health

- The majority of sub-Saharan African girls have a first sexual experience during their teen years (83%).[3] Among ten East and Southern African countries,* the majority of women ages 20–24 say that their first sexual experience occurred before age 18, while they were unmarried.[2]
- The prevalence of early marriages vary throughout the region: from 10 to 54 percent of 20- to 24-year-olds entered their first marriage before they reached age 18.[2]
- Among sub-Saharan African girls, 55 percent have had a child by age 20.[3]
- Maternal mortality in 1991 was nearly double for mothers under age 20. Babies born to teen mothers face increased risks of low birthweight, fetal distress, and death—at the time of birth and during the first 5 years of life.[3]
- The World Health Organization (WHO) estimates that the risks of dying of pregnancy-related causes is five times higher for mothers ages 10–14 than for mothers ages 20–24. The risks are twice as high for mothers age 15–19 compared to mothers ages 20-24.[4]
- Young women in sub-Saharan Africa suffer one-fourth to one-half of all reported complications from abortions.[2]

Sexually Transmitted Infections and HIV

- About 7,000 people throughout the world who are age 10–24 are infected with HIV daily—approximately 2.5 million per year. Nearly 2 million of these infections occur in Africa. In contrast, 700,000 new infections per year occur in Asia and the Pacific.[5]
- Half of new HIV infections are among 15- to 24-year-olds. Sub-Saharan Africa is the epicenter of the AIDS transmission, with two-thirds of the AIDS cases reported worldwide.[5]
- Sexually transmitted infection (STI) rates are four times higher in sub-Saharan Africa than in North Africa and the Middle East, and three times higher than in North America.[2]
- Of young people ages 10–24 in the region, 30 to 60 percent report knowing another youth with an STI; 10–20 percent report having had at least one STI themselves.[4]
- Of the 460,000 estimated AIDS-related deaths of children under age 15, 420,000 occurred in sub-Saharan Africa.[5]

---

* *Botswana, Kenya, Madagascar, Malawi, Namibia, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe.*

Table 1:
Impact of AIDS Deaths on Southern and Eastern Africa: Life Expectancy and Estimated Number of Children Left Orphaned by the Death of Both Parents

Country	Life Expectancy with/ without AIDS[6]	Number of Orphans due to AIDS[6]	Percentage of Total Population (mid-year 1999)*
Botswana	41/70	25,000	1.7
Kenya	48/66	350,000	1.2
Malawi	40/53	270,000	2.7
Namibia	41/64	7,300	0.5
Rwanda	41/51	94,000	1.1
Uganda	—/—	1,100,000	4.8
South Africa	47/64	180,000	0.4
Zambia	42/60	360,000	3.7
Zimbabwe	41/66	360,000	3.2

Contraceptive and Condom Use

- Worldwide, young people now† report higher rates of contraceptive use than previously reported.‡ However, in the most recent Demographic and Health Surveys (DHSs) in ten East and Southern African countries,[5] fewer than 20 percent of unmarried, sexually active women age 15–19 reported condom use. [2]
- In a study of Kenya, Zimbabwe, Tanzania, and Nigeria, no more than half of those reporting premarital sexual activity ever used condoms.[7]
- Reported use of contraception is higher among males than among females throughout the young adult age groups.[7]

Key Points:

- Young adults make up a large proportion of the population in East and Southern Africa.
- Sexual activity is common among young adults and occurs within and outside of marriage.
- Young women face risks and negative outcomes directly related to sexual activity, including STIs, pregnancy, and childbirth, whether consensual, forced, or coerced.
- More research and regional analysis of existing research on YARH is needed in East and Southern Africa.
- There is also a need for a broader range of services and for services that will reach more youth in the region.

---

* *Percentages calculated from estimated number of orphans and population figures reported by PRB (reference number 1).*

† *From the late 1980s to the 1990s.*

‡ *From the 1970s to early 1980s.*

[6] *Botswana, Kenya, Madagascar, Malawi, Namibia, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe.*

Host Country Focus: A Young Adult Reproductive Health Portrait of South Africa[3]

South Africa has a population of 44 million, 41 percent of whom are between the ages of 10 and 24. The majority of youth age 10–19 are in school, and 200,000 children ages 10–14 work for pay. Just over half of the total population resides in rural areas, more than 5 kilometers (less than 3 miles) from the nearest health services. Nationally, boys tend to initiate sexual-activity at about age 14; girls, at age 15. Contraceptive use among young adults varies and includes many "traditional" methods that are not medically reliable. Up to 90 percent of sexually active girls report that they never use condoms. Of older youth, 30 percent have multiple partners. Males reported having more partners than females. Most sexually active school students have had one or two sexual partners. While awareness of HIV/AIDS is high, and people generally recognize that it can be transmitted sexually, the quality of what young people know about the disease and how to prevent it varies widely.

Rates of teen pregnancy in South Africa range from around 9 to 19 percent. Some provinces have seen teen pregnancy rates decline since 1994. Pregnancy rates in most provinces, however, have changed little or have even increased slightly. In 1995, one-third of first pregnancies and 40 percent of all pregnancies were teen pregnancies.

Although termination of pregnancy (TOP) was recently legalized, only 31,312 TOPs were actually reported the year after legalization, compared to 120,000 prior to legalization. Black South Africans are least likely to accept TOP as a woman's right and most likely to consider TOP morally wrong, despite the number of abortions performed annually.

Gender violence is a major concern in South Africa. Nearly one out of three urban, black youth reporting having experienced forced sex. Coercive and violent intercourse is often a normal part of the lives of many pregnant teenage girls.

Though often neglected in health studies, male street children, primarily ages 11–17, are a growing group in South Africa. Within this growing population, rape, prostitution, sexual bartering, casual sex, and romantic sex all occur. Of street youth, 50 percent report having had sex for money, for protection; or out of fear. Protection from HIV/AIDS transmission, however, is not a priority to street youth. Rather, such youth are concerned for their survival.

Overall data regarding HIV/AIDS are frightening. Of all HIV infections, 60 percent occur in the 15–24 age group. Rates of infection among those under age 20 increased 65 percent between 1997 and 1998. Experts predict that 2,226 youth ages 15–19 and 10,438 youth ages 20–24 will die in the next year. Young females are more vulnerable than males. Of teachers in South Africa, 14 percent are HIV positive. Reports of male teachers having intercourse with their students are not uncommon.

Partly in response, South Africa developed a national policy on adolescent RH. The National Policy Guidelines for South African Adolescents and Youth (ages 10–24) set forth the following principles:

- Adolescent development underlies the prevention of health problems.
- Problems are interrelated.
- Adolescence and youth are periods of great opportunity and great risks.
- All youth are not equally vulnerable.
- The social environment influences behavior.

In adopting the guidelines, policymakers sought to build consensus by bringing together various segments of society: youth, advocates, and policymakers. The finalized national policy will guide the provision of services and the allocation of resources for YARH over the following years.

B. Key Questions:

What factors related to culture and lifestyle have an impact on young adult reproductive health behavior and decision making? What are the differences among young adults based on age, stages of development, gender, and class, and how do these factors influence YARH?

Both internal and external factors influence the reproductive and sexual health choices and circumstances of young adults. Table 2 summarizes the major individual and societal characteristics that help determine RH behavior.

Table 2:
Contextual Factors that Influence Young Adult Reproductive Health Behavior[4]

Individual Characteristics	Societal Characteristics
■ Biological and Developmental Factors ❑ Gender ❑ Physical Maturity ❑ Psychological/Emotional Development ❑ Risk-taking Behavior ■ Socioeconomic ❑ Poverty ❑ Social/Political Stability ❑ Socioeconomic Status ❑ Urban versus Rural Area ❑ Village Environment ■ Family Characteristics ❑ Family Composition ❑ Family Supports ❑ Education (of self and family) ❑ Employment (of self and family) ❑ Religious Commitment ■ Factors Influencing Motivation for Abstinence ❑ Desire to Prevent Pregnancy or Disease ❑ Desire for Pregnancy ❑ Marriage/Childbearing Aspirations ❑ Peer Influences ❑ HIV Pandemic ❑ Educational Aspirations and Opportunities ❑ Occupational Aspirations and Opportunities	■ Cultural Conditions and Influences ❑ Status and Roles of Women ❑ Gender Roles, Expectations and Constraints ❑ Union/Marriage Patterns ❑ Childbearing Expectations ❑ Communications/Media Influences ❑ Age Sets* and Rites of Passage ❑ Positive and Harmful Traditional Practices: ❖ Female genital mutilation (FGM) ❖ Nutritional restraints (i.e., preference for feeding males first and giving them the better quality of food) ❖ Bed-warming (custom requiring widows to sleep with their late husband's male relatives). ❖ "Dry" sex (which involves inserting powders, herbs and other items in the vagina) ❖ Wife inheritance (whereby the wife of a deceased man is automatically given to the brother-in-law or other designated family member) ■ Access to RH Information and Services ❑ Legal Status ❑ Societal Views on Information and Services ❑ Availability of Information/Misinformation ❑ Accessibility/Availability of Services

** Cohorts of youth who are around the same age who go through life transitions and experiences as a group.*

Education

Access to education, particularly for girls, cuts across several of these categories. Gender and culture largely influence family choices regarding who should get schooling and for how long. Economic factors, in the home and at the national level, control school availability and family ability to pay school fees that are required throughout the region. As young girls age, their educational opportunities diminish. Girls are less likely than boys to attend or complete school, and attendance drops sharply as girls get older.

- Young women today are more likely to have seven or more years of education than women ages 40–44, yet fewer than 25 percent of 18- to 19-year-olds have completed 10 years of education.[2]
- In Zimbabwe and Kenya, women who received seven or more years of education are much more likely to delay childbearing beyond age 18.[2]
- In most countries, the rates of secondary schooling are higher for males than females.[2]
- Young females may be discouraged from attending school, ultimately decreasing their participation, limiting their desire to continue their education, and reducing other educational and occupational opportunities.

Gender and Gender Relationships

Both male and female young adults face RH risks. The situation for girls, however, is usually more difficult. The lower social status of women and limited opportunities available to girls put young girls at higher risk. However, more needs to be known about the reproductive and sexual lives of young adult males.

For young women, early initiation of sexual activity, inside or outside of marriage, brings risks of impaired health, primarily from early and frequent pregnancies. The physiology of young adult women, combined with cultural practices such as female genital mutilation (FGM), increase vulnerability to STIs. Early marriage limits not only a girl's opportunity for education and employment, but also her control over fertility-related decisions. Although the age of marriage is rising, reducing the number of births to very young wives, rates of out-of-wedlock births are increasing throughout East and Southern Africa.

Studies show that African girls work harder and more often than boys. Kenyan girls spend about 32 hours per week on domestic tasks. Boys, on the other hand, work about 18 hours a week around their homes. Still, girls are half as likely to be compensated for their work.[7] Some domestic chores imposed on young girls can be physically overbearing. Furthermore, some of the work that girls do (e.g., domestic service to family, extended family, or friends, and commercial or transactional sex work) is overlooked outright.

- HIV rates among 15- to 19-year-olds in a four-country* study showed that young women have four to six times the rate of infection than young men.[7]
- Differences in reported rates of premarital sexual activity among young men and women vary. Young men are 1–3.5 times as likely to have had

* *Nigeria, Tanzania, Kenya and Zimbabwe.*

In their own words: Hazel, aged 20, peer educator

It was 1983, I was 5 years old. It was my first year in primary school. One evening I came home and my father was not there. Only the gardener was there. I remember vividly being raped by the gardener. I remember him forcing me, going to a room where he ate lunch. I don't remember telling my parents. Somehow, my mother knew and they took me to the hospital. In 1985, I was sexually abused by my dad's brother. I went on with life—children do that.

My father had trouble accepting me, since I am very dark and he is colored (my mother is black). My grandmother asked me if my father sexually abused me. My father has never done any such thing! Never until this day!

In 1989, my paternal grandmother moved from our place to a more high-class neighborhood and she took me from my parents, who she considered to be low-class.

premarital sex as young women according to the four-country* study.[7] The impact of sexual conduct for young women, however, has disproportionate risks. Young women are more vulnerable to many STIs, including HIV, because of their immature cervix and their lack of control over condom use. Girls risk not only infection, but also pregnancy and increased complications related to STIs. They also risk premature childbirth and the health of the child.[8]

- Pressure from peers of both the opposite and same sex influences sexual activity. Young women often feel pressured to incorporate sex into social life at a young age. There is little direct communication about sex between sex partners. Young men often have sex as a means of gaining social status and acceptance among peers.[7]
- Between 18 and 24 percent of girls have been sent to live with another relative or friend, a practice that increases their chances of being exploited or abused.[4]

Sexual abuse and coercion

Sexual exploitation is an unfortunate outgrowth of the low status of women, very early marriages, and poverty. Traditional practices (such as bed-warming and wife inheritance), combined with high levels of unemployment, poverty, and health-related myths (for example, that virgins have a curative power for AIDS), also lead to forced and coerced sex.

- In Kenya and Uganda, 40–50 percent of sexually active schoolgirls reported being forced or "cheated" into having sex.[7]
- Nearly one-third of urban, black South African youth reported having experienced forced sex.[3]

Family

Young people more often look to their parents for guidance on issues related to sexuality. When parents and family members are confident about their own RH knowledge, they are more comfortable responding to and educating their children. Unfortunately, many parents are uncomfortable talking about sex with their children, often because of their own lack of information or their belief that sex should not be openly discussed with young people.

* Nigeria, Tanzania, Kenya and Zimbabwe.

When youth cannot get information at home, they seek it from other sources—peers, other adults, or the media.[9]

In many cultures, older siblings, aunts and uncles, or close family friends are responsible for educating the children about sexuality. The older person may serve as a mentor or confidant. However, even where discussion of reproductive health practices and behaviors do not occur between children and adults, young people still learn from observations of male and female interaction within their family or community and among their peers.

Religion

Religion was not an underlying theme during many of the sessions. Religion guides behaviors and beliefs in much the same way as cultural norms. Either religion is viewed as a barrier to some or all RH services, or RH services are thought to undermine religious beliefs and practices. Service providers sometimes assume that services will not be accepted in specific communities because of religion when, in fact, they may be accepted. Some religions have strict prohibitions against certain sexual behaviors. Others are less restrictive. Some communities are diverse, with many different religious faiths coexisting. Others may blend several different religious practices, including traditional belief systems and imported ones. Still others are more homogeneous.

Strict doctrine may not be followed, especially where religious communities are interested in strategies that prevent RH risk behaviors. However, given religion's role in influencing and guiding behavior, it is important to:

- identify prevailing religious perspectives, in doctrine and in practice;
- engage the faith community when reaching out to community members or leaders; and
- establish common concerns and common ground and maximize collaboration.

Economic Influence on Risk Behaviors

East Africa has the lowest per capita gross national product* (GNP) on the African continent (US $260).[1] Although the per capita GNP is highest in Southern Africa (US $3,000),[1] the economic stress on young adults in that region remains acute. At the national level, governments have little capital to expend on the young adult population, beyond primary education. Little is apportioned to job preparation and training. Many young people in the region are concerned about finding jobs that pay livable wages. Young people often cite fear and uncertainty about their futures as contributing factors for RH risk-taking behaviors. Those who do not envision positive futures tend not to engage in protective behaviors.

Where household sizes are large and poverty is acute, older children, particularly males, are displaced. Some end up on the streets. Displaced girls are likely to be fostered out. If they end up homeless, initiation into the commercial sex trade can soon follow. Sex with "Sugar Daddies" and "Sugar Mommies" and commercial sex

1 The value of all of one country's domestic and foreign monetary output divided by the total population.

work often provide a way for young adults to ensure their daily subsistence.

In addition to costs to the client, countries face direct and indirect costs in both providing services and maintaining the infrastructure to make them available. Included in the government expenses are trained providers; service delivery sites and workers at those sites; and materials and supplies for distribution, including condoms, contraceptives, and medicines to treat STIs. The costs—to individuals, health-care settings, and countries—for some treatments, such as new treatments for HIV/AIDS, are completely out of reach.

Media and Globalization

Trends and styles from throughout the world influence the behavior of young people. Entertainment media—music, movies, videos, and sports—link youth through common interests and fads. The sub-culture of youth crosses regional, national, and cultural borders. This merging of culture and style has positive and negative influences on YARH. On the one hand, merging sub-cultural norms makes it easier to adapt positive messages (such as messages designed to normalize responsible sexual behavior by promoting condom use or delaying sexual debut) to a broad range of societies and cultural contexts. On the other hand, irresponsible media practices may introduce or reinforce negative behaviors, such as casual sex, sex without the use of contraceptives, or sexual aggression. The establishment of the global marketplace for products and ideals complicates YARH issues when styles promoted through media and advertising conflict with cultural norms and the economic capacity of individuals, communities, and societies.

Key Points:

- Educational attainment is related to delayed childbearing.
- Both males and females who are displaced from home face additional risks resulting from the lack of traditional support systems, and they are at greater risk of becoming involved in commercial and transactional sex.
- Both males and females face pressure to initiate sexual activity.
- Socioeconomic status often determines access to RH information and services.
- Religious beliefs and practices can either promote or undermine the goals of YARH.
- The broad range of contextual factors that influence YARH suggests that solutions must also be broad, inclusive, and multifaceted.

C. Key Question:

What are the physical, behavioral, and developmental characteristics of adolescence?

Adolescence, by nature, is a time of change. During this period, children transition into adulthood, acquiring numerous new skills and capacities along the way. It is commonly agreed that adolescence begins with puberty—sexual maturity for boys and menarche for girls. The end point of adolescence is less clear. In addition to being marked by significant biological changes, adolescence is also a time of self-discovery, of identifying and challenging beliefs, and of stretching limits.

Although adolescence is the period that approaches adulthood, distinct differences between the two life stages have a significant effect on YARH. During adolescence, youth

- tend to have limited monetary resources;
- can lack power or skills to make RH decisions (especially young women);
- are developing cognitive skills and abilities;
- may disconnect behavior from its consequences—even though they may know the connections intellectually;
- may face restrictive cultural norms, laws, or policies relating to sexual norms and to access to information and services.

The developmental characteristics of adolescence partially account for the challenges experienced by youth and those who serve them. The transition from childhood to adulthood is not manifested only in physical changes. Rather, adolescence is a consolidation of everything that has been learned through observation, imitation, and education. Emotional attractions are joined with physical sensations that are new, thrilling, and somewhat frightening. All of these changes expose developing young adults to new feelings, thoughts, and behaviors. They think more critically about what they have been told and may begin to challenge tradition, authority, and rules. It is important for health providers to understand the relationship between the developmental stages and characteristics of adolescence and to devise outreach and service strategies that promote health and reduce the life-altering risks that are often initiated during this critical stage in the life cycle.

Key Points:

- Adolescence is a time of change and opportunity.
- Young adults share common characteristics, but they are not a homogeneous group.
- Information about the transition from childhood to adulthood should be used in program development and implementation.
- Interventions and programs should take into account the defining characteristics of adolescence and match strategies to adolescent developmental stages.

Table 3:
Excerpt from FOCUS on Young Adults Developmentally Based Intervention Strategies for Promoting Health and Reducing Risk Among Adolescents[18]

Developmental Stage	Key Developmental Characteristics	Goal of Program or Intervention	Recommended Program Strategies
Pre-puberty	■ Learns to master skills ■ Uses play as an essential way of learning ■ Has limited language skills (difficulty putting feelings into words)	■ To facilitate the establishment of communication techniques (e.g., self-expression, parent/child communication)	■ Build activities and information around games and other fun activities ■ Work with adults, especially teachers, who work with this age group
Early adolescence	■ Learns to master skills	■ To help develop negotiation skills ■ To provide information about availability of youth programs and services	■ Provide opportunities to practice newly acquired skills ■ Provide opportunities for youth to learn about programs and services
Middle adolescence	■ Challenges rules and tests limits	■ To address clusters of "risk behaviors" (e.g., using alcohol and drugs, participating in sexual activity, and dropping out of school)	■ Provide information and education related to associated issues such as substance use/abuse and violence ■ Use multimedia approaches ■ Use trained peers to communicate information and values ■ Ensure that staff members are sensitive to and can identify other risk factors ■ Develop programs to reach out-of-school youth
Late adolescence	■ Shows improved problem-solving skills and greater understanding of behavioral consequences ■ Has a clearer definition of self	■ To facilitate life planning ■ To prevent unwanted primary and secondary pregnancies ■ To aid in disease prevention	■ Make RH information and services available ■ Provide information related to the advantages of child spacing ■ Provide education related to sexuality, STIs, and HIV/AIDS

D. Key Question:

How do culture and lifestyle influence young adult behavior and decision making?

Societies support the transition from childhood to adulthood in many ways. Collectively these are known as adulthood rites or rites of passage. Rites of passage, traditionally led by elders, teach the customs of the group and may require physical and mental endurance tests and surgical procedures.[11] Some rites of passage are ancient rituals, like initiation schools, circumcision, and marriage. Others are social rites that carry their own significance, such as wearing makeup, short skirts, and high-heeled shoes. Some are socially anticipated norms or routines, like leaving home, marrying, getting a job, or attending university. Still others are based on developmental markers or physiological events such as menarche and the capacity for ejaculation or pregnancy and childbearing. Some cultural practices promote behaviors such as FGM and child marriage and negatively influence RH. Others, such as the teaching of societal norms, expectations, and responsibilities related to sexual behavior, can help foster positive attitudes about sexuality and sexual behavior.

Case Study:

Maendeleo Ya Wanawake Organization, Kenya

Maendeleo ya Wanawake Organization, in partnership with the Program for Appropriate Technology in Health (PATH), developed a renewed rite of passage program designed to replace FGM with positive information about YARH. Ending a longstanding cultural tradition is not easy. The rite of passage program owes much of its success to its careful attention to community dynamics. Many methods are used to build acceptance, including peer outreach to girls, women, men, and boys; family life education in schools; and education through the media. The program includes key roles for circumcisers—the women who previously did the cutting, such as the mothers and the godmothers. Girls participate in a week-long training on RH issues, including pregnancy and HIV/AIDS prevention, the harmful effects of FGM, and personal hygiene. The training culminates in celebrations and gifts to mothers and families. Initiates also receive the community's traditional wisdom and codes of conduct in a special booklet—the same type of information that was included in the traditional adulthood rites.

Key Points:

- Traditional customs that negatively impact on YARH can be modified to have a more positive influence.
- Traditional mechanisms for educating youth about adulthood and RH can be coupled with modern information and technology to enhance communication and cultural relevance.

E. Key Question:

How do adult and provider attitudes toward young adult sexuality affect adolescent access to reproductive health information and services?

Many adults are uncomfortable with the notion of young adult RH and sexuality because it forces them to accept that some young people are sexually active. Many societies have social taboos related to sex outside of marriage, and any evidence of such behavior brings shame to the family and community. Adults who hold these and similarly critical views are likely to communicate their biases in their work with young adults. It is no surprise, then, that many young adults find it difficult to seek information about RH from parents, providers, and other adults in their communities.

Adults who provide services to youth need a basic set of skills if they are to be effective. Even adults who work in classic youth development settings, such as youth clubs, can benefit from routine training on interacting with and engaging youth. Youth workers need training that:

- helps them to learn how to effectively communicate with young adults;
- helps adults develop empathy toward and build trust with youth who live under particularly challenging circumstances; and
- provides knowledge about additional resources available to youth.

Providers also need support in the actual work environment. Confident, informed workers who are secure about their jobs are better able to meet the personal challenges required to change their own behaviors and beliefs. Providers need:

- information, particularly on their job expectations and performance;
- a good working environment and adequate tools to do their jobs;
- supervision that motivates and guides their work;
- organizational support; and
- skills and knowledge through continued professional development.

Case Study: PRIME

PRIME is a program for international training in health. The PRIME approach to performance improvement provides a customized, step-by-step analysis to professionals who work with youth. The approach results in interventions that build the professionals' capacity to serve youth. The process is designed to assist providers in becoming more effective by helping them:

- uncover personal values that can enhance or hurt their interaction with young clients;
- increase provider knowledge about sexuality, physical changes, common youth concerns, referral resources, family-planning methods and RH needs; and
- increase positive provider behaviors such as listening and being nonjudgmental.

Key Points:

- Adults can and should gain knowledge and skills to help them work more effectively with young adults.
- Organizational support and training opportunities are key to helping improve provider effectiveness in reaching and serving youth.

F. Key Questions:

What are the issues related to where and how youth should be served, what types of facilities are needed, what hours of operation should be provided, and what range of services should be considered?

The environments where young adults come for RH services can be intimidating. Settings that work well for adults may not work for youth. Some youth-friendly approaches to providing services include:

- separate space for young adult clients;
- convenient hours, including evenings or weekends;
- drop-ins or short appointment intervals;
- short waiting times;
- trained staff members who are committed to work with young adults;
- emphasis on privacy and confidentiality;
- extra time for counseling;
- comfortable clinic surroundings;
- encouragement of young male participation;
- free or reduced cost for services;
- youth involvement in program design, development, and implementation;
- community participation;
- special materials that deal with issues that are of particular concern to youth;
- pamphlets and educational materials with images and content designed to attract and engage youth; and
- information that contributes to youth development, such as voter registration and job training announcements.

Finally, programs should involve youth at every stage. Youth can help with planning, data collection, and the development and review of products. They can serve as full-time, part-time, supplemental, volunteer, or paid staff. Youth can recruit peers or provide educational services. They may act as researchers to plan and evaluate the programs and serve as leaders on governing or advisory boards.

Youth involvement brings increased relevance to programs; helps in the identification of popular activities, messages, and communication channels; and provides avenues for recruiting and for publicizing activities. Youth involvement also provides an opportunity for young adults to develop a sense of ownership of programs and activities and to acquire the skills necessary to manage programs in the future.

Case Studies:

National Adolescent-Friendly Clinic Initiative (NAFCI)

NAFCI is an integral component of a broader social marketing campaign in South Africa called Love Life. Love Life, a media campaign, provides messages and programs encouraging positive RH behaviors among South African youth.

To promote adolescent-friendly services, NAFCI has developed a charter of adolescent sexual and reproductive rights; established criteria for adolescent-friendly services; and designed a package of essential services for adolescent-friendly clinics, procedures for clinic accreditation and self-assessment, and a resource guide for training.

Assessing and Planning for Youth-Friendly Reproductive Health Services (YFS)

The YFS tool, developed by FOCUS on Young Adults, is organized by the youth-friendly characteristics that relate to access and service barriers. Those characteristics are captured in table 4.

The YFS tool was developed on the basis of reviews of literature on young

Table 4:
Youth-Friendly Services Framework[12, 13]

Youth-friendly service Characteristics	Health Facility Characteristics	Provider and Staff Characteristics	Administrative/ Program Design Characteristics	Young People's Psychosocial Characteristics
	■ Provide convenient hours	■ Have been specially trained	■ Involve youth	■ Perceive facility as private
	■ Have a convenient location	■ Show respect for young people	■ Welcome and serve boys and young men	■ Perceive that boys and young men are welcome
	■ Provide adequate space and sufficient privacy	■ Honor privacy and confidentiality	■ Provide for group discussions	■ Perceive that confidentiality is honored
	■ Provide comfortable surroundings	■ Allow adequate time for interaction with client	■ Allow for delay of pelvic examination and blood tests	■ Perceive that youth are welcome regardless of marital status
		■ Include peer counselors	■ Make necessary referrals available	■ Perceive that surroundings are comfortable
			■ Welcome drop-in clients and arrange appointments rapidly	■ Perceive that providers are attentive to youth needs
			■ Make a wide range of services available	
			■ Charge affordable fees	
			■ Make educational material available	
			■ Use publicity and recruitment to inform and reassure youth	

adult RH and program experience to date.[12] It examines three components of health facilities: 1) physical layout; 2) staff characteristics, and 3) how the program is designed and administered. The tool also takes into account young people's psychosocial characteristics that influence whether young people decide to utilize RH services and whether they "reach the door" of a health facility.[13] These characteristics may vary greatly from one setting to the next, depending in part on resources. Even within one community youth may have different perceptions about what makes services appealing and accessible to them.

Key Points:

- The physical layout of health facilities affects whether young people view the facilities as youth "friendly."
- Programs should take into account the needs and interests of youth and modify facilities accordingly.
- Places other than clinics that offer RH information and services, such as pharmacies, need to be "youth friendly" as well.

G. Key Question:

Are national policies necessary to facilitate the provision of and access to quality services for young adults?

In some countries, the development of a national policy has brought YARH issues to the forefront of national, community, and individual discussions. National policies have also provided the impetus for increased attention to and resources for programs and services. However, in other countries, the development of a national policy has polarized communities and increased tensions between factions on opposite sides of the adolescent sexuality and sexual activity issue, particularly when the sexual activity occurs outside of marriage.

National YARH policies can:

- open the door for comprehensive health services for youth where none exists. As a result, communities can reduce reliance on nongovernmental organizations (NGOs) and the donor community to meet YARH needs. Only national governments can command the infrastructure and resources that allow programs to reach enough people to make a difference.
- lead to the widespread delivery of key health-encouraging messages, the promotion of healthy behaviors, and the delivery of essential health services.
- raise awareness of negative and counterproductive cultural practices that cannot be changed without the force of political commitment. Such practices include physical and sexual violence against women and children,

FGM, child prostitution, and child marriage.

In contrast, national policies can inhibit access to RH services when governments:

- limit services, for example, only to married couples or to persons who are already pregnant, have children, or have an STI;
- prohibit specific types of services;
- require highly skilled practitioners to deliver services when few of these professionals are available; and
- provide a rigid framework within which services must be offered, undermining the ability of providers to serve those in greatest need.

One strategy suggests that it is best to allow program initiatives to grow and flourish before pursuing laws and policies to govern their activities. Program experience, coalition building, research, and evaluation can serve to support program strategies. Programs confronting controversial issues, in particular, can benefit by first demonstrating success. By building a critical mass of services and a grassroots support network, programs can expand their circle of influence. This strategy is especially important considering that, when a national adolescent RH policy is being established, controversial aspects become more visible and, thereby, can lead to new and greater opposition.

Programs and national policies can work together in numerous ways. Theoretically, programs can drive policy, as described above. Conversely policies might guide programs, or the two can be strategically coordinated. In practice, however, program models tend to lay the groundwork for national adolescent RH policies in a variety or combination of ways:

- Pilot programs can test new approaches, demonstrating what works and does not work and show where resources can best be used.
- Programs that operate in the spaces between laws and policy or in contradiction to them can sometimes provide data that can sway national policies.
- Independent program ventures can illustrate innovative ideas that inform policy.
- Programs demonstrating cooperation between NGOs and government can set a standard for new ways of collaboration that can guide the creation of national programs and new policies.
- Programs that are specifically created by legal mandate or policy and are tested can support the value of their parent policies.

Policies must promote and protect the rights of young adults to RH services. Further, they must ensure that young adults are fully informed of all the foreseeable consequences of any RH care they receive.

The national climate must be understood and cultivated before a national policy agenda is pushed forward. A good national policy can help ensure that all young adults have access to needed information about reproductive and sexual development before they initiate sex. Policies, however, need to be supported by:

- realistic dissemination/implementation plans,
- adequate resources,

- systematic monitoring and evaluation of implementation, and
- participation of governmental and nongovernmental stakeholders.

Finally, effective policies must safeguard the rights of young adults to RH information and services, privacy, confidentiality, respect, and informed consent.

Case Study:

Government of Ghana Adolescent Reproductive Health Policy

The draft ARH policy statement of the government of Ghana provides a comprehensive model that acknowledges at the outset the important role young adults play in national stability and their value to social and economic development. The policy begins with broad-based statements supporting the education of youth about their transition into adulthood, the transmission of values, the provision of services, and the responsibility of the nation to its young people. The policy clearly states that it "...provides a legal framework through which the reproductive health needs of young Ghanaians can be met...."[14] The policy's goals statement reads as follows:

> *The policy on adolescent reproductive health aims at: Promoting the physical, mental and social well-being of adolescents in Ghana through programs that address adolescent sexual and reproductive health issues, such as early pregnancy, unsafe abortion and sexually transmitted diseases including HIV/AIDS. These will be done through the promotion of responsible and healthy reproductive and sexual behavior such as abstinence, safer sex practices and family planning for the sexually active, counseling services suitable for this age group, and the exchange of reliable and adequate information on adolescent reproductive health.*
>
> *Encouraging the development and implementation of activities and services by government, district assemblies, communities, religious bodies, nongovernmental organizations and private agencies that will enhance and expand the options available to adolescents in the area of reproductive health.*
>
> *Inculcating in the youth the idea of responsible sexual behavior, small family size norm, pursuit of career, values of responsible adulthood, and mutual respect for people of the opposite sex.*

Key Points:

- Timing is critical in determining when a country is ready to establish a national YARH policy.
- Policies can provide the legal foundation for the delivery of services and for a commitment of resources to YARH.
- Policies can be used to limit access to services or limit the types of services made available.
- Policies should affirm the potential of youth as a valuable national resource.

H. Key Questions:

What are the special needs and interests of sub-groups of youth, including refugees, commercial sex workers, youth orphaned by AIDS, children living on the street, married youth, and out-of-school youth? How can they best be reached and served? What innovative strategies seem to be effective in reaching and serving youth in special circumstances?

The circumstances of some young adults are more likely to lead to negative RH. This is especially true when youth are:

- made refugees by war or famine;
- orphaned by the AIDS pandemic or as a result of war or disease;
- displaced from home by extreme poverty, too-large families, or the lack of adult caretakers;
- forced to sell or barter sex in exchange for money, shelter, food, education, or protection;
- married at a young age and face very early childbearing, closely spaced births and other maternal and child health concerns; and
- lacking in opportunities for employment and self-sufficiency because they have not been able to attend school, complete their education, or acquire skills.

Young adults who face these and other challenging circumstances are particularly vulnerable. These youth, perhaps more than others, lack power and a voice.

Youth with special needs require:

- policies that support programs and services that meet the needs of special populations;
- aggressive services that reach out to them in their environment;
- services in a safe, supportive environment from caring and nonjudgmental providers;
- easy access to services;
- affordable services;
- access to education and job training;
- access to loans and credit to encourage entrepreneurship;
- job training in a variety of skills;
- factual information;
- holistic approaches that address the range of needs of young people; and
- participation and youth involvement.

Case Studies:

Uganda Women's Effort to Save Orphans (UWESO)—Caring for AIDS Orphans in Uganda

Uganda has been particularly hard-hit by the AIDS pandemic, and orphans under age 18 constitute a major national concern. In Uganda, children under age 15 make up nearly 50 percent of the population. About one quarter of the people are young adults. Uganda has 1.1 million children who have lost both parents to AIDS.[6]

Masulito Children's Village—a project of UWESO that is supported by the first lady of Uganda—provides a model of how to care for children who have lost both parents and have no relatives who can care for them. The village provides a nurturing

In Their Own Words: Sarah, age 15, Masulito Children's Village Resident and Peer Educator

I was orphaned by my father's death from AIDS when I was six. My mother died from AIDS when I was seven. There were five of us left orphaned: two boys and three girls. After our parents died, we were all left under the care of our grandmother who could not meet our basic needs like school fees, food and clothing. In 1992 my young sisters and I joined UWESO's Masulito Children's Village. The boys went to live with a maternal aunt who also died of AIDS in 1995. I have not heard from my brothers since.

At the village, I have found living in the children's home extremely wonderful. The home is safe and the environment is friendly. There are three similar houses, each with 12 children; we live as one large family. Health care is provided at a nearby clinic or at the hospital for more serious illness. We have gardens for vegetables and larger plantations for banana, sweet potatoes, and cassava. We also have passion fruits, which we can use to have juice with our meals. We have chickens for eggs and dairy cows for milk. Counseling happens during the holidays, three times a year. The counseling is very useful; it has taught me to know myself, to know my sexuality and know myself as a woman. I feel prepared to be a mother and to protect myself from HIV/AIDS. Counseling has helped me move towards the future without fear.

environment for 36 children, living together in three houses as a large family. The children attend school (school fees are paid by the program) and work to sustain themselves by gardening and raising chickens and cows. UWESO provides health care and the children receive health counseling three times a year. In that counseling, they receive information and education on RH and how to prevent STIs.

Esselen Street Clinic, Hillbrow, Johannesburg, South Africa.

Commercial sex work (CSW), although illegal in South Africa, is thriving in the face of lack of opportunity, high unemployment, a racially segmented labor market, migrant labor, and low levels of education. An estimated 5,000–10,000 women are CSWs in the Hillbrow neighborhood of Johannesburg alone.

Preliminary research revealed the following:[15]

- Of CSWs in Hillbrow, 52 percent are 15–24 years old.
- Of CSWs in Hillbrow, 73 percent have children of their own and 95 percent are supporting at least one child.
- CSWs show high STI rates: 30 percent have gonorrhea, 10 percent have chlamydia, 29 percent have syphilis, and more than 50 percent are HIV-positive.
- Reported condom use* is high (95 percent), but not consistent. Some CSWs make more money or avoid abuse by providing "skin-to-skin" contact.
- Thirty-six percent reported violence associated with their work.

The Esselen Street Clinic illustrates one approach to providing information and increasing condom use among commercial sex workers. This is done by providing support by trained CSW peered.

*Both male and female condoms are used.

Key Points:

- Many sub-populations of youth in East and Southern Africa are vulnerable to increased negative outcomes of early sexual activity.
- For many of these groups, poverty and the lack of social supports drive sexual risk-taking behaviors.
- Survival is of greater concern than long-term health for young people in high-risk populations.
- Many of the most vulnerable youth are charged with caring for their own children or siblings, for other family members, or for orphans or younger refugees.
- Successful responses need to address both YARH needs and the social circumstances related to the sexual decisions young people make.

I. Key Question:

How are social marketing and information, education, and communication messages formulated and materials developed?

Media strategies that promote YARH ideals have often been used to help raise awareness within the broad community as well as among target audiences. Programs and commercial time on radio and television broadcast networks, theater, puppets, storytelling, music (recordings and live performances), and written materials such as comic books and other visually attractive materials augment work on YARH issues. The SOTA Course highlighted the use of a variety of information, education, and communication approaches. Presenters from local programs and international NGOs voiced the need for:

- a framework or model linking the provision of information to specific outcomes, such as raising awareness, increasing knowledge, or motivating behavior change;
- research that identifies the types of media most attractive to targeted groups of young adults;
- research that clarifies the positive and negative impact of different types of messages on youth;
- production standards that compete with and complement commercial media;
- youth involvement at every stage—not just as study participants and message recipients;
- messages that are targeted to specific segments of the population; and
- branding—that is, the identification of words, images, phrases, packaging, and logos with a particu ar type of product or service. Examples range from condom brand names and logos to clinic logos and media slogans. The idea is to get the products and services that promote and protect YARH to become household names and phrases.

Case Studies:

National Social Marketing Program in Uganda

Marie Stopes International in Uganda has instituted a youth-based condom promotion campaign that integrates various media with product branding. The

campaign is designed to increase condom use. The program aims to meet unmet demand through youth participation in several major components, including the following:

- A music campaign, entitled "Hits for Hope," is designed to promote the delay of sex among 15- to 19-year-olds. A cassette of eight "Hits for Hope" songs was commercially released.
- The Funky, Frank, Straight Talk Communication Campaign advccates sexual restraint for youth and educates young children about abstinence, body awareness, and knowing their r ghts as children.
- The social marketing component promotes a specific condom brand, *Life Guard™*.

Radio ads and videos are used to normalize communications about sex and promote the *Life Guard™* brand. One video shows that it is acceptable for girls to carry condoms; a second one is more about romance. Both have messages about protecting life. *Life Guard* ™ vans equipped with projection screens and *Life Guard* ™ boats help promote the brand. A traveling play stimulates discussion during community presentations. A song contest resulted in the creation of a hit song with a positive message. An increase in condom use from one to 11 percent was noted since the initiation of these activities.

Population Services International (PSI)

Social marketing, defined by PSI as involving the use of commercial marketing techniques to empower low-income people to improve their health, is not a new approach to delivering health services to communities. Though it is not a replacement for YARH education and services, it can help make products and services more accessible, available, and affordable. Social marketing is particularly effective where there is a clear product and brand. It has been used to market contraceptives in many areas of the world. Fees are charged for products because studies show that people place greater value on items for which they personally pay. Additionally, PSI's commercial partners require compensation for the time they invest in selling the products. Social marketing campaigns rely on access, demand, and branding to fuel product interest.

Successful messages targeting youth are those developed with youth input. PSI tests various media products and programs in a variety of markets to ensure that the messages are acceptable. PSI also adapts social marketing messages and techniques to enhance cultural relevance.

Key Points:

- Research is key to developing effective media strategies.
- Social marketing uses commercial marketing techniques in innovative ways to benefit YARH.
- Youth involvement is important at every stage to insure that the messages and strategies are relevant and appropriate.
- Media strategies can be broad sweeping and can reach large audiences, but they are also limited in the depth of information they can provide.

J. Key Questions:

Are peer educator programs effective in reaching youth? How can peer educators be better managed and supervised? Should they be paid or should they be expected to volunteer their services? What kind of data can/should they keep? How are they selected and trained? What supports do they need?

Peer education is a popular approach to informing and educating youth. It is based on the belief that youth seek and prefer to get information and guidance from their peers or near-peers.* Even when youth prefer to get information from adults, they also seek knowledge among their peer group.

Ironically, evaluations of peer programs suggest that the greatest impact of these programs has been on the peer educators themselves rather than the targeted youth. In and of itself, this is a positive, though unexpected, consequence. There are also examples of peer programs that indicate positive effects on the target population. Although some argue that peer education components should be eliminated because of the poor evaluation findings, others believe that the programs need stronger supports if they are to realize the multiplied effect of youth reaching youth. The data on the use of peer education should be revisited to determine the most appropriate use of peers in helping young adults learn about YARH.

Research should seek to understand what factors may be needed to improve the usefulness of peer approaches. Critics argue that:

- Peer program interventions are not always well matched to the goals by which they are measured.
- Youth need resources. Failure to compensate peer educators may lead to inconsistent involvement and high peer educator drop-out rates.
- Supervision varies among and within programs.
- Youth would prefer guidance and information from parents and other adults.

To build stronger peer education programs, the programs need:

- selective recruitment based on specific criteria;
- intensive training, support, and supervision;
- funds to pay peer educators; and
- strong evaluation followed by program modification.[16]

Peer education programs should maintain data that will help improve the program and measure outcomes. The key is to choose outcomes that match the scope of the peer educators' activities. Data should go beyond process measures like the number of education materials or talks delivered. Some sense of information transfer, knowledge retention, and behavior change should also be measured.

** Near-peers are slightly older youth who have the respect of younger people and can still relate to the way they think, behave, and communicate.*

Despite the challenges, peer education is an attractive and viable approach. Youth participants in the SOTA defended peer educator programs, arguing that more responsibility and integrated youth involvement could help improve peer education's impact on YARH.

Case Study:

Esselen Street Clinic, Hillbrow, Johannesburg, South Africa

The Esselen Street Clinic trains current CSWs to work with peers and promote healthy behaviors. Because of the present economic climate, the program does not try to persuade the educators or CSWs to "leave the business." Rather, the program provides skills, training, and support through the peer education network.

The peer educators provide education and referrals to young CSWs. They demonstrate correct condom use and distribute condoms at the hotels where CSWs work. Peer educators use pictures and videos to familiarize CSWs with the human reproductive system and teach them to recognize symptoms of STIs. Peer educators meet weekly and keep records that are reviewed by program coordinators as a means of quality control.

Next steps for this program include:

- designing new interventions and strengthening existing services;
- addressing issues of substance abuse in relation to HIV/AIDS;
- completing a curriculum designed to increase STI/HIV awareness;
- designing an inner-city STI project, offering hotel-based treatment services and special programs for youth involved in sex work;
- addressing issues of emotional, sexual, and physical abuse in relation to HIV/AIDS;
- addressing self-esteem, self-worth, and identity as related to HIV/AIDS;
- conducting further research on boys and young men engaged in sex work; and
- holding a national meeting to inform the debate on decriminalizing sex work.

Key Points:

- Peer education programs are attractive because they provide a way of involving youth.
- Peer educators are not a cure-all for programs intended to reach youth. Without proper supports and resources, peer education programs may not meet expectations.
- Peer education taps the energy and enthusiasm of youth; in return, programs must provide young adults with the proper training, supervision, support, resources, and compensation to build consistency, to limit turnover, and to allow young people to develop their expertise.
- To gain the best peer education team, programs must nurture peer educators' capacity and identify their special talents.
- Peer educators must face the same challenges as the youth they serve.

K. Key Question:

How can young adults and communities become involved in program development, implementation, and evaluation?

Youth involvement is broadly considered to be an important aspect of program success. But youth involvement requires a tremendous commitment. Programs face barriers from adults and traditional service delivery systems. Both tend to have limited perspectives of youth and their involvement in program development and implementation. Although it is easy to see youth as advisors and peer leaders or as providers of input through surveys and focus groups, it is more challenging to include youth as true partners and decision makers.

The first barrier to meaningful youth involvement is recognizing the capacity of youth and the depth of their understanding of issues related to YARH programs and services. Youth attending the SOTA training course sought guidance on needs and concerns not unlike those expressed by their adult counterparts:

- fiscal management, sustainability, and fundraising;
- program and policy development;
- assessment; and
- integrating youth into programs*

Giving youth the autonomy to function in partnership with adults is not easy. Youth often bring greater enthusiasm and are willing to take more risks. At the same time, they sometimes lack the maturity, skills, and experience that enable sound decision making. Therefore, programs must be prepared to offer a higher level of training and support to maximize the strengths of young people and facilitate their growth.

Working with youth as partners requires a change in adult attitudes. A Ugandan peer educator presented findings from a workshop where youth and adults learned that effective youth participation benefits when adults:

- talk in the language that youth understand;
- are patient;
- avoid imposing ideas on youth;
- encourage youth to pursue their goals;
- allow young people to express their opinions;
- value the expertise of youth;
- allow youth to settle their own problems;
- genuinely believe in youth;
- instill in youth a sense of responsibility;
- focus on the strengths of young people;
- allow youth to determine for themselves the value of their work; and
- are not judgmental.

The message echoed throughout the meeting is to involve youth in all aspects of programs, from conception through evaluation and redesign phases.

** Expressed during a pre-meeting gathering of youth with conference planners and other adults.*

Key Points:

- Trust youth and understand the benefits of involving them.
- Anticipate and minimize the challenges associated with young colleagues who bring fresh ideas and enthusiasm.
- Be tolerant, flexible, and understanding when working with youth.
- Be realistic about what youth can accomplish and provide the supports needed for them to be successful.

L. Key Question:

What are the critical YARH needs, and how can programs be adapted to address them?

Although the SOTA training course highlighted program innovation, there is a critical need for existing programs to develop the capacity to integrate new or enhanced program components that address the needs of youth. Programs that have traditionally employed adult service models can be adapted to also serve youth and can establish a welcoming environment for youth. Programs that provide other services, such as recreation or education, can add RH components.

The service characteristics that satisfy adults are often not the same characteristics that attract youth. New programs can design strategies that are specifically tailored to youth. Existing programs have to modify not only the way they approach serving youth, but policies and longstanding practices as well. To better meet the needs of youth, programs need:

- administrative will and support for working with young people;
- updated information on the young adult population;
- staff-development training to modify and enhance the skills of current staff to meet the needs of youth populations;
- appropriate service delivery approaches and assessment tools, such as the YFS tool discussed earlier in this report; and
- support to adapt to the changes.

Case Study:

Banja La Mtsogolo* (BLM), Malawi

Banja La Mtsogolo (BLM) provides RH services tailored for young people in Malawi. BLM has developed innovative schemes to offer family-planning services targeting young men (or all men) in the workplace. More recently, BLM has been instrumental in developing services and educational programs for young adults.

Meetings with clinic staff indicated that BLM faces a number of challenges. Most important among those challenges were providers' unfriendly attitudes and lack of understanding about how to work with youth. Providers indicated that part of their behavior resulted from their discomfort with youth, who asked too many questions in an atmosphere in which providers were encouraged to move patients along to avoid long waits.

** Meaning "Family of the Future" in Chichewa.*

In addition to addressing staff issues, BLM took the following steps to transform the service delivery environment:

- encouraged youth to come to the clinic through outreach activities;
- opened the back door of the clinic to encourage youth to just "hang out";
- played music for youth who hung out in the clinic;
- trained everyone, from the guard to clinicians, to be more receptive of youth;
- painted the clinic to make it visually appealing to youth;
- trained more than 200 youth community-based workers, who were selected by the community;
- made peer educators available to make referrals for other services and to accompany new clients to the clinic;
- selected supervisors to work with the youth coordinators; and
- made fees affordable or free for youth at extreme risk.

Despite challenges faced by BLM, including opposition from those who think such programs encourage promiscuity and staff discomfort with the topics, BLM continues to strive to make its services (which provide 61 percent of the contraceptive coverage across all age groups in Malawi through 18 clinics) more accessible to youth.

Key Points:

- Existing programs can be adapted to effectively reach youth.
- Program administrators must maximize opportunities for staff to adapt to new service strategies and environments.
- Managers must choose or use personnel who have an affinity for working with youth.
- Programs must be flexible and willing to address youth issues not directly related to their core services.

M. Key Questions:

How can research, monitoring, and evaluation better inform program development and implementation? What kinds of data need to be collected?

Research—whether basic or applied, whether designed to document what is occurring in a program (monitoring) or to assess the impact of a program (evaluation)—is a key component of program design. The best reason to conduct research, monitor program activities, and evaluate outcomes is to guide program design, maintenance, and refinement. Research is the foundation upon which programs are built. Further, it supports continuous program improvement. Unfortunately, the lack of regional data on young adults and limited information on the effectiveness of new program approaches weaken overall program implementation efforts.

Solid information is also needed to determine the size and scope of programs, identify target populations, track population trends, measure program performance, and bring effective programs to scale. Programs benefit from the availability of the following:

- Ongoing research on RH by age, gender, locality, ethnic group, and other

demographic categories. The information must include traditional measures such as pregnancy and birth rates, STI rates, rates of marriage, school enrollment rates, and contraceptive use and continuation rates. Documentation or solid estimates of homeless, runaway and street youth; CSWs; and rape and sexual abuse prevalence are also beneficial.

- Clear analysis and translation of findings about motivational factors that drive sexual and RH behaviors and decisions. Program planners need to know about the economic and social circumstances that fuel transactional sex and sexual exploitation—including rape and other violent acts—and the displacement of children from parents and traditional family settings.
- Research about the value of longstanding and innovative program models.
- Research describing the attractiveness, appropriateness, and acceptability of materials, methods, measures, and curricula.
- Data reflecting the community, city, province, nation, and region.
- The variety of evaluation tools and strategies using accessible technologies.

Research is most useful when the issues surrounding YARH are clear and the RH events and behaviors that will be measured are familiar and easy to document. For example:

- National surveys document the population demographics at a specific point in time. They are useful for documenting the current status of YARH for ongoing monitoring, for making comparisons with programs that serve specific population groups, and for summarizing the regional status of RH in several countries.
- Program designers can sometimes use the data from large-scale surveys to answer questions about young adult populations.
- Examples of large-scale, national surveys include the World Fertility Survey (WFS) and the Demographic and Health Survey (DHS).
- Surveys give insight into sexual experience and indicators by demographic characteristics. They allow program designers to see associations between population characteristics and RH outcomes.
- Surveys can show where services are needed or can illustrate the impact of policies or service delivery changes.

Qualitative research covers a variety of techniques designed to gather more individualized information, but it cannot be generalized to a larger population. Key informant interviews focus on one person's story. Other approaches strive to collect a range of views. Qualitative data add depth to population-based research methods and are essential for gathering information on issues and areas where there is limited information. Some common qualitative research methods include:

- focus groups;
- in-depth interviews;
- observation of individuals and situations; and
- techniques for drawing or mapping communities, resources, or ideas, including the ways people think about YARH issues and relationships between people, institutions, systems, or strategies.

Findings from comparative research allow program planners to understand the effect of program interventions. Comparison data from a sample of people similar to the target population or from broader surveys help determine how much of the change in knowledge, skills, or behavior is the result of program activities.

Case Study: Partnership for Adolescent Sexual and Reproductive Health Project (PALS), CARE, Zambia

Participatory Learning for Action (PLA) is a group of approaches designed to allow people to analyze what they know and to act on that knowledge. PLA is based on the principle of learning through visualization.

In Lusaka, Zambia, the PLA approach has been used to:

- determine the status of YARH services provided in selected compounds; and
- help reduce young adult sexual and reproductive morbidity and mortality.

The objectives of PLA are to:

- determine potential intervention points by exploring adolescent knowledge, attitudes, and practices regarding sexual behavior; and
- identify obstacles to increasing utilization of services.

Primarily an assessment tool kit, PLA offers numerous adaptable techniques for conducting research. Initial research was conducted during a five-day appraisal in Chawama compound. The research focused on 150 in- and out-of-school 12- to 17-year-old teens. This research was repeated in two other compounds. Methodologies included:

- social mapping, to discover how youth perceived the compound layout and facilities;
- body mapping, to determine youth's knowledge of the reproductive system;
- ranking and scoring, to evaluate options for decision making (e.g., contraceptive preference);
- Venn diagrams,* to measure the degree of facility utilization;
- focus-group discussions, to discuss and probe issues arising from observations;
- in-depth interviews, to get personalized data;
- sketch drawing/picture stories, to understand sexual behavior and the decision-making process; and
- transect walks,† or systematic walks around the neighborhood or community, to observe the diversity of resources.

The investigators found that:

- the average age of first intercourse was 12 for girls and 14 for boys;
- sexual activity within families was common, mainly with cousins;
- young people engaged in sex, for money, sweets, and transport;

** Venn diagrams (also known as circle or chapati diagrams) visually organize issues, ideas, roles, or other items that relate to a question. A group diagrams each item in a circle; then the group places the items on the ground so that items that are similar are close together and items that are not similar are placed farther apart. Thus, the relationships between items can be observed visually.*
† Transect walks are walks with observers and community members through a neighborhood or community to identify characteristics of the area. For example, one could determine where young adults hang out, areas that young people avoid, and areas that they frequent.

- many youth did not see themselves at risk for HIV;
- the majority of youth discussed RH with friends or grandparents;
- clinic use was shunned or used as a last resort; and
- reasons for avoiding clinics included the lack of knowledge of services, the perception that clinics are for older and married people, the cost of medical fees, the lack of available drugs, fear of insensitive staff, and the lack of confidentiality.

In response, a community-clinic partnership was developed. The partnership was charged with adapting the clinicians' training curricula, training 22 public-sector clinicians, and forming Youth-Friendly Corners within clinics. Community-level interventions provided training of peer counselors to reach both in- and out-of-school youth, as well as strategies that encourage the use of diverse communication channels.

Through this action-oriented method, program planners, participating clinics and the community learned that young adults increase their use of RH services and that providers can change attitudes in positive ways. This approach helped build community support for YARH.

Key Points:

- Research is a good tool to help adults hear and see what is happening within young adult populations.
- Research provides a foundation on which to build programs and program components.
- Research findings need to be translated so that program designers can make effective use of the information.
- Quantitative research, which reflects the population, is essential for drawing comparisons and measuring large-scale program effects.
- Qualitative research adds depth to statistics and raises issues to fuel additional research.
- Evaluation and monitoring of program activities facilitate program strengthening and refinement.

N. Key Question:

What are the critical YARH needs related to HIV/AIDS and STIs, and how can programs be adapted to address them?

Many issues influence YARH needs in relation to STIs and HIV/AIDS. The importance of recognizing the impact of STIs in the region cannot be overemphasized. East and Southern Africa are currently at the center of the AIDS pandemic with respect to transmission of the disease, deaths from it, or the resultant orphans.

The needs of young people are wide-ranging. Young adults need access to appropriate information, services, and products that will help them avoid initial or repeat exposure to STIs. Young adults, particularly young women, also need the freedom and empowerment to act on that knowledge. Some young people need support—shelter, clothing, food, money—to make up for family members lost to AIDS or need to identify alternative means of support that put them less at risk of infection themselves. Although resources

are often limited, the need for testing and treatment is paramount.

Although the devastation from HIV/AIDS is clear, the impact of other STIs is less apparent. Left untreated, such STIs can also cause reproductive complications, including infertility and cancer.* Although broad intervention is needed, participants recognize resource limitations.

Case Study: Africa Alive!

Africa Alive! is an HIV/AIDS prevention initiative targeting youth between ten and 25 years old throughout sub-Saharan Africa. Keeping Africa alive in the new millennium will involve international and interagency partnerships. The Enter-Educate+ approach will be used to attract attention and provide a forum for delivering behavior change messages.

According to UNAIDS Executive Director Peter Piot, Africa Alive! promotes four challenges in response to the HIV/AIDS pandemic in Africa:

- breaking the silence;
- focusing on the next generation;
- making AIDS a development issue; and
- scaling up Africa's response to the epidemic.

Africa Alive! is a partnership of African institutions, executing agencies, bilateral and international organizations, and youth, who are directly involved in the planning and implementation of this project. These partners rely on formative research to set the direction of the project. The initial planning phase has included establishment of administrative operations on the regional and national level, a stakeholders' meeting in Harare, working group meetings in the eight participating countries, work with international agencies to build regional capacity, and fundraising activities.

The next phase involves implementation of national sexual responsibility campaigns in the eight countries.

Key Points:

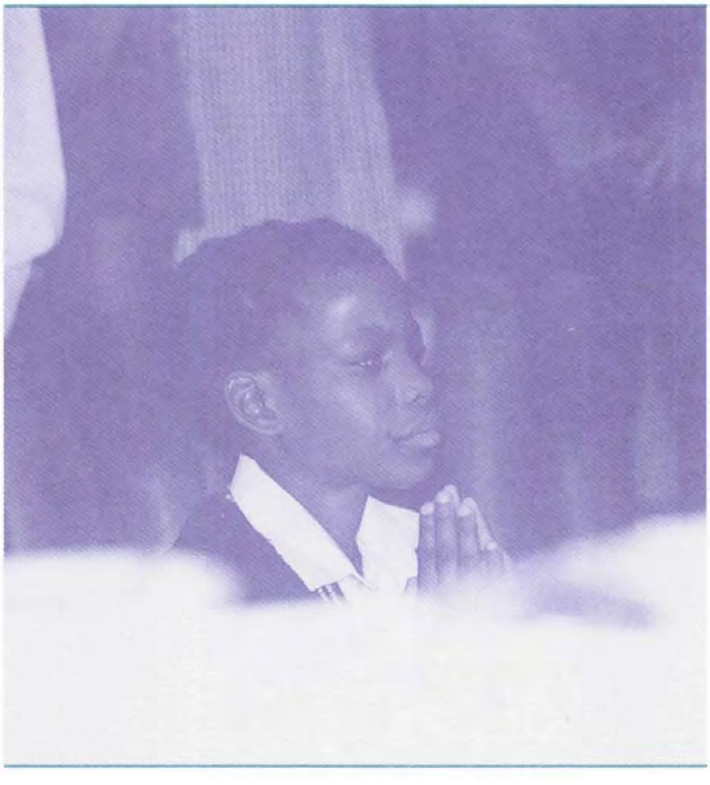
- Young adults are vulnerable to STIs at many levels. As noted throughout this report, the physical, cognitive, social, economic, family, and behavior situation and stage of development are all contributing factors.
- Young adults need education, services, contraceptives, and other supports to protect themselves and avoid unsafe and unwanted sexual contact, increase awareness, change behavior, and reinforce those changes.
- Young adults can be at the forefront at every level of the debate, discussion, and intervention from the local to the international level.

** For example, human papilloma virus can lead to cervical cancer; chlamydia and gonorrhea both can lead to reduced fertility.*

+ Entertainment and Education.

III Promises and Actions

The East and Southern Africa Regional Young Adult Reproductive Health State of the Art Training Course was an opportunity for sharing information and ideas for further work on YARH. The gathering illustrated both interest in YARH issues and readiness to address them. It also showcased the talent and capacity of individuals within the region who are already mobilized to address the needs of youth.



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A. Summary of issues raised during SOTA

The East and Southern Africa Regional State of the Art Training Course provided an opportunity for policy-makers from throughout the region to review and discuss a broad range of YARH issues.

Reproductive Health Issues Addressed

- Age at sexual debut and the circumstances surrounding first intercourse
- Trends in pregnancy and birth rates among young women
- STI rates, including HIV/AIDS
- Abortion and post-abortion care
- Trends in traditional practices, including early marriage
- Trends in the use of condoms and other contraceptives
- Sexual abuse, including incest, rape, and coercion
- Family disruption as a result of HIV/STIs, political unrest, war, and so forth
- Commercial and other transactional sex (sex in exchange for money, goods, or protection)
- Social norms and sexual behavior
- Adolescent development and transition to adulthood
- Gender roles
- Impact of globalization on sexual norms and behaviors of young adults
- Protective nature of increased education for girls
- Research, monitoring, and evaluation needs and methodologies
- Service characteristics that meet the needs and desires of youth

B. Critical issues and gaps

The SOTA Course clarified core issues around YARH. It helped identify needs, possible interventions, and existing approaches to improving the lives and circumstances of young adults. Participants were also able to identify gaps in knowledge, information, and service delivery that must be addressed.

Critical Issues

It was apparent throughout the course that issues are interrelated, which necessitates a different way of funding, designing, and implementing programs to meet the varied needs of youth and maximize limited resources.

The key issues from the SOTA Course presentations and discussion fit the following broad categories:

- cultural influences;
- information;
- program design;
- program support; and
- regional collaboration and coordination.

Cultural

Early marriage, FGM, gender differences, and the status and treatment of women are all driven by cultural norms. Traditional practices and beliefs about sexuality and reproduction may conflict directly with contemporary information or restrict communication on the topic. Cultural norms can, however, have protective benefits, as when they delineate clear standards of behavior and mechanisms for

communication between adults and youth. These mechanisms can then be adapted or adopted by YARH initiatives.

A challenge for participants was how best to balance respect for cultural practices with current information on effective and appropriate practices. Participants discussed the need to:

- work with the positive or protective aspects of traditional culture;
- improve the skills of parents and other adults as role models and communicators with children at all stages of life;
- identify ways to increase the education of girls and young women and maximize the protective effects for reproductive and fertility outcomes;
- deal with social taboos in discussing sex between parents and children, between male and females, or between sex partners;
- face the prevalence of rape and sexual abuse (including incest);
- address practices that lead to lowering the age of sexual debut* and increasing the risk of STI and pregnancy; and
- address the poverty that leads to transactional sex of all kinds.

The influences of peers, media, and role models are other areas of concern, but these influences also provide opportunities for advancing the YARH agenda. Participants pondered how to transform negative impacts into positive ones in an attempt to effectively reach youth for whom these influences are important.

Information

If programs in the East and Southern African region are to be supported and measured effectively, the quality of available information must be improved. Specific data on the region is lacking, particularly information on the sexual and reproductive health issues of males and younger age groups. The information available is often limited to small groups or to young women over the age of 15. Information for all the ages in the young adult period and regional summary data must be obtained.

Also, more research should be conducted into the factors related to RH outcomes to determine the extent to which changes in context can improve or worsen life outcomes for youth. There is further need for appropriate measures of the varied life circumstances of youth so that researchers can gain a better understanding of how to reach and serve them.

Program Design

SOTA participants had the opportunity to examine a number of program designs; many were familiar adaptations, and some were true innovations. Most of the participants were particularly interested in learning how to improve their ongoing efforts. Specifically, participants were interested in:

- improving the training of clinicians, traditional healers, peers, teachers, lay workers, professionals and others who work with youth in RH and related issues;
- strengthening self-esteem and essential life skills for youth. There was

* Initiation of sexual intercourse.

a call not only for methods, but also for measures to address these youth development skills and concepts;

- balancing the involvement of youth as educators and trainers with the traditional appeal of elders as educators; and building holistic programs.

Program Support

Sustainability, funding, and attracting government support and commitment to scale up successful interventions are all key issues. The reality is that youth programs have limited resources, and programs that target only youth may never fully support themselves. (With so much emphasis on the media, many programs highlighted during the SOTA had plans to develop market-driven program components designed to buy some degree of autonomy for programs, attract commercial support, or both, either in the form of corporate sponsorship or in-kind services.)

Regional Collaboration and Coordination

Better regional collaboration and coordination is clearly needed. Despite the challenges of establishing networks among projects, participants agreed that more programs of this type should be developed and nurtured. Youth and adult participants were interested in additional networking opportunities and other methods of information sharing between and within countries in the region.

Many program models observed in and around Johannesburg were able to rely on sophisticated infrastructure that might not be available in more rural areas or in countries with limited resources. Participants examined these approaches, however, with a view toward adapting strategies to suit their realities. Furthermore, since broadcasts from South Africa reach surrounding nations, better partnerships can increase the effect of programs.

Study tours were identified as another way people could spend more time observing programs "on the ground." The SOTA meeting responded to the interest in networking and coordinating efforts by gathering participants in affinity groups and working groups throughout the course.

Gaps

Participants identified gaps in YARH knowledge throughout the region. Additional opportunities should be provided to explore regional issues and build regional capacity. The following questions suggest directions for continued training efforts and include a brief discussion of the relevant issues. Program examples are included where they were available.*

1. ***What strategies have programs used to engage parents, extended family members, communities, and teachers?***

   SOTA Course participants identified the need to train parents, extended family members, and practitioners to communicate more effectively with youth. However, in so doing managers

The programs listed below are summarized in Appendix B, Program Models Presented, or Appendix C, Program Site Visits.

must consider how to best weave parental support and family-strengthening activities into youth programs without jeopardizing confidentiality.

Program example: Tsehpo-Temba Youth Center (site visit) provides traditional youth services such as skills training, recreation, arts, and services. The program also provides services for elders and income-generating activities for women in the community.

2. ***What approaches should be used to encourage public/private-sector partnerships? What roles can the private sector play?***

Some programs presented at the SOTA Course included examples of public/private partnerships. However, more needs to be shared about the challenges of developing and maintaining those partnerships. Given the desire for sustainability, and the interest in working with businesses, particularly on media strategies, both public and private sectors should be part of any follow-up training.

Program example: Working for Water combines a public initiative to increase the water supply and improve the environment by removing nuisance vegetation with the provision of RH information and services to workers. It also includes an entrepreneurial component that fosters job creation and skills building.

3. ***How can programs be developed that provide youth with "real life," tangible skills?***

The integration of life skills is less apparent in YARH programs than in the field of youth development, generally. As a result, a greater emphasis needs to be placed on building skills that prepare youth for the independence of adulthood and for supporting themselves and their families. More holistic programs were an emerging trend. Several models presented provide excellent examples of building life skills through multifaceted programs for youth.

Program examples: UWESO provides loans to families to help them start up businesses in areas devastated by AIDS. *Working for Water* provides jobs for young people while addressing a tremendous environmental issue in South Africa, by removing indigenous trees that interfere with the water supply. The program takes advantage of the access to young adults by including YARH information and education. *Tshepo-Temba Youth Center* (site visit) provides case management, job training, and entrepreneurial opportunities in addition to YARH education. Remarkably, the center was built by youth who went on to start their own building company.

4. ***What elements could you use or adapt for your country programs? How can what you have seen better inform your policies and programs?***

On the final day of the SOTA Course, participants formed in-country affinity groups to discuss ongoing activities in

their respective countries. The plans of action developed from these meetings, along with the individual commitment letters, form the framework for continued work in participants' home countries. In addition, participants called for more communication within regions to facilitate the sharing of lessons learned. To further determine how to exchange and adapt program strategies, participants wanted to see:

- more study tours that expose people in the East and Southern Africa region to promising program models they would like to emulate;
- greater access to available program models through clearinghouses that increase participant knowledge of the programs; and
- more training, with more specific hands-on skills and capacity building.

Program example: East African Reproductive Health Network. *As a result of the International Conference on Population and Development (ICPD) recommendation for South-to-South initiatives, Kenya, Tanzania, and Uganda have established a network to strengthen reproductive health in the region by fostering technical exchanges, networking, shared experiences, and advocacy.*

5. ***What kinds of training approaches are most effective? What types of curricula are available?***

   These two questions are related in that one addresses the range of curricula available while the other examines the quality of the curricula. There are several clearinghouse resources for materials, including FOCUS' *Annotated Bibliography of Training Curricula for Young Adult Reproductive Health Programs*,[17] which was distributed on diskette to all SOTA Course participants. Although many of the programs have not been subjected to rigorous evaluation, the curricula does provide important information about key content areas by target audience.

6. ***What are the advantages and disadvantages of various service strategies?***

   This is a very broad question, but one that clearly interests anyone designing programs. Youth and adult participants expressed interest in new approaches and best practices. Future training should provide a comparison of service approaches so that participants weigh different strategies against the needs of the young people and communities in which they work.

A common theme in each of these questions is that they require a deeper examination of YARH methods, tools, issues, and contexts. The questions compare the quality and content of resources that programs need to get started and keep going.

C. Conclusion of the Course

The SOTA Course provided an intensive, valuable examination of the state of YARH in East and Southern Africa. The interaction between youth and adult participants, access to innovative information and programs, contact with operating programs, and opportunities to build commitment all provided attendees with a satisfying experience.

Participants are eager for more in-depth training courses that build capacity at various levels. They seek networking relationships that will allow peer-to-peer mentoring and more education programs involving both youth and adult participants and presenters. The critical examination of strategies still needs to be made accessible to the people who are designing, funding, administering, and conducting the broad array of programs that include or seek to include YARH components.

Future training courses will also benefit from more emphasis on holistic approaches to YARH. More opportunities for firsthand observation of what others are doing is also desired.

Building Commitment

In addition to the affinity groups organized by countries and special interests, participants developed individual plans of action for applying what they learned from the SOTA Course. Each participant completed a form documenting his or her personal commitment to improve YARH. The enthusiasm participants brought to this exercise is evidenced by their statements of commitment, summarized here.

- Share information from the SOTA Course with the youth and youth workers in my area.
- Assist various local and governmental entities in improving the quality of RH care for youth.
- Positively influence the behavior of at least six young people.
- Check in with SOTA participants on areas of mutual concern for the purpose of developing work relationships to strengthen YARH programs.
- Participate in working groups that are developing, finalizing, and enriching YARH materials or documents.
- Discuss the training experiences with family.
- Make a commitment to being open about YARH issues starting with both family and staff.
- Assist in developing or finalizing a YARH policy and strategy.
- Involve more youth in programs.
- Collaborate with other organizations.
- Develop and modify existing programs to include youth and address YARH more fully.

Almost all the participants committed themselves to sharing the results of the SOTA Course with other youth and professionals, including individuals in government entities, nongovernmental organizations (NGOs), and communities. The fact that professionals personalized their commitment should go a long way to advance the YARH agenda. The most important commitment of all, however, was reflected in the number of people who vowed

to continue to build a supportive community by talking with their own families and being a part of the fundamental change required to bring what they learned about YARH to the very foundation of society and their own lives.

IV Appendices and Attachments

Appendix A. SOTA Course Agenda
Appendix B. Program Models Presented
Appendix C. Program Site Visits
Appendix D. Country Reports
Appendix E. Presenters and Participants
Appendix F. Youth Meeting Participants

Appendix A.
SOTA Course Agenda

East and Southern Africa Regional State of the Art Training (SOTA) Course

Young Adult Reproductive Health
Johannesburg, South Africa
September 27 – 29, 1999

Sunday, September 26, 1999

6:30 p.m. – 8:00 p.m.
Reception

Monday, September 27, 1999

8:30 a.m. – 9:30 a.m.
Introduction

9:30 a.m. – 10:45 a.m.
Overview – Presentation of Regional Demographic Data related to Young Adult Reproductive Health (YARH)

10:45 a.m. – 11:15 a.m.
Break

11:15 a.m. – 1:00 p.m.
Contextual Factors and Their Impact on YARH

1:00 p.m. – 2:00 p.m.
Lunch

2:00 p.m. – 3:30 p.m.
Adolescence: A Time of Transition

3:30 p.m. – 4:00 p.m.
Break

4:00 p.m. – 4:45 p.m.
Adolescent Reproductive Health Policy Developments

4:45 p.m. – 5:30 p.m.
Review/Wrap-up

Tuesday, September 28, 1999

8:30 a.m. – 9:00 a.m.
Review agenda/Outstanding issues

9:00 a.m. – 10:30 a.m.
Special Young Adult Populations

10:30 a.m. – 11:00 a.m.
Break

11:00 a.m. – 12:45 p.m.
Innovations in YARH Programs and Services

12:45 p.m. – 1:30 p.m.
Lunch

1:30 p.m. – 5:30 p.m.
Site Visits

Wednesday, September 29, 1999

8:30a.m. – 9:00a.m.
Review agenda/Outstanding issues

9:00 a.m. – 11:00 a.m.
Site Visit Feedback and Discussion

11:00 a.m. – 11:30 a.m.
Break

11:30 a.m. – 1:15 p.m.
Adapting Ongoing Programs to Meet the Needs of Young Adults

1:15 p.m. – 2:15 p.m.
Lunch

2:15 p.m. – 3:30 p.m.
Research Methodologies, Selected Research Findings, Using Research in Program Design and Implementation

3:30 p.m. – 4:00 p.m.
Break

4:00 p.m. – 5:15 p.m.
HIV/AIDS: A Major Reproductive Health Issue Among East and Southern African Young Adults

5:15 p.m. – 5:45 p.m.
Wrap-up/Next Steps

Appendix B. Program Models Presented

The SOTA Course provided a forum to review innovative programs being implemented in the East and Southern Africa region. A list of programs follows, including those described during the course presentation or mentioned during the discussion sections. When possible, program information has been augmented by information from brochures or information posted on the World Wide Web. Program sites visited by attendees appear in Appendix C.

A. Working for Water (WFW) and the Community Based Reproductive Health Program

Julitta Duncan
Planned Parenthood Association of South Africa (PPASA)
Melville, South Africa

Working for Water is a program of the South Africa Department of Water Affairs and Forestry (DWAF). Initiated as an environmental project to remove trees that are alien to South Africa; to replace the trees with indigenous, drought-tolerant varieties; and to conserve precious water resources, WFW also provides employment opportunities to 10,000 people and builds

individual and community capacity in partnership with NGOs. During a three-year period, program participants clear trees, learn various uses for the claimed wood (from charcoal production to woodworking), get assistance with contracts for their products, and are taught entrepreneurial skills that encourage them to go into business for themselves. Employment policies encourage women (60 percent of the employees), youth, and people from rural communities to participate.

Because a significant number of employees are youth, DWAF approached PPASA to pilot a community-based health education and contraceptive distribution program for the employees at the three WFW sites. Twenty community-based distribution (CBD) agents provide reproductive health information, contraceptives, and follow-up services through home visits. Other NGOs provide information, education, and services for a holistic program approach, including nutrition education, crèches and day-care centers, primary health-care awareness, substance abuse prevention and intervention, immunizations, basic business skills, and monitoring and evaluation activities for the project. Challenges include accessing permits to provide a full range of contraceptives at each site and building effective partnerships.

B. Better Life Options

Peggy Curlin,
Center for Development and Population Activities (CEDPA)
Washington, D.C., USA

The Better Life Options program is a global initiative initiated by CEDPA to challenge gender inequity and to expand life options for girls and young women. Launched in 1987, the Better Life Options program helps girls and young women develop literacy and vocational skills, learn about reproductive health care, and improve health and environmental conditions in their homes and communities. The program currently serves girls and young women in Egypt, Ghana, Guatemala, India, Kenya, Mexico, Nepal, Nigeria, Pakistan, and South Africa.

The program promotes opportunities for girls and young women, ages 12–20, that are designed to enhance their choices with regard to fertility, education, health, employment, and civic participation. Three levels of education are offered: (1) informal education, (2) skill and vocational training, and (3) family life education and reproductive health education. Youth-serving NGOs in host countries collaborate with CEDPA in the program. The program uses a family life education volume called Choose a Future! to educate youth about RH issues. In South Africa, CEDPA has developed a new volume of Choose a Future! targeting boys.

C. East African Reproductive Health Network (EARHN)

Jotham Musinguzi
East African Reproductive Health Network
Kampala, Uganda

As a result of the ICPD recommendation for South-to-South initiatives, three East African countries—Kenya, Uganda, and Tanzania—formed the EARHN partnership to promote the dissemination of information for adolescents on RH issues, including the prevention and management of STIs/AIDS. Making use of existing institutions and infrastructures, the network seeks to strengthen RH in the region by fostering technical exchanges, networking, sharing experiences, and advocating jointly. The partnership plans to create centers of excellence and share best practices. Operating under a five-year plan, the network will address a series of RH issues. Information is shared through a network newsletter, study tours, workshops, and meetings. EARHN encourages the development of a broader partnership throughout East and Southern Africa. Challenges include inadequate communications systems and insufficient funding to support EARHN-related activities.

D. Reproductive Health Youth Camp

Holo Hachonda
Youth Activists Organization
Lusaka, Zambia

The Reproductive Health Youth Camp aims to increase the participation of men age 14–24 in reproductive health, family planning, and child health. In doing so, the program challenges traditional norms, practices, and religious beliefs. Although the primary targets are young men, the program also targets parents and the community as a secondary audience that is critical for the support of planned youth activities.

Young men are attracted to the camp to develop football (soccer) skills. Program activities include:

- Football Trainers' Orientation Session—Five community members are selected to become football trainers for rural youth.
- Fathers' Orientation Session—The focus is on family planning, sexual and reproductive health, and the role of men in the family.
- Reproductive Health and Football Training—This strategy provides RH education sessions to football coaches. The coaches, in turn, work with youth on both football and RH skills.
- Community Mobile Video Shows—Films such as Consequences, Everyone's Child, and Stepfather are provided to the community, and a community discussion ensues.

- Mothers' Family Planning Sessions—These sessions introduce modern contraceptive methods and natural family planning to women.
- Fathers' and Mothers' Family Sessions—These joint sessions are designed to help parents address decision making and the role of men in the family.

E. Social Marketing for Youth

Josselyn Neukom
Population Services International
Washington, D.C., USA

PSI implements social marketing programs at 50 sites, including sites in Botswana, Malawi, Rwanda, South Africa, Tanzania, and Zambia. Using a range of commercial marketing techniques and behavior-change communication strategies, PSI empowers low-income populations to improve their health. PSI initiatives focus on accessibility, with programs that promote youth-friendly, affordable products and services in convenient outlets and that use peer educators as sales agents. Educational entertainment is also used to maximize interpersonal communication. Upbeat messages rely on popular culture with input from youth. As a result, brand images that ensure youth appeal are developed.

PSI creates demand for its subsidized products by using culturally relevant advertising and communications—from radio and TV to rock bands and soap operas. Strategies involve youth in the development of messages and distribution techniques. For example, youth promoters in Botswana and South Africa spend most of their time interacting with young people at community events and teen hangouts, educating about safe lifestyles, and becoming role models for their peers.

The Social marketing for Adolescent Sexual Health (SMASH) program was implemented in urban areas of Botswana, Cameroon, Guinea, and South Africa. Those areas shared the goal of increasing knowledge and understanding, improving health, and strengthening interpersonal communication. Common strategies included promoting in-school activities; facilitating the linkage of brand concepts to clinical services; working within existing programs; collaborating with partner organizations; and involving youth in the design, implementation, and research phases. An advocacy component was also implemented. It used the results of the evaluation studies to inform stakeholders and to network with others working in adolescent reproductive health (ARH).

F. Y-Centres

Sipho Dayel
PPASA-Gauteng
Braamfontein, South Africa

PPASA has established several Y-Centres in South Africa to encourage young people to seek proper information, education, and early care regarding their reproductive health. The centers seek to develop appropriate, effective, and holistic services for adolescents. As a result, many also have recreation, entertainment, and vocational skill development components in addition to health education, contraceptive,

and STI treatment services. Trained peer educators, workshops, and counselors are available. Radio stations are active partners providing links that engage youth. They organize entertainment events, market the center, host talk shows, and engage celebrities who share positive messages.

G. Radio YFM

Dirk Harford
YFM
Johannesburg, South Africa

Radio YFM, at 99.2 FM in Gauteng, is the fastest- growing station in the country and is the preferred station of young adults. Radio YFM is a youth-oriented media initiative in Johannesburg. It was started because of the lack of radio stations and magazines targeting youth. In addition to playing reggae, hip-hop, and kwaito, the station features talk shows that serve as a voice for youth. The success of the radio station has been overwhelming. Within 18 months of its inception, YFM gained the largest listenership in Johannesburg. As a result of the overwhelming response, the station started Y magazine to increase access of young adults to information and education and to provide entertainment.

H. Multi-Sectoral Adolescent Sexual and Reproductive Health (SRH) Program

Georges Georgi
UNFPA
Maputo, Mozambique

Existing in a post-war environment, Mozambique is experiencing a high degree of social violence and gender-based discrimination, as well as an alarming increase in the prevalence of AIDS. As a result, a comprehensive multi-sectoral intervention strategy has been developed. Strategies, which include providing clinical and counseling services and outreach activities, have a special focus on girls' issues and young male involvement. The program coordinates activities between the Ministries of Youth/Culture and Sport, Health, Education, and NGOs. The challenges to this multi-sectoral approach include coordination and collaboration, ownership and leadership, and the struggle between centralization and independence for the participating ministries and agencies. Other challenges include providing services of adequate quality and quantity, reaching out-of-school adolescents (60–70 percent of all adolescents), working with traditional and cultural values, and working with weak institutional and technical capacities.

I. National Adolescent-Friendly Clinic Initiative (NAFCI)

Kim Dickson-Tetteh
Helen Rees
Reproductive Health Research Unit
Julitta Duncan
PPASA
Berthsham, South Africa

NAFCI is being introduced to encourage health facilities to adopt practices that will make them accessible and acceptable to adolescents. NAFCI is an integral component of a broader social marketing campaign called Love Life. Love Life is a South Africa–based media campaign that produces messages and programs that encourage positive RH behaviors among South Africans.

To promote adolescent-friendly services, NAFCI has developed a charter of adolescent sexual and reproductive rights; has established criteria for adolescent-friendly services; and has designed an essential package of services for adolescent-friendly clinics, procedures for clinic accreditation, and procedures for self-assessment, as well as a resource guide for training.

J. Theatre for Community Action

Cont Mhlanga
Fortune Ruzungunde
Amakhosi Productions
Bulawayo, Zimbabwe

The Amakhosi Theatre Group uses theater as a means of stimulating community action and mobilization. Using theater program producers as point people, Amakhosi builds a bridge with the community to assess its needs. A creative team then identifies and develops a performance product such as a play, dance, or song in response to those needs. Community workers promote the program in advance of the actual performance. Selected people catalyze the discussion following the performance. The results of the presentation and information about the performance are documented and subsequently used to motivate change within that community.

K. Family Planning Private Sector (FPPS)- Puppet Theater

Muriithi Kinyua
Family Planning Private Sector
Selemani Malenga
SIDAREC
Nairobi, Kenya

The FPPS Puppet Theater integrates art, murals, and cultural communication techniques to communicate family planning and community action information. As an IEC process, puppetry reduces inhibitions

and makes it easier to talk about sex, condoms, and other issues. Puppets are also less expensive than actors. Serious messages can be delivered in a nonthreatening manner. FPPS provides training in puppet manipulation, puppet construction, and message design. Through its training program, FPPS has empowered many community groups.

L. Maendeleo ya Wanawake Organization

*Asha Mohamud**
PATH
Washington, D.C., USA

*Note: Dr. Mohamud did not attend the SOTA meeting

Maendeleo ya Wanawake Organization provides a new rite of passage program, which is designed to replace the long-standing cultural tradition of FGM with positive information about reproductive health. PATH and Maendeleo ya Wanawake Organization, Kenya's largest grassroots women's organization, have collaborated on developing alternative rites of passage that preserve some traditional aspects—seclusion, family life education, celebration, and gift-giving—while avoiding physical harm to girls. The program pays careful attention to community dynamics, introduces new roles for traditional rituals, celebrates the transition to adulthood, and perpetuates the traditional wisdom of the community while giving accurate, appropriate RH information.

Since the program was launched in August 1996, more than 1,100 girls from several communities had "graduated" in a dozen ceremonies by late 1998. Another sign of success is that not one of these girls has reversed her position on FGM.

M. PRIME

Sharon Rudy
INTRAH/PRIME
Chapel Hill, N.C., USA

PRIME is a performance improvement approach that analyzes and identifies root causes of poor performance by service providers and that customizes improvements that are based on provider needs. The PRIME approach is used to improve the delivery of services to adolescents by helping service providers identify strengths and weaknesses in their ability to serve youth; then a five-stage performance improvement method is applied. The PRIME initiative is based on the premise that people need five things to perform well:

- information about their performance, including clear job expectations and clear feedback;
- the proper physical environment and tools;
- motivation and incentives;
- organizational support; and
- skills and knowledge about how to do the job.

The approach is used to improve YARH service settings by helping providers become more effective, getting them to assess personal values that affect their client interaction; increasing knowledge about the different needs of adolescents, including their reproductive health needs; and encouraging positive interaction behaviors between adults and youth.

N. UWESO

Perusy Ntanbirweki
Sarah Mbabazi
UWESO
Kampala, Uganda

The Uganda Women's Effort to Save Orphans (UWESO) was founded in Uganda in 1986 by the president's wife, Mrs. Janet Museveni, who rallied women's groups throughout the country to help the millions of children left orphaned and destitute by war and by AIDS. UWESO projects help communities and families cope with orphaned children by providing local, sustainable, income-generating programs to families and to young people, helping both become self-reliant. The Masulito Children's Village is a project of UWESO that provides a home to children who have lost both parents and have no relatives capable of caring for them. The Masulito Children's Village has become a model for providing a nurturing home for orphans. Policies are in place to support youth-friendly health programs, easy access to information on reproductive health, and life skills programs in schools. Program activities focus on keeping girls in school, providing counseling, and providing an outreach program. Services also target out-of-school youth and economic development projects.

O. Esselen Street Clinic

Vusi Hlbano
Portia Hltshwayo
Geriy Kheso
Esselen Street Clinic
Johannesburg, South Africa

The Esselen Street Clinic, located in the Hillbrow section of Johannesburg, serves, among others, CSWs, who are at high risk for STIs and HIV infections as well as other negative RH outcomes. An estimated 5,000–10,000 women engage in commercial sex work in the Hillbrow neighborhood of Johannesburg, many of whom are adolescents and young adults. The clinic initiated a program to train CSWs to provide STI/HIV prevention education, condoms, and referrals to their peers.

The clinic provides training, educational materials, monitoring, and feedback to the peers. The Reproductive Health Research Unit in South Africa is currently studying the project to determine the level of programmatic success.

P. Partnership for Adolescent Sexual and Reproductive Health Project (PALS)

Rose Zambezi
CARE
Lusaka, Zambia

The PALS project brought together young adults from different compounds in Lusaka, Zambia, with adults to research how young people view their local world and

the circumstances that affect YARH. A set of tools called Participatory Learning for Action (PLA) was used to allow the young people to participate in their own research by describing and assessing their communities and the relationships between people within their community. For example, the young people used drawings to illustrate their compounds and their understanding of their own bodies. They also used a variety of other methods to illustrate relationships with adults and people who serve young adults at clinics. The approach is used to improve YARH service settings by helping providers become more effective, by getting them to assess personal values that affect their client interaction, by increasing their knowledge about the different needs of adolescents and ARH needs, and by encouraging positive interaction between youth and adults.

Investigators found the following:

- the average age of first intercourse was 12 for girls and 14 for boys;
- sexual activity within families was common, mainly with cousins;
- young people engaged in sex for money, sweets, and transport;
- many youth did not see themselves at risk for HIV; and
- the majority of youth discussed RH with friends or grandparents. Clinics were shunned or used as a last resort.

In response to the findings, a community–clinic partnership was developed and charged with adapting the clinicians' training curricula, training 22 public-sector clinicians, and designing and forming Youth-Friendly Corners within clinics. Community-level interventions included training of peer counselors who reach both in- and out-of-school youth, and provided strategies that encourage the use of diverse communication channels and increase the comfort of youth in clinic settings.

Q. Africa Alive!

Holo Hochanda
Youth Activists Organization
Lusaka, Zambia

Africa Alive! is an HIV/AIDS prevention initiative targeting youth age 10–25 throughout sub-Saharan Africa. This initiative kicked off in January 2000 with the purpose of keeping Africa alive in the new millennium. The program involves international and interagency partnerships and uses the Enter-Educate approach to attract attention and provide a forum for delivering behavior-change messages. Africa Alive! targets the four challenges facing Africans in response to HIV/AIDS:

- breaking the silence;
- focusing on the next generation;
- making AIDS a development issue; and
- scaling up Africa's response to the pandemic.

R. Nationalized Social Marketing Program in Uganda

Judith Butagira
Marie Stopes International
Kampala, Uganda

Uganda has instituted a youth-based condom promotion campaign. The program aims to meet the unmet demand for condoms through youth participation in several major activities. These activities include a music campaign called "Hits for Hope," which is designed to delay sex among 15- to 19-year-olds. The Funky, Frank, Straight Talk Communication Campaign advocates practicing sexual restraint and abstinence, understanding one's body, and knowing one's rights as a child. The social marketing component promotes a specific condom brand, Life Guard™.

Radio ads and videos are used to normalize communications about sex and to promote the Life Guard™ brand. One video shows that it is acceptable for girls to carry condoms. A second one is more about romance. Both communicate messages about protecting life. Life Guard™ vans, which are equipped with projection screens, help promote the brand. A traveling play stimulates the discussion during community presentations. A song contest inspired the creation of a hit song with a positive RH message. These activities have increased condom use.

S. Banja La Mtsogolo

Dorothy Ngoma
Marie Stopes International
Lilongwe, Malawi

Banja La Mtsogolo* (BLM) provides tailored RH services in Malawi. The program anticipates that it will serve 300,000 men, women, and adolescents this year. BLM has developed innovative schemes to offer family-planning services targeting men in the work place. More recently, BLM has been instrumental in developing services and educational programs for adolescents.

By working directly with staff members and youth, BLM has identified and addressed unfriendly attitudes and behaviors toward serving youth and has helped build understanding about working with youth. BLM addressed staff issues and transformed service delivery by:

- encouraging youth to come to the clinic through outreach activities;
- opening the back door of the clinic to encourage youth to just "hang out";
- playing music for youth who hang out in the clinic;
- training everyone, from the guard to clinicians, on how to be more receptive of youth;
- painting the clinic to make it more visually appealing to youth;
- training more than 200 youth community-based workers who were selected by the community and their peers;

* *Meaning "Family of the Future" in Chichewa.*

- making peer educators available to make referrals for other services and sometimes accompany new clients to the clinic;
- selecting supervisors to work with the youth coordinators to support their work; and
- making fees affordable or providing free services to youth who are at extreme risk.

Appendix C.
Program Site Visits

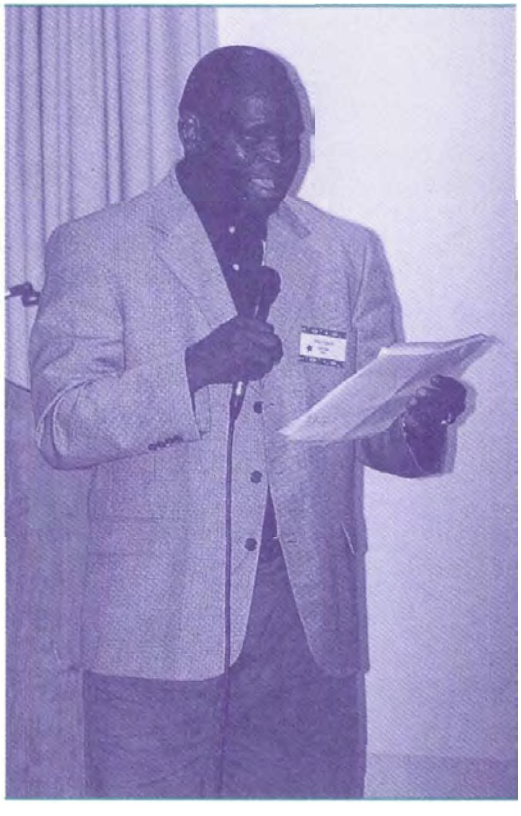
Participants visited seven program sites in the greater Johannesburg area. They were asked to summarize their observations by listing the challenges and constraints the program faced, the major lessons learned for the group, the take-home pieces of information, similarities and differences between programs in the group's home countries, and the features of the program that should be publicized internationally. The essence of the site summary reports is captured here. (Note: the Winterfeld site combines both the community-based distribution and clinic programs.)

Program name and contact information	Program description	Challenges	Lessons learned
Soul City P.O. Box 1290 Houghton, 2041 Johannesburg, South Africa Telephone: 27-11-728-7440 Fax: 27-11-726-8516	■ Is a non-profit NGO that uses radio, TV, drama, and print media ■ Promotes health through the use of mass and modern media ■ Produces one-hour television series, "Soul City" ■ Developed half-hour program on sexuality for SABC Television ■ Produced 60 radio drama episodes in nine languages ■ Conducts extensive research and evaluation to inform program development	■ Negotiations with TV and radio stations are necessary ■ Media exaggerates messages	■ Negotiating with broadcasters is a win-win situation ■ Forgoing big profits for prime broadcast time is worthwhile ■ Profits from advertising can be passed on to stations ■ Extensive research is important ■ Target group should be included in planning
Tshepo-Temba P.O. Box 34 Maraisburg, 1700 Johannesburg, South Africa Telephone: 27-11-674-5406 Fax: 27-11-674-5485 Email: saayc@apc.sn.org	■ Is a multipurpose, community-based youth center ■ Provides counseling, case management, computer employment training, life skills, leadership development, policy/advocacy, drama, dance, games, arts, soccer, local/international exchange programs, environmental education, youth camps and holiday programs for youth ■ Has six paid staff and nine volunteers ■ Provides space for elders ■ Offers a sewing training program for women ■ Has a building constructed by youth, some of whom went on to have their own construction businesses ■ Uses volunteers who are not "paid" but receive stipend and assistance with life goals ■ Involves youth, who pass on principles and values through the program ■ Brings practical skills to youth ■ Employs people from within community ■ Is open for community use	■ Center timelines and expectations must be adjusted to those of youth ■ Reliability of youth can sometimes pose a challenge ■ Government priorities do not meet the priorities and needs of the center ■ Funding must be raised ■ Government support is inadequate ■ Ground is leased from the government ■ Support from corporate and international donors is needed	■ Youth will actually use this type of center ■ Health messages need to be integrated into programs ■ Community members have been empowered and engaged, and their involvement has been maintained

Program name and contact information	Program description	Challenges	Lessons learned
Esselen Community Health Clinic 17 Esselen Street Hillbrow, 2001 Johannesburg, South Africa Telephone: 27-11-725-6711 Fax: 27-11-725-5966 Email: omartin@mweb.co.za	■ Is funded by greater Johannesburg Metropolitan Council ■ Provides variety of services to youth and adults in Hillbrow, a predominantly migrant community ■ Provides HIV/AIDS training and information, a resource center, IEC materials, condoms and a hotline ■ Provides STI treatment, family planning, and outreach to sex workers, youth, and the gay community ■ Has a special unit where peer educators, who are sex workers, are trained to work with other CSWs ■ Generates income for a group of women living with AIDS ■ Mandates a contract signed by peer educator sex workers who must agree not to drink or do drugs so that they may be role models for other CSWs ■ Pays volunteer counselors so that program can be sustained	■ Funding must be raised ■ Staff must be maintained ■ Working conditions are dilapidated ■ No staff development program exists ■ No government vision exists for the program ■ Hillbrow area is insecure ■ No community outreach program exists ■ Peer program is an effort to rehabilitate the CSWs,but it is not yet known how successful this program will be ■ Although the program is strategically located, the location also poses a challenge	■ Staff members are very dedicated ■ Effective IEC materials can be developed for this population ■ A hotline is an effective means of providing a service to this population ■ A wide array of services is important if needs are to be met ■ Sex work is a global problem and should be of concern to everyone
Winterfeld Clinic and Community-Based Distribution Program 771 Church Street Arcadia, 0083 Johannesburg, South Africa Telephone: 27-12-343-4959 Fax: 7-12-343-1313 Email: zkarl@intekom.co.za	■ Is a PPASA clinic site ■ Includes Community Based Distribution (CBD)program that provides door-to-door oral contraceptives and counseling and information on sex, relationships, HIV/AIDS, STIs ■ Offers youth educators 5 days of basic and 5 days of advanced training ■ Provides tests for pregnancy and STIs and provides life-planning skills ■ Produces a talk show that provides backup for RH education ■ Engages young people in drama, dance and song	■ Stigmatization of sex and sexuality among parents, church, and others must be dealt with ■ Idleness is linked to drug use and an increase in teen pregnancies ■ The project will not receive additional funding and may not be sustainable ■ Nominal fee may have to be raised ■ Special permission must be granted to start CBD and hand out contraceptives in South Africa	■ Young people, if given a chance, can become leaders today ■ Young people are self-motivated and will work for the joy of seeing the results of their work. ■ Youth need incentives ■ Programs are having an impact

Program name and contact information	Program description	Challenges	Lessons learned
Orange Farm Y-Center P.O. Box 32023 Braamfontein, 2017 Johannesburg, South Africa Telephone: 27-11-403-7740/1 Fax: 27-11-403-2385 Email: papagau@wn.apc.org	Provides recreational and health services to adolescents in partnership with PPASA ■ Offers computer training, counseling on RH, CBD, and sports ■ Building is accessible and facilities are well used ■ Y-Centers are holistic, with integrated services ■ Places interventions in a strategic high-density area for maximum outreach ■ Is part of Love Life initiative	■ Adequate space is not available for all activities ■ Program still in formative stage ■ Youth and the community need to be invoived ■ Information systems must be put in place ■ There is a high incidence of child sexual abuse in the area ■ Do not have adequate data collected to verify HIV rates	■ Facility actively used by youth ■ Facilities need to be located near targeted communities ■ Environment affects use of facilities ■ Promotion through local radio station, YFM, plays an important role
Orange Farm CBD P.O. Box 32023 Braamfontein, 2017 Johannesburg, South Africa Telephone: 27-11-403-7745/1 Fax: 27-11-403-2385 Email: ppagau@wn.apc.org	■ Is a PPASA site ■ Employs one supervisor and 12 workers full time ■ Provides pills and condoms ■ Has no clinic but refers clients to government clinics ■ Serves 15,000 youth per month ■ Meets an unmet need for health education and other methods	■ More people could be reached ■ Facilities are far away and do not have good linkage or relationship to referral site ■ Wide variety of contraceptives is available ■ Numerous political parties located in the area cause problems; thus community activities are avoided	■ Although staff are sincere, they need better training ■ It helps to get input from communities as to who would make a good CBD worker ■ Counseling skills for methods other than Depo Provera ™ should be developed. (Depo Provera ™ is given to 88 percent of women in South Africa
Mofolo Center in Soweto P.O. Box 32023 Braamfontein 2017 South Africa Telephone: 27-11-403-7745/1 Fax: 27-11-403-2385 Email: ppagau@wn.apc.org	■ Is a pilot site testing partnership between NGO (PPASA) and Department of Health ■ Features family planning and STI counseling, sex education, friendly nurses, and friendly peer education ■ Is open every day (admission free for 13- to 22-year-olds) ■ Uses peer educators to provide information in the community and in schools	■ Program needs to be sustained ■ Using local youth as volunteers presents challenges	■ Government commitment is critical ■ Youth are interested in the health of their peers

Appendix D. Country Reports



Participants gathered in affinity groups to discuss how to build on the lessons learned and relationships strengthened during the SOTA. Each group was asked to identify at least one critical activity to undertake following the SOTA, the types of resources needed to carry out the activities, their expectations, and a reason why they felt the activity was critical to adolescent reproductive and sexual health efforts. The following table summarizes each working group's ideas regarding the next steps to take in-country.

Country	Critical activity	Rationale	Resources needed	Expectations
South Africa	Focus on youth peer education programming. Test a peer education manual that PPASA has developed.	The manual will help empower youth and improve the quality of training.	Money and peer education materials. Explore resources through PPASA, JSI, CARE, and FOCUS in Tanzania.	Development of a standardized peer education manual.
Botswana	Facilitate the establishment of ARH clinics and develop an ARH policy	The policy will provide an overall framework for coordination as ARH clinics have been identified as a major gap in the RH program.	Technical assistance, networking.	Improved indicators in the area of ARH (e.g., increased use of condoms and decreased STI and HIV incidence)
Ethiopia	Work with the national RH task force to generate a commitment to ARH as a priority	Generating political commitment is a critical requirement for ownership of the strategy.	Resources to be generated on the basis of identified activities.	Development of a refined national strategy document.
Zambia	Strengthen current mass media campaigns moving air times into prime time. Build public- and private-sector partnerships.	Improving the quality of services and the health status of youth is needed.	Financial and technical support from partners and the business community.	Increased awareness and enhancement of behavior change for ARH and increased use of RH services.
Uganda	Finish the current draft document on RH and draft a five-year strategy by February 2000. Develop a training manual on providing teen friendly services and begin to train providers to improve the developmental accessibility of services. Improve health management information systems and look at how youth are involved in these activities and plans.			

Country	Critical activity	Rationale	Resources needed	Expectations
Tanzania	Sensitize people to YARH issues, stop doing pilot programs, and take these programs to scale.			
Malawi	Commit to continuing the dialogue and work to include these issues in existing networks. Look for areas of collaboration for both products and economic opportunities and be more holistic in our approach by including economic opportunities, food security, education and nutrition.			
Kenya	Improve networking by developing a comprehensive inventory of ARH organizations in the country.	A comprehensive inventory does not exist.	Available documents and reports. Solicit for funding from Pathfinder for the activity.	Improve and strengthened collaboration and networking. Improved advocacy for ARH programs. Information shared with stakeholders.
Zimbabwe	Increase IEC management training, production and distribution with greater involvement of youth in rural areas.	Outreach to the target group, including rural youth, is needed.	Technical support, professional skills, financial resources, and materials.	Increased health seeking behavior and increased counseling-seeking behavior.
Mada-gascar	Develop ARH curricula and implement a training program with a focus on sexuality.			
Eritrea	Discuss YARH issues with family, the Ministry of Health, and the youth with whom I work. Conduct a peer educator training for CSWs using income from the youth project income-generating activity.			

Country	Critical activity	Rationale	Resources needed	Expectations
Nigeria	Share lessons learned from the SOTA with the young adult/ adolescent network. Adapt media information, making it more youth friendly. Share and maintain linkages between West Africa and East and Southern Africa.			Development of an exchange program between West and East and Southern Africa.

Appendix E. Presenters and Participants

Delegate List
Focus On Young Adult Reproductive Health
South Africa 27 –29 September, 1999

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Delegate List
Focus On Young Adult Reproductive Health
South Africa 27 –29 September, 1999

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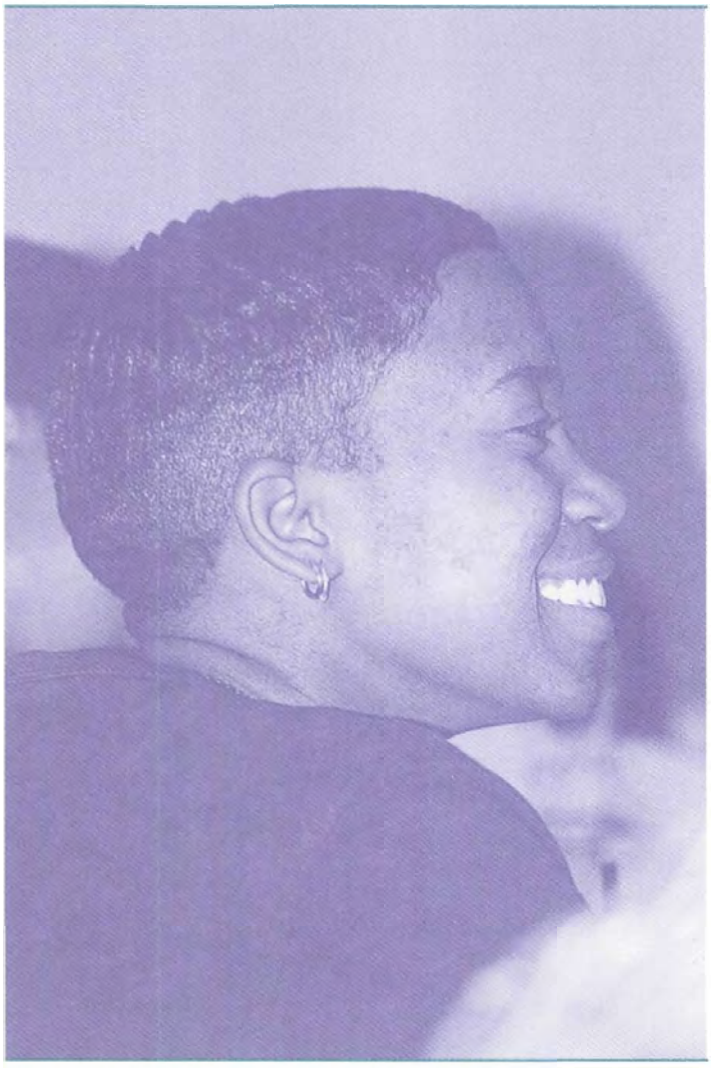
V REFERENCES



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