Reproductive Health Outreach Programs for Young Adults

Judith Senderowitz
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CONTENTS

PREFACE

This paper is one in a series of four "key elements" papers. These papers have been commissioned by the FOCUS on Young Adults Program in an effort to: (1) document the current state of knowledge as to what works in reproductive health programs aimed at young adults; and (2) identify key issues requiring further research. The series of papers is organized around four major program areas: school-based programs, health facility programs, community-based/outreach programs, and social marketing/mass media programs.

One of the mandates of the FOCUS program under its Cooperative Agreement with the U.S. Agency for International Development is to advance the current level of understanding as to what ensures effectiveness in programs aimed at influencing reproductive health outcomes among young adults. The logical starting point in carrying out this mission was to examine the published literature for relevant "lessons learned." However, since many apparently successful programs and interventions have not been well documented and few have been subjected to rigorous evaluation, the literature reviews undertaken at the outset of the project yielded relatively few firm conclusions as to relevant "key elements" or "best practices" for young adult reproductive health programs.

Accordingly, in order to establish a knowledge baseline that better reflected the accumulated experience in programming for young adults which could be used to guide the FOCUS Program research and evaluation agenda, a consensus panel process was undertaken. The goal of this initiative was to systematically document the current thinking as to what makes reproductive health programs aimed at young adults effective. This was done by combining information from the published literature with observations based upon field experience. For each of the four program areas, an individual or organization with relevant expertise and experience was engaged to prepare an initial discussion paper. These background papers were then disseminated for review, after which FOCUS convened a consensus panel meeting to discuss each of the draft documents. The papers were then revised based upon comments and suggestions offered at the consensus panel meetings, sent out for external review, and revised a final time. The current paper represents the end product of this process for each program area.

Based upon the findings of this consensus panel process, FOCUS intends to seek opportunities to collaborate with implementing organizations. This cooperation will be useful in: (1) undertaking evaluations of programs of different types that conform more or less to the "best practices" identified and; (2) undertaking operations research and other types of studies to provide information on issues identified as requiring further investigation.

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ACRONYMS

AfY	Advocates for Youth
AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
APROFAM	Asociación Pro-Bienestar de la Familia de Guatemala
ARBSA	Africa Region Boy Scout Association
ARFH	Association for Reproductive and Family Health
ARHEC	African Regional Health Education Centre
BFLA	Belize Family Life Association
CA	Cooperating Agency
CARE	Cooperative for American Relief to Everywhere
CASA	Centro para los Adolescentes de San Miguel de Allende
CFI	Centre for Family Initiatives
CBD	community-based distribution
CORA	Centro de Orientación para Adolescentes
CRUSH	Community Resources for Under 18's on STDs and HIV
CSW	commercial sex worker
FCI	Family Care International
FGAE	Family Guidance Association of Ethiopia
FHI	Family Health International
FLE	family life education
FPA	family planning association
FPAK	Family Planning Association of Kenya
HIV	human immunodeficiency virus
ICAF	International Center for Adolescent Fertility

ICRW	International Center for Research on Women
IEC	information, education, and communication
INPPARES	Instituto Peruano de Paternidad Responsable
IPs	influential peers
IYF	International Youth Foundation
IPPF	International Planned Parenthood Federation
IPPF/WHR	IPPF/Western Hemisphere Region
KAP	knowledge, attitudes, and practice
MIPFAC	Centro Materno Infantil y de Planificación Familiar
MOH	Ministry of Health
MSI	Marie Stopes International
NGO	nongovernmental organization
PI	Pathfinder International
PRB	Population Reference Bureau
PSFN	Prosuperacion Familiar Neolonesa
REDESS	National Education, Research, Training and Service
Jovenes	Network for Youth
SERVOL	Service Volunteered for All
STD	sexually transmitted disease
UN	United Nations
UNFPA	United National Population Fund
UNHCR	United Nations High Commissioner for Refugees
UMATI	Chama cha Uzazi na Malezi Bora cha Tanzania
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

WAYI   West African Youth Initiative

WHO   World Health Organization

YWCA   Young Women's Christian Association

I. INTRODUCTION

The concept of "adolescence" is a relatively recent development. This is particularly true in developing agricultural countries, where the transition from childhood to adulthood is rapid, marked by reproductive maturity and accompanying socioeconomic privileges and responsibilities. An extended period of time spent moving from one life stage to the other is a modern response to expanded education for both men and women, the need for more extensive vocational training, the increasing work aspirations of young women, and the recognition that adolescent development deserves investment and special treatment.

Reproductive health is a major concern of the young adult period, in part because earlier sexual maturation and later marriage have increased the period of risk for nonmarital pregnancy. In many parts of the world, changes in familial and societal patterns and values have also resulted in a relaxation of social constraints on nonmarital sexual activity. Consequences include not only unintended pregnancy, but also psychosocial problems and disease. HIV infection is the most recent, and most serious, addition to the array of sexually transmitted diseases (STDs) common in this age group.

The delivery of reproductive health information, counseling, and services to young adults, other than to married women who are generally treated as adults whatever their age, is a new and emerging area. Many of the earliest efforts involved education in the schools, but such courses typically avoided the more sensitive sexual issues and often, especially in Africa and Asia, sidestepped sexuality altogether. Furthermore, not all adolescents attend school, especially in Africa. Health facility programs have tended to accept young women if they are married; only recently have services been offered to, and set up specifically for, unmarried young people. Up until now, however, most young adults are reluctant to use these services.

In view of the difficulties in reaching young adults in the schools and in health facilities, other ways to serve this population are being devised. Many of these innovative approaches are being tested and implemented by nongovernmental organizations (NGOs) and include youth centers, where young people are attracted to a multipurpose site that broadly addresses diverse needs, and outreach activities, in which trained peers or professionals seek sites where young people gather, work, and spend leisure time.

While reaching out to young people reluctant or unaware of how to seek information and services is key to serving larger numbers of young adults in general, it is critical to successfully connecting with less mainstream youth. Among young people today, especially in urban areas, there are increasing numbers who are living or working on the streets and in other ways marginalized and at greater risk of sexual exploitation, STDs, and HIV infection.

With such groups, trust and understanding are particularly important characteristics of those outreach workers who provide them with information, counseling, and services or referrals.

Very often, members of their own peer groups are trained to work with young people such as "street youth" or commercial sex workers (CSWs). Peer programs appear to be effective ways to reach and inform specific target audiences of young people.

A. Content and Methodology

This paper on outreach programs for young adults is part of a process to identify projects and set a practical research agenda so that program planners can build upon a body of evidence regarding successful model projects and key program characteristics. It describes various models that are not based in clinics or schools but are designed to reach young people both by attracting them to centers or reaching out to them where they gather for social, vocational, and recreational activities. It provides evidence about project achievements, presents programmatic lessons learned on strategic and operational elements, sets forth key elements for outreach activities, and suggests some critical research questions for the future.

In order to obtain information about program models and characteristics, several actions were taken. There was a review of published and unpublished literature, including project reports and evaluations. Organizations active in the field of adolescent reproductive health were contacted to obtain information about projects implemented or assisted by them as well as any analyses of lessons learned resulting from these experiences. While many of these groups were USAID Cooperating Agencies (CAs), international donor and other agencies such as UNFPA, UNICEF, WHO, and IPPF were also included. Discussions were held with professionals specializing in adolescent reproductive health issues in such areas as program design, implementation, technical assistance, and evaluation. In that regard, and in the absence of significant documentation of effectiveness, the author also relied on her experiences in these areas, especially in connection with a global thematic evaluation on adolescent reproductive health programs just completed for UNFPA.

This paper covers youth centers, peer promotion programs, outreach programs, and NGO efforts to reach youth, primarily through youth-oriented organizations. In regard to youth centers, experiences and recommendations are largely limited to multipurpose centers that provide information and services for diverse educational, health, psychosocial, vocational, and recreational needs, of which reproductive health services are one but not necessarily the dominant offering. Clinics focused on reproductive health services are covered in a companion paper on health facility programs. Furthermore, outreach activities in this paper focus on peer promotion projects and outreach to workplace and "street" settings with the emphasis on information, education, motivation, and referral. Although information, education, and communication (IEC) materials are necessarily part of these efforts, and condom distribution is often a component, a separate paper addresses projects primarily designed as IEC and social marketing activities. Education efforts (e.g., family life education, or FLE), peer programs within the school setting, and clinic services conducted at schools and universities are covered in the paper on school-based programs.

B. Summary of Project Models and Elements

The approach of attracting young people to special sites designed just for them or reaching out to them where they congregate for work or play goes beyond tailoring an existing clinic or school offering to meet their reproductive health information and service needs. These models are creating entirely new efforts, beginning with the youth perspective itself: what they need, where they are, and who should serve them. Compared to school and clinic programs, these models

are much more likely to begin with assessing actual needs and involving youth in their design and implementation.

Several diverse models are reviewed in this paper. These include:

> • *Youth centers* — both those that assist pregnant and parenting teens to pursue educational and vocational objectives and those that try to prevent too-early pregnancy along with other risky behaviors while helping to enhance life skills.

> • *Peer promotion programs*, which have the advantage of delivering activities by peers similar in age and background to their target audience and other outreach efforts to place services in the community and workplace. These types of efforts have been successful in identifying and contacting difficult-to-reach populations such as out-of-school youth, street children, and commercial sex workers.

> • *Other outreach programs*, that is, projects reaching youth in the community but delivered by adult professionals. An interesting type of project developing along with the economies of some countries is the workplace model, where information and services are provided by the employer and/or at the place of employment.

> • *Reproductive health projects developed by youth-oriented organizations* for their constituents. These are often characterized by a high degree of youth involvement in the planning, implementation, and evaluation phases. They also have expansion potential if part of a national or international NGO federation.

There have been some notable trends among these types of programs in recent years, especially an increasing emphasis on expanding outreach and downplaying activities at a fixed location. Because of the AIDS pandemic, it has become more urgent to get lifesaving information and services to people, including young adults who disproportionately take risks and are soon to begin or have already begun childbearing. Also, given the target audiences at high risk for HIV infection, which include young people living on the street, CSWs, and other marginalized people, nontraditional outreach efforts have had to be devised and implemented.

While very few evaluations have been done on the model projects covered in this paper, there are promising indications.   There is some limited evidence that centers for pregnant and parenting teens can delay a second pregnancy, but these facilities are very costly. Such programs have definitely succeeded, however, in improving educational policies so that young mothers can return to school. Multiservice youth centers designed to prevent too-early pregnancy are also costly; furthermore, no clear conclusions can be drawn about if and how they succeed in improving adolescent reproductive health or which of the many components play what kind of role in doing so.

There is evidence that outreach programs, specifically, those using peer promoters, are less costly per contraceptive user than fixed centers. They appear to be effective in reaching their target audiences and in distributing or referring for contraceptives. In HIV prevention programs, in particular, peer outreach programs have resulted in increased knowledge and more positive attitudes about health promotion; there are some promising indications about behavioral change regarding STD/HIV prevention. Also, assessments indicate that compared to adult educators and counselors, young people seem to prefer their peers in this role and may be able to learn more effectively from them.

NGO activities have not been extensively evaluated. Several implementation issues, however, are becoming clear. Many NGOs, especially the well-established groups, have strong positive track records and reputations upon which to build a project for young people. This is especially important in the area of reproductive health, which can be very sensitive during the early program introduction stages. At the same time, the difficulty of incorporating a challenging issue has tended to be underestimated. When groups have an existing, broad social agenda, extra time and care need to be provided in order to successfully integrate a new project area.

While some limited evidence exists about the success of projects, practically none is available for individual project components or characteristics. Nevertheless, there is considerable agreement among professionals in the field concerning what elements are necessary and likely to result in improved operations and better outcomes. These conclusions derive in part from focus-group discussions and other information from young adults themselves but also from significant field experience in developing, observing, and evaluating projects.

A summary of key elements, values, and benefits from their inclusion in young adult programs and examples of their implementation follows as Table 1.

Table 1: Outreach Programs for Young Adults on Reproductive Health: Key Elements

Element	Value/Benefit	Selected Example(s)
A. PRELIMINARY ACTIONS 1. PROGRAM DEVELOPMENT AND DESIGN		
a. Strategic approach	• establish clear, achievable and measurable objectives • ability to achieve what is proposed • project is politically acceptable	• offer options for clients (e.g. "Fleet of Hope": abstinence, fidelity and monogamy, condoms)
b. Target audience identification	• ability to serve intended population most effectively	• pinpoint target group, such as out-of-school youth, ages 12-18 in specific geographic area
c. Needs assessment	• information obtained for how best to reach target group with what activities and services • ability to identify different gender-specific needs	• understand role of sex to target population (e.g., street children), then develop messages which acknowledge, rather than deny, such a role
d. Youth involvement	• fostering "ownership" of, commitment to, and participation in project	• formalize youth involvement through a Youth Advisory Council with power to influence decisions and alter plans if necessary
e. Community involvement	• greater understanding of project by community resulting in enhanced support, and/or less opposition	• conduct workshops for community leaders to learn about, become supportive of, project
f. Parental involvement	• parental understanding and support contribute to their children's participation • parental ability to reinforce positive health messages	• hold regular meetings for parents to increase their understanding of project • include parents in some project activities, such as craft classes
g. Evaluation design and monitoring	• learning how a project is (or is not) meeting objectives can allow managers to change operations to become more effective • showing evidence of project success can increase revenues	• track "graduates" of program to provide evidence of long-term successes; this can be used for program purposes (e.g., to attract participants) and financial support (to attract donors)
B. PEER PROGRAMS IMPLEMENTATION 1. RECRUITMENT AND TRAINING		
a. Peer selection according to characteristics	• identification of those young adults with best potential and interests to serve in project tasks and who appeal to youth	• develop criteria, including such characteristics as acceptability to peers, credible role models, commitment to reproductive health issues, good communication skills
b. Training to assure competence for tasks	• high comfort and competence level of peer promoters	• establish training courses according to content and skills needed; e.g., counselors need training in interpersonal communication, problem-solving, and decision-making • provide refresher courses

Element	Value/Benefit	Selected Example(s)
B. PEER PROGRAMS IMPLEMENTATION 2. PEER PROMOTER TASKS		
a. Effective provision of information	• target group acquisition of factual and practical information • peer educators become known as a source of accurate information; they are then sought out	• enable peer educators to communicate useful information in skills-building ways; e.g., demonstrating condom use, followed by participant practice, is an effective exercise
b. Responsive counseling	• ability to assist clients with decision-making, problem-solving and development of coping strategies	• empower counselors to handle most needed responses by a combination of direct help or adequate referral to a medical or technical source
c. Effective referral	• effective linkage to a service not able to be provided results in more adequately addressing clients' needs	• arrange usable channels of referral to needed services as determined by client profile • give special attention to referrals for HIV and sexual abuse counseling
3. KEY CHARACTERISTICS OF PEER PROGRAMS		
a. Clearly defined responsibilities	• More effective and efficient implementation, with less confusion and overlap, results from peer promoters' understanding what is expected of them	• if minimum activities are expected, define for peer promoters quantitative objectives for achievement within specified time periods; e.g., peer educators should reach 200 young adults with condom-use discussions within a one-month timeframe
b. Effective supervision and support	• more confident and supported peer promoters can better assist their clients • peer promoters can feel comfortable seeking the help they need to do a good job	• schedule regular meetings (group and individual) for review of progress, questions, problems to ensure that promoters feel competent to carry out tasks
c. Participant access to adult professional(s)	• adults available for consultation ensures that those young adults who need to speak with older, more mature professionals can meet their needs within the program	• ensure that an adult professional is on call, either at the project's home base or at a referral site
d. Minimization of / Planning for turnover	• ready reserves of peer promoters allow a project to remain at full strength in the event of absentees or dropouts	• reward efforts to lengthen peer promoters tenure • train more peer promoters than needed in order to provide alternates
e. Use of relevant materials	• educational materials that are accurate, interesting and relevant help promoters teach and communicate better • gender-sensitive materials can help strengthen program and empower young women	• ensure that providers have interesting, youth-oriented IEC materials, such as comics, videos and games, in order to foster interaction and participation

II. TYPES OF OUTREACH PROGRAMS FOR YOUNG ADULTS

A. Background

Given that adolescence is a newly acknowledged life phase in many developing countries, the practice of serving this group with tailored information and service activities, particularly regarding reproductive health, is a recent development. Schools have been hesitant to offer (or mandate) effective sexuality education, and because many children drop out of school before such courses become available, other ways to reach and attract young people with reproductive health information and services are being devised. Such approaches are particularly needed in view of adolescent reluctance to use health clinics, especially public facilities.

This chapter will review types of programs that operate outside of schools and clinics, covering strategic ways to attract young people to special facilities and bring services to young people where they are. It will include youth centers — both those that help pregnant and parenting teens pursue educational and vocational objectives and those that try to prevent too-early pregnancy along with other risky behaviors while trying to enhance skills and potential. It will also assess peer promotion programs, other outreach efforts to place services in the community and workplace, and special initiatives by youth-oriented organizations to develop projects by and for youth. Evidence of success in reaching target audiences and favorably affecting knowledge, attitudes, and behavior will be presented along with some cost comparisons of different models.

There have been some notable trends among these types of programs in recent years. For example, in Latin America, where multidimensional youth centers are most prevalent, there is an increasing emphasis on expanding outreach and downplaying activities at the fixed location, in some cases shutting down the center altogether. This results, in part, from struggling with the high costs of running centers with significant educational, psychological, health, and recreational services. Part of the rationale for such broad offerings was to increase the attractiveness to youth and to "package family planning" in the broader, less visible, context of multiservice youth centers. This model also recognized that young people have pressing needs beyond those of sexuality and reproductive health.

However, aside from high costs during a period of cost-cutting, the AIDS pandemic has created new needs and changed certain perceptions of health protection and promotion. It has become more urgent to get lifesaving information and services to people, and critical to reach young people who disproportionately take risks and have begun or are soon to begin childbearing. Politically safe packaging is starting to give way to effective delivery of health information and methods. Also, given the target audiences at high risk for HIV infection, which include young people living on the street, CSWs, and other marginalized groups, nontraditional outreach efforts have had to be devised and implemented. The newly implemented AIDS prevention projects, which have significantly better design, monitoring, and evaluation elements — no doubt because they benefit from years of developing such mechanisms in related public health areas — are of interest as examples of new and innovative approaches.

There is also an apparent trend for agencies to implement many outreach activities simultaneously. Thus, a center might offer vocational training and FLE, dispatch promoters to provide counseling and barrier methods, train teachers to give sex education courses, develop materials for the media, and refer for STD treatment. In a sense, such combinations help assure that young people will get the messages and assistance they need from a source that's relevant to

them, reinforced by consistent information from elsewhere. With so many influences and stimuli in young people's lives, it is practical to channel information and motivation through as many of them as possible.

As the International Center on Adolescent Fertility (ICAF) asserted in a review of projects, program designers will need to become even more creative in the future in finding ways to take programs to youth rather than making youth come to them (Barker et al., 1991). The outreach concept is based on the belief that more young people would like reproductive health information and preventive methods if they knew they were available and/or that they need outside motivation and reinforcement to use contraception (Brabin, 1995). Bringing services to youth also solves the problem of distance — both physical and psychological. It eliminates distance as a barrier to access and can better penetrate the distrust and alienation of such hard-to-reach groups as unemployed school dropouts and "street children" (Paxman, 1993; WHO, in press).

B. Program Models

1. Adolescent/Youth Centers

a. Centers for pregnant and parenting youth

For political and practical reasons, it has been easier to provide services for pregnant and parenting teens than to take actions to prevent the first pregnancy. Such projects as those that provide academic and vocational instruction along with health and family planning services in an effort to help young women complete a certain level of education (or return to school) and prevent the second pregnancy have been in existence longer than most of the newer outreach activities. They present a mixed record, including some clear successes, and they have accomplished two other significant objectives. These projects, some of which have been adapted from others, show that projects in differing cultural settings can learn from one another. They have also raised awareness about the situation of pregnant schoolgirls and, in a few cases, have instigated a change in public policy regarding school attendance (Pathfinder International [PI], 1993; PI, 1995; Senderowitz, 1995c).

The center credited with developing the model adapted by others is the Jamaica Women's Center. Founded in 1978 to help girls who became pregnant while in school to reenter the system after giving birth, the program provided academic instruction to those who could return to school and skills training and vocational counseling to those past school age. The program has since expanded to six other main centers and 13 outreach stations serving rural populations.

Recently, activities intended to delay the first pregnancy have been added, including after-school academic assistance and family planning counseling for nonpregnant teens (Barnett et al., 1996; McNeil et al., 1990).

This project has been evaluated in various ways over the years, including a static group comparison (with 89 and 26 girls in two intervention groups, Kingston and Mandeville, and 111 girls in the comparison group) for short-term effects and a nonexperimental survey of 66 older graduates to assess longer term effects. Results showed that 55 percent (Kingston) and 73 percent (Mandeville) of recent Center graduates had returned to school, compared to only 15 percent in the control group. Compared to a repeat pregnancy rate among control group women

of 39 percent, 15 percent of Kingston graduates and only eight percent of Mandeville graduates experienced a subsequent pregnancy within three years (McNeil et al., 1990).

A case study of the Center undertaken by Family Health International (FHI) using focus-group research reported that program participants credited this program with helping them to realize they could control their fertility and that they have a clear responsibility for what happens to them as sexually active women (Barnett et al., 1996). Program staff confirm that this is taken seriously: over the years the pregnancy rate of participants through completion of secondary school has fallen to 1.3–1.4 percent annually (Barnett et al., 1996).

Along similar lines, Tanzania's nongovernmental family planning association, UMATI, established the Adolescent Pregnancy Drop Out Program at the Dar es Salaam Vocational Training Centre in 1986. Twenty adolescent mothers who had dropped out of primary school were provided academic instruction, counseling, vocational training, health services, family planning, childcare, and family life education. According to an internal evaluation by the Pathfinder Fund in late 1987, during the first 15 months, the project faced numerous start-up problems, logistical snags, and design questions. Of most concern were four repeat pregnancies among the 20 participants, prompting the project to intensify its counseling, FLE, and family planning components. The evaluation also recommended more work with the adolescents' parents and the "baby fathers" (Cooper et al., 1988).

In fact, changes to the program, including greater involvement of parents, appears to have effected significant outcomes. A later review, also by Pathfinder, reports that no repeat pregnancies occurred among the second group of students and that a briefing and regular meetings with parents resulted in more investment by them in their daughters' futures, demonstrated by a greater number taking over the financing of secondary school enrollment from the Center (PI, 1995).

The Educational Center for Adolescent Women in Botswana, implemented by the YWCA, is patterned after the Tanzanian model. Their outcomes on repeat pregnancies were remarkably similar, dropping from four out of 20 in the first group to none in the second. Parental involvement was also encouraged; in the Botswana center, parents are actual participants in activities such as crafts programs. Students and staff indicated that the counseling effort had a substantial effect on students' attitudes and self-esteem. And, as in Jamaica, but not in Tanzania, the project was able to favorably influence public policy regarding school readmittance of adolescent mothers (PI, 1995).

Although these programs for adolescent mothers offer some indication of success in delaying the second pregnancy, as opposed to programs for teen mothers that have been tested in the United States (Moore et al., 1995), they are very costly. In the Jamaican project, the cost for one girl for one academic year is U.S.$437, and providing care in the nursery for her baby costs U.S.$83 (McNeil et al., 1988). NGO support helped start this program, and although external donor contributions continue to help, the program is under the auspices of the Jamaican government, with a majority of funds provided by it (Barnett et al., 1996).

Governments in other countries support some less comprehensive efforts for girls forced to drop out of school because of pregnancy, such as the Golden Opportunities School in Antigua. However, the school has no nursery and limited instructional hours; furthermore, Antiguan policy prevents a return to school after childbirth (Senderowitz, 1995c). Sri Lanka and Indonesia

have training centers for dropouts, including girls who left because of pregnancy, but Indonesia does not include FLE in its course offerings (UNFPA, in press).

b. Multiservice Youth Centers

Youth centers have been developed, especially in Latin America, with multiple health and social services to address the broad needs and concerns of youth, in some cases with a significant objective of addressing reproductive health. Where young people's reproductive health needs are served, especially before a first pregnancy has occurred, centers have often faced more political opposition — real and feared — than those assisting pregnant girls. Although evidence exists to the contrary, the long-standing concern expressed by adults that adolescents will be encouraged to have sex if family planning is available has persisted in every region.

In response to this concern, some program planners created a more broad-based service facility, which provides educational, vocational, and recreational services along with counseling and reproductive (and other) health care; this proved a useful approach in places where a single focus on family planning was not acceptable (Paxman, 1993). The provision of diverse psychological and health services also allowed treatment of the young person in a more holistic way, addressing root causes of multiple problems and meeting various needs at the same time (Paxman, 1993; WHO, in press).

Such centers also helped attract young people, very often the out-of-school youth so in need of many services. Importantly, these centers attracted young men in ways that health facilities failed to do. Not only could their current problems be addressed but their future concerns, such as preparing for and finding a job, were strongly emphasized. In fact, when young people in the Caribbean were asked to describe an ideal place to meet and get reproductive health care, their responses sounded like some of the best-developed youth centers. They outlined a center with many services, including reproductive health, which would not look like a clinic, open to both boys and girls at convenient hours (after school and in the evening), staffed by empathetic and knowledgeable counselors, offering social and sports activities, and providing job training (Kurz et al., 1995). A friendly and responsive staff appears critical to the success of a teen center (IPPF/WHR, 1995).

The Centro de Orientación para Adolescentes (CORA), founded in Mexico City in 1978, was a pioneer in providing multiple services to young adults. At the beginning, it offered individual and group counseling, medical services, health education (including reproductive health), and cultural and recreational activities. Beginning in 1983, CORA expanded both its number of facilities and the services offered. Outreach activities, including training and a postpartum education project for teen mothers in a major hospital, were added, along with a drama forum for young people throughout the city. Development of educational materials and research began so that experiences gained at CORA could be shared. In fact, adaptations of the CORA model have developed in Mexico, in other Latin American countries, and in Africa (Monroy et al., 1988; Monroy, 1992).

A 1987 evaluation of CORA revealing that the center attracted relatively small proportions of its target population (about 16 percent) prompted the organization to increasingly use peer promoters to reach young people with sex education, family planning information, and contraceptive methods. These promoters reach into the schools, the community, and factories (see section e., below, for a cost comparison of various CORA strategies) (Monroy et al., 1988).

A similar center, Centro del Adolescente "El Camino," was established in Guatemala City in 1979 by APROFAM, the nongovernmental family planning association (FPA). The center was purposely sited in a facility separate from the FPA, centrally located and easily reached by inexpensive transportation. Although sex education and family planning were priority areas, these were integrated with counseling, outreach, and medical and dental services. The integrated approach was deemed necessary both to avoid too heavy an emphasis on family planning, which might bring unfavorable public and political notice, and to attract young people. In fact, on the urging of young people, additional program elements were added, including recreational activities, tutoring, vocational courses, and dental services (Andrade, 1985).

Youth promoters were trained and began service in 1983, presenting talks and videos and distributing educational materials in the schools and in community settings. Although it was decided that they would not distribute contraceptives, they referred young people to El Camino for family planning. This program component had a major effect on the center's contraceptive provision profile: more than 80 percent of the barrier methods distributed by the center were to adolescents referred by the promoters (Andrade, 1985).

There is no doubt that this type of operation is costly (IPPF/WHR, 1995). And if family planning is the major objective, the many additional components necessarily increase the per user costs. This became an issue between El Camino and its funders. Yet the center participants and staff saw El Camino's evolution as a rational strategy in a traditional society; El Camino survived and attracted young people for a variety of reasons, many of whom were then introduced to family planning (Andrade, 1985). At the same time, some of these programs, including El Camino, have been forced to reduce certain services because of scarce funds, either temporarily until new resources are found or permanently (IPPF/WHR, 1995).

Several other centers in Latin America and the Caribbean attract young adults with their combined reproductive health care and other services needed by this group. The Under-20s Clubs in Grenada and other Caribbean sites, run by the FPAs, offer adolescents a chance to socialize and get help with homework while also providing counseling, health education, physical exams, and contraceptives (Kurz et al., 1995). CASA, in San Miguel de Allende, Mexico, is run by a private NGO and provides psychological and vocational counseling, social and cultural events, and medical services as well as promotes youth reproductive health in the community via peer educators (PI, 1995). In Trinidad and Tobago, the Adolescent Development Program of the organization Service Volunteered for All (SERVOL) reaches school dropouts, emphasizing skills they need to obtain jobs and helping them plan for their future, while relating desired family size to the use of contraceptives (Kurz et al., 1995; Population Council, 1996).

Centers have begun operations in Africa more recently. The Gambia Home Economics Association established a Vocational Center in 1990 to help out-of-school young girls learn skills. FLE was incorporated into the curriculum and the Center counseled and referred for family planning services, working closely with the FPA. The program was designed to use peer counselors; however, the referral rate was very low and the rates of family planning use significantly lower than among survey figures for sexually active youth (Paxman, 1993). It was realized that young people were hesitant to come to the Center for counseling or to the FPA for contraceptives; future plans called for using alternative sites and distribution methods. Another challenge was the persistent taboo nature of peer counseling for girls (PI, 1995).

The Family Guidance Association of Ethiopia (FGAE) succeeded in establishing a program in a country where strong cultural taboos limit discussions about sexuality between parents and

children and deter unmarried women of any age from using family planning clinics. FGAE's youth program, started in 1990 in Addis Ababa, included a youth counseling center, FLE sessions, clinical consultations and contraceptive services, outreach to schools, and an additional site for out-of-school youth that offered information, education, condom distribution, and recreational activities.

Although the program overcame many challenges, some limitations persisted. One key shortfall is the need to refer to another site for STD diagnosis and treatment and for pregnancy testing. Another is the growing demand for services from an already overburdened staff. Nevertheless, the program remains the only source for contraceptives accessible to young people in the country. Records indicate a significant distribution of condoms, and steady rates of new and continuing acceptors, many of whom never used condoms before coming to the center (Hawkins et al., 1992; PRB, 1994).

Another African example is the Youth Programme of the Family Planning Association of Kenya (FPAK), which operates two centers, in Nairobi and Mombasa, where they provide counseling and educational and recreational activities. A major feature, prompted by the difficulty of young people getting to the centers, is the network of volunteer promoters providing outreach, primarily to schools (Themmen, 1996). In light of the political context, however, they have chosen an extremely cautious role for the promoters, stressing abstinence and using referral to the FPAK clinics for sexually active youth. Referrals have been minimal — less than 100 per year (Marie Stopes International [MSI], 1995).

Although documentation of clients served, presentations given, and contraceptives distributed are typically available for projects such as these (usually required by the donor agency), there are virtually no data regarding the relative effectiveness of one component or another. Given the high costs and multiple interventions, some analysis is needed regarding which specific activities are meeting what needs at what costs.

The high cost per client provided with reproductive health services is exacerbated by the low turnout experienced by many centers. Too often, the same small group of young people "hangs out" at a center, usually for socializing and recreation (Ajayi, 1996). This has changed strategies for many of the centers, which have increased the use of outreach, usually peer promoters, to actively recruit and/or deliver information and contraceptives to young people in schools, at work or where they congregate.

2. Youth Peer Programs

Many fixed centers trying to attract and recruit participants concluded that peers could play this role quite well. Peer programs typically combine several important factors useful in health promotion and development: strong identification with the social and cultural environment of the target group, promotion of social norms and values supportive of positive attitudes and healthy behavior, and actual involvement of young people in programs targeted to them (Fee & Youssef, 1993). AIDSCAP (n.d.) summarizes the benefits of the peer education approach as culturally appropriate, community-based, accepted by the target audience, and economical. Downsides include high turnover as well as the need for a significant degree of supervision and continuous training (AIDSCAP, n.d.; IPPF/WHR, 1995).

Most centers now have a major peer promotion component, increasingly providing information, counseling, and services outside the centers, where they reach young people. One Mexican program, Gente Joven, closed its centers altogether and switched to a peer outreach strategy.

Gente Joven, established as the youth program by the Mexican FPA Mexfam, had set up 13 centers from 1986 to 1988. However, they observed that the numbers of young people coming to the center were low and the costs were high. The changeover was thus made to use trained coordinators and 1,500 youth promoters, the latter high school volunteers aged 16–20. Some of these receive additional training to enable them to distribute condoms along with information and education. Referrals are also made to Mexfam's clinics for counseling and broader reproductive health services (International Planned Parenthood Federation [IPPF], 1994; Marques, 1993).

The program is based on the use of many communication materials appealing to youth and on creative alliances with various youth subpopulations. For example, Gente Joven created a light, humorous radio series combining popular music, relevant topic discussion, and reliable information for decision-making in relationships and sexual matters. Videos developed for different age groups are used for discussion starters. Printed educational materials are different in approach, content, and tone from traditional resources used with adults. A major effort combines a partnership with a difficult-to-reach group — gangs — and a special approach, street theater. Promoters also carry their messages into the schools and factories employing young people (IPPF, 1994; Marques, 1993).

The youth program of the Belize Family Life Association (BFLA, an IPPF affiliate) also started as a fixed center. Originally attracting primarily in-school youth, it moved toward more emphasis on outreach, mainly through peer educators, with a job-oriented center serving out-of-school youth (Bartling et al., 1996; Stewart, 1996).

Another NGO, the Centro Materno Infantil y de Planificación Familiar (MIPFAC), also has fixed clinical services but has developed its youth component, PROJUVE, as a peer outreach program. The trained promoters work in the community, providing informal and organized talks and presentations, contraception (condoms and foam), and referrals back to the clinics. An evaluation of these components conducted in 1989 reviewed records, conducted interviews and focus groups with promoters and staff, and surveyed students and factory workers (PI, 1995).

In the community outreach component, the evaluation found that 88 percent of the promoters entering the program before 1988 were "considered effective" as measured by their knowledge of fertility, their ability to conduct educational sessions, and their level of contraceptive distribution. At the time of the evaluation, however, the number of active promoters dropped from 150 to 34 and their effectiveness rating to 56 percent. This was attributed to a temporary lack of staff to train and supervise youth promoters (PI, 1995).

"Together We Can," an HIV/AIDS peer education project, is a collaborative effort between the Jamaica Red Cross and American Red Cross designed to increase safer sexual practice among youth aged 14–19. The project involved youth extensively in the design, implementation, and evaluation of the program. Its materials and training methods were carefully tested and revised and activities were well documented, with both qualitative and quantitative evaluations conducted. Education sessions led by the peers were held throughout the country in school and community settings, in homes, and in various spaces outdoors (on "verandas and under trees") in both rural and urban sites (Kauffman et al., 1996).

Key findings, based on measurements of a sample of 364 youth peer educators' responses to pre- and post-training questionnaires, showed that in the short term, the intervention had a significant impact on youth peer educators 14–19 years old. There were significant gains in knowledge about HIV transmission and about where young people can go for help with STDs. Also significant were a dispelling of myths and a positive change in attitudes toward persons living with HIV/AIDS. Furthermore, data suggested that the peer educators intended to delay sexual intercourse and to use condoms if sexually active during the following year. Some disappointing results were found, too, after the training experience. Many of the peer educators still believed that their peers would laugh at them if they resisted sex, and only a few believed that boys and girls should not start having sex while in school (Randolph, 1996). Unfortunately, an attempt to measure the extent to which knowledge, behavior, and attitudes were sustained by the peer educators over time was unsuccessful.

Furthermore, project staff found it extremely difficult to obtain sufficient data on the results of the peer educators' work with the youth that they reached (Kauffman et al., 1996).

In Asia and Africa, the use of peers as educators and counselors has been slower to take hold. A peer counseling project was successfully pioneered in Thailand in the mid-1980s, though the peers, typically college students, were generally older than those active in Latin America; they were based within their schools and did not distribute contraceptives. Furthermore, as the implementation transferred from a hospital center to the health ministry, the strategy moved to a greater dependence on teachers for education and referrals because the turnover was not so great (Senderowitz, 1995c).

African projects, of which there are still only a handful, have also tended to use university students as peer educators in Kenya, Tanzania, and Nigeria (covered in the school-based paper). As mentioned above, some peer promotion projects have also started in connection with youth centers as in Kenya and Gambia. A two-country project operating in Nigeria and Ghana, the West Africa Youth Initiative (WAYI), is designed to help small nongovernmental and governmental projects already starting up or planning activities to provide reproductive health education to youth at a community level, primarily through peer education activities. A collaboration of Nigerian and U.S.–based NGOs concerned with adolescent reproductive health provides training and technical assistance to the projects. Important objectives include the development of project approaches and lessons learned for replication and expansion, and documentation and evaluation of the pilot projects (ARFH/Advocates/ARHEC, n.d.).

In an evaluation of the WAYI project, findings indicate positive effects on knowledge, self-efficacy, and behavior. The target population showed increases in knowledge and in use of modern contraceptive methods at the post-intervention survey compared to the baseline. In addition, compared to a control group, the target population scored significantly higher on a self-efficacy scale surveying feelings of confidence around saying no to sex, asking a partner to use condoms, and buying contraceptives. The intervention group also indicated a greater willingness to pay for condoms and foam than the control group, and significantly more of the intervention group reported taking protective measures against STD/HIV such as abstinence, limited total number of partners, and condom use (Lane, 1997a).

Program activity appears to be on the verge of significant escalation, stimulated by the AIDS pandemic. In 1992, CARE Kenya started the CRUSH (Community Resources for Under 18's on STDs and HIV) project. The key strategy is peer education based on the premise that young people are the best resource for STD/HIV prevention and control. The training of "influential

peers" (IPs) began with mini-lectures, but when a midterm evaluation identified this approach as too boring, more discussion-centered and interactive methods were substituted. The midterm evaluation also found the target audience was broad and unspecified; the project adjusted its approach to focus on out-of-school youth aged 12–18. The final evaluation, consisting of semistructured interviews, focus-group discussions, a KAP survey of 224 participants and two control groups of 90 and 56, reported that participating youth like CRUSH's approach; survey results indicate that they are displaying better knowledge, more positive attitudes, and signs of positive behavioral changes toward STD/HIV prevention than the control group (Chege et al., 1995).

In Asia, an experimental intervention was carried out in northern Thailand with single female adolescent factory workers by ICRW's Women and AIDS Research Program. Three interventions were tested with a sample of 240 to determine the relative effectiveness of health education and communication approaches. These included providing materials only, material and informal education provided by health educators, and materials plus informal education provided by peer leaders. Results indicated that the girls attending the peer leader sessions demonstrated the most significant improvements in both knowledge and enabling skills. They also exhibited the largest increase in perceived vulnerability to HIV infection but the smallest degree of fear because they learned how to protect themselves (Cash & Anasuchatkul, 1993).

3. Other Outreach Programs

While interviews and focus-group discussions have revealed considerable support for peers as educators, young adults have expressed interest in also having access to a knowledgeable adult if needed (Chege et al., 1995; MSI, 1995). Many programs have chosen to use adult professionals because of stability and turnover reasons and because they are deemed more appropriate for certain target audiences. Some simply have not considered the use of peers and have pursued a traditional staffing approach. Judging from trends reviewed above, however, there may be some movement in the future toward a mixed staffing pattern based on the acceptability and effectiveness of the differing counseling possibilities.

The PROJUVE project in Ciudad Juarez used peers to reach young people in the community, as reviewed above, but used adult professionals to reach young factory workers. Initially, there was opposition from employers who resisted the workplace services and education plan, but agreed to work with PROJUVE to jointly develop course content after being convinced that postponing pregnancy among workers results in economic benefits. Course content included information on human sexuality, family planning, STDs, and abortion, offered as an introductory session to workers, followed by one to three additional sessions (PI, 1995).

The 1989 evaluation found that factory staff were generally satisfied with the courses and factory nurses reported an increase in requests for family planning. A survey completed by 48 factory workers who had recently attended a PROJUVE presentation (and by 77 workers who had not) showed that participants had significantly more knowledge about all types of contraceptive methods, their correct use, and a source for obtaining them than did those who did not attend. Participants also demonstrated more favorable attitudes toward contraceptives, and more planned to use them in the future than control group members (PI, 1995).

More unusual is the workplace model in which the company provides its own education and health service program. In India, the Tata Iron and Steel Company, through its Centre for Family Initiatives (CFI), seeks to establish a model of corporate action to help young people

become informed on sexual and reproductive health matters. It targets adolescents aged 14–18, single or newly married, living in nearby residential and slum areas, as well as those whose parents work in the company. Specific objectives for its education and health service program are preventing/minimizing child marriage, premarital sex, unwed pregnancies, and deaths of young mothers. Income is generated for the project through performances of the CFI Drama Troupe consisting of unemployed young people (WHO, in press).

Other programs face the challenge of reaching people not already organized at a setting. This task becomes even more difficult as the target group becomes more marginalized, such out-of-school youth, the unemployed, and those working or living on the streets. Added to the logistical task of finding and reaching them is the psychological challenge of gaining their trust and involvement.

In Honduras, Proyecto Alternativas provides education and social services to working children in the informal sector and their families and to completely abandoned street children (WHO/UNFPA/UNICEF, 1995). The project has recreational activities, primary health care, and a food supplementation component that has had a positive effect on young people's nutritional status and on morbidity (International Youth Foundation [IYF], 1992; Wright et al., 1993).

In Brazil, a model HIV prevention project was developed for children and adolescents living and/or working in the streets. The multifaceted approach put considerable emphasis on factoring into the plan the realities and value of sex for this population and the overwhelming concern of daily survival. Highlighting entertainment to educate and motivate, the team developed a set of communications materials (including a video and comic book) and provided opportunities for group discussions, role plays, and theater and art activities. The process evaluation shows considerable participation, with 68 percent of the youth exposed to two or more activities. Preliminary analysis of the outcome evaluation, conducted by pre- and post-test surveys, suggest an encouraging trend in reducing risky behavior (Merritt & Raffaelli, 1993).

In the United States, a project was designed for reduction of risk-taking behaviors among runaway youth in New York City, focusing on building knowledge about HIV/AIDS, developing coping skills for risk situations, providing access to health and social services, and addressing dysfunctional attitudes leading to unsafe sexual practices. Trained adults led the program's 20 sessions, each lasting 1 1/2 to two hours. A baseline interview was followed up at three and/or six months after the intervention; 78 participants and 67 controls completed this phase. Researchers found that the number of sessions attended significantly predicted increases in consistent condom use and reductions in high-risk sexual behavior patterns. For this project, at least 15 sessions seemed necessary to alter behavior; as a general conclusion, the results suggested that in order to modify sexual risk behaviors among high-risk groups, HIV/AIDS programs must be extended beyond the common format of two or three sessions (Perry & Sieving, 1991).

4. Youth-Oriented Agency and Youth Network Programs

In the early stages of a country's taking on the task of reproductive health information and services for youth, it is often NGO efforts that make a breakthrough and test possible approaches. Because they are not connected with the government, they are not as politically vulnerable. They have fewer layers of bureaucracy and approvals, tend to be smaller and more flexible, and have strategic agendas and constituencies already in place. If NGO objectives and

concerns relate to youth — or even health, women's development, or social change — reproductive health care for young adults can dovetail with their programs.

Since many NGOs are specifically concerned with children and youth, they provide a practical and effective avenue for reaching this group. This is especially true for marginalized young people and those in crisis who are difficult to connect with and mistrustful of traditional services (United Nations High Commissioner for Refugees [UNHCR], 1995). Furthermore, if NGOs are part of a network associating other related groups within their region or country, a much larger potential audience becomes reachable. Some NGOs are affiliates of international federations; in these cases, program elements such as strategic planning, training, and curricular materials can be jointly developed and used.

Any NGO network or federation provides the potential for expansion, but given the limited coverage of NGOs compared to governmental programs, the NGO effort can never "scale up" fully to broadly reach young adults in need of information and services. Yet NGOs are, and remain for the future, an innovative testing ground and a willing pioneer for venturing into new territory. In fact, as a result of successful NGO model projects, governments have been able to forge partnerships with NGOs to expand activities or build on new political acceptability to assume programs directly.

 An example showing the potential for multicountry coverage is the family life education project implemented by the 29-country Africa Region Boy Scout Association (ARBSA). The project's goal is assisting young boys with their emotional and sexual development by providing information necessary to make responsible decisions about relationships, sexuality, parenthood, and maturation. An important objective was to raise awareness and responsibility on gender issues among the participating young men. Centered around the creation of an FLE merit badge, project activities included training seminars, development of a handbook, and regional workshops (Paxman, 1993).

Although the program design called for the eight participating countries to adapt strategies and training issues covered in the multicountry orientation, this process was apparently more challenging than anticipated (PI, 1995). Similarly, the difficulty in getting a traditional, male youth-oriented group to understand and be motivated to act on reproductive health issues was underestimated (PI, 1995; UNFPA, in press). In Kenya, a major battle developed over content of the manual — as part of a larger debate on providing reproductive health information and services to adolescents — which the scout organization was not prepared for (UNFPA, 1996). Importantly, while some evaluation efforts were undertaken, these were insufficient to plan adjustments in the program and continuation and/or expansion activities (UNFPA, in press).

In another effort involving multiple countries, in this case from different regions, a variety of national and local NGO groups became implementing agencies under the guidance of IPPF. beginning in 1990, six countries (Colombia, Egypt, Jamaica, Senegal, Sierra Leone, and Sri Lanka) participated in Youth for Youth. Projects were developed at the country level, choosing their own target groups and activities to reach them. Thus, a diverse group of young people were reached by the project as a whole, including those in urban slums, in prisons, in schools, in the military, and those already parenting (IPPF, 1993; IPPF, 1994; Senanayake, 1992).

In addition to involving many countries and agencies, the project also pioneered some significant activities. For example, in Sierra Leone the project addressed female genital mutilation, the first

time this issue has been taken on by a youth group (IPPF, 1993). A participatory evaluation was conducted early in the implementation phase by reviewing documents, observing training and education sessions, and conducting interviews and focus groups. The evaluation concluded that empowering young people had been the key to success, that the bottom-up approach (with young people developing their own programs) had worked well, and that working with local NGOs (including incorporation of reproductive health issues into their existing activities) had enabled the project to reach a large number of people at low cost (IPPF, 1993).

In a project involving both NGOs and public agencies, the Philippine National Program for Adolescents Working and Living on the Streets operates in 17 cities. This UNICEF-supported advocacy and social mobilization campaign builds on a collaborative planning and oversight effort in each city. Starting in 1986 with only five NGO projects for adolescents in the street, it has grown to about 500 projects in metropolitan Manila alone, with another 350 projected nationwide (WHO, in press). A more broad-based national network, REDESS Jovenes — addressing overall youth needs — operates in Peru to facilitate information and resource sharing among youth-serving groups. In addition to participating in that network, the Peruvian FPA, INPPARES, has also led the Peruvian Youth League, a consortium of youth groups seeking to expand access to sexual health programs (IPPF/WHR, 1995).

Other projects are implemented by country affiliates of international NGOs, which, while not actually part of a formal umbrella program, nonetheless gain from their agencies' overall experience, resources, and reputations. Examples of such projects are YWCA projects focused on counseling and IEC in Botswana and Ghana and a project targeting working youth on HIV/AIDS prevention run by the Red Cross and Scout Organization in Ghana (Population Council, 1996; Riley, 1995; Themmen, 1996).

Some useful insights have been gained from aspects of both successes and failures of these projects. In the Scout project, it was realized that some very important youth development issues, such as sexuality and reproductive health, were going unrecognized by youth organization programs (Paxman, 1993). In that project and in similar ones, there is both the opportunity and challenge to incorporate such concerns into a broad approach to youth, thus relating sexuality issues to other parts of young people's lives. From a program planning point of view, these projects showed that young people could participate significantly in planning and carrying out projects to meet their needs, adapted to their own country and community situations, though greater preparation and planning time may be necessary for successful outcomes.

C. Peer Projects and Other Models

Although approaches are difficult to compare because diverse preparation and implementation factors are not standardized, a few studies have made comparisons of models to serve young adults, including some assessment of cost differentials. In fact, two of these studies purposely set out to determine relative cost-effectiveness for program planning intentions.

In a well-known study conducted by The Population Council, two alternative strategies to provide young adults with sex education and family planning by Prosuperacion Familiar Neolonesa (PSFN) were tested. One strategy involved Integrated Youth Centers, which combined such education and services with counseling, academic tutoring, and recreational activities in a fixed setting. This was compared with a Community Youth Program that trained young adults and community counselors to work through informal networks to provide sex education and family planning information, including referral to PSFN for contraception.

PSFN's ongoing community-based distribution (CBD) program (20 percent of whose clients are under 22, the same target group for the tests) served as a control group (Townsend et al., 1987).

The evaluation found that it is possible to reach an underserved group with a variety of approaches. Furthermore, all these models were well accepted by the community and young adults themselves. In terms of cost-effectiveness, the results suggested that the Integrated Youth Centers were neither the most effective nor least expensive alternative. The Community Youth

Program was able to reach young adults at less than one-third the cost per active contraceptive user. However, when compared to the CBD program, these specialized services for young adults were 12 to 40 times more costly per user (Townsend et al., 1987).

Cost alone does not tell the whole story. Each approach was able to attract young adults with differing characteristics. Both youth programs reached younger, unmarried groups previously unserved by the CBD program. The Community Youth Program primarily served single males (95 percent) while the Centers attracted more females (60 percent) (Townsend et al., 1987). Thus, depending on the overall program's objectives and in view of unmet needs, costs may need to be factored into decisions as one of several items.

Another study compared two peer promotion projects, PROJUVE and the peer promotion activity of El Camino, both summarized earlier. Both projects used peers to provide information in informal settings and referred to their base clinics, as necessary. However, PROJUVE's promoters themselves distributed contraceptives, while El Camino's did not. The study concluded that the multiservice approach, which is the basis for El Camino's service provision, was less effective and more costly than the PROJUVE project's strategy, which more directly addressed family planning goals (Lobo, n.d.).

In association with The Population Council, CORA researchers assessed the cost-effectiveness of reaching young adults in three settings: the school, the workplace, and the community. In all three approaches, peer promoters gave formal and informal talks to young people on sex education and contraception and distributed methods. Comparisons were made of cost per user within the three models, with the following results: school-based distribution was the least expensive model (at U.S.$0.34 per user/month), community-based was next (U.S.$1.29), and factory-based was most expensive (U.S.$3.65). Some explanation of the cost differentials relates to the volume of users available for contact at the schools and in the community; CORA was unable to gain entry to factories with large numbers of young employees (Monroy et al., 1988).

A follow-up to one of these comparative studies was conducted to assess long term effects. PSFN's youth program in Monterrey, Mexico — begun in 1985 and evaluated in 1987 — remained active after five years of nonfunded activities, expanding to three marginal communities and in collaboration with a local school of social work, developing a wide distribution network of young promoters. PSFN identified and tracked a sample of 116 individuals who had participated in their youth program five years earlier. Interviews with them, and with a control group of 204 youths, were conducted to measure current levels of knowledge, attitudes, intentions, and practices related to sex education and family planning (Infante et al., 1993).

Results showed that the participant group had significantly better levels of knowledge and more positive attitudes toward fertility regulation and sex education than the control group. For example, 92 percent of the experimental group knew effective, modern methods to avoid

pregnancies compared to 76 percent of the control group. No significant demographic impact was seen, however. Researchers suggest that a possible explanation is that the cohort is still so young (less than 25 years old), with few children, and thus differences may not yet have developed (Infante et al., 1993).

III. PROGRAMMATIC LESSONS LEARNED

This chapter covers major strategic concerns and program characteristics and offerings that have been identified in project evaluations or recommended as elements in programming for young adults. It must be underscored, however, that there are few rigorous evaluations conducted in developing countries from which to draw conclusions and on which to base program development.

Some studies in the United States and in other developed countries provide insights and promising directions, but circumstances vary enough to make them unreliable as the sole basis for developing-country program planning. Nevertheless, there are materials short of scientific evaluations that lend valuable ideas and suggestions about the best ways to proceed. These include qualitative or process evaluations, project reports and testimonials, expert opinion, and interviews and focus-group sessions with providers and clients (young adults themselves). While some of the models covered in Chapter II have undergone evaluations of varying sorts, these studies have not assessed the relative contributions of each program characteristic or strategy. Most conclusions regarding key elements in this chapter, therefore, are derived from professionals who have managed, funded, or observed programs for young adults.

Focus-group research and expert opinion strongly identify many of the most important and relevant program elements for young adults (which will be articulated further in IV, below), as follows:

A. Strategic Planning

A strategic approach to planning programs can greatly influence their acceptability, outcomes, and success, both perceived and actual. A common mistake is promising more than a project can deliver, whether through optimism, inexperience, or desire to please donors or the target population (Senderowitz, 1995a). Thus, it is important to determine what will be feasible to implement and what outcomes will have the most impact yet are reasonable to project (IPPF, 1995; Koontz & Conly, 1994; Themmen, 1996; WHO/UNFPA/UNICEF, 1995).

Clearly stating both process and behavioral objectives before the project begins is a prerequisite to measuring project success once the project is under way. At the same time, projects that are flexible, able to adjust to realities and newly recognized needs, have been found better able to meet their objectives (WHO/UNFPA/UNICEF, 1995). Objectives themselves may need to change over time.

What is feasible depends not only on what human and financial resources enable a project to take on, but also what the cultural and political environment will accept. An AIDSCAP study of lessons learned in Haiti, for example, found that providing a variety of prevention options both offered target audiences a choice and allowed gatekeepers the opportunity to remain neutral or supportive of certain activities. Such an effort was "The Fleet of Hope" approach, which offered three "boats" (abstinence, fidelity and monogamy, and condoms) for clients to choose from, perhaps even moving among the three. Given that acceptable options were included, support could be given by diverse community groups, such as religious leaders (AIDSCAP, 1996).

Those in the field have also found that it is practical to build on existing structures and experience and apply lessons learned from others' efforts in related programs (WHO, in press). CORA undertook a prospective study to determine which of their current approaches, as

reviewed above, would be most cost-effective to expand in the future. An important finding of this study was the ability to project likely costs and outcomes without actually implementing the changes in services before assessment takes place, which is the usual way (Monroy et al., 1988).

Sometimes unplanned positive outcomes result from programmatic efforts that are useful for strategic planning. For example, in Bangladesh it was realized that many young unmarried women were learning about family planning at an early age from a variety of sources not intended to reach them. Once picked up by a few young people from such sources as the community-based family planning agent and the media, the information passed through peer groups very quickly (Mita & Simons, 1995). Understanding of such diffusion potential is an important area of information for future program planning.

B. Target Audience Identification

In recent years there has been an enormous increase in projects for young people, especially in the areas of pregnancy and STD/AIDS prevention. Most of these activities broadly define "youth" or "adolescents" as their target audience. In reality, groups of young people are very different, and are attracted by different approaches and messages; in fact, the same socioeconomic or cultural group may need different messages at different stages of their young adulthood (Brabin, 1995).

It is important to pinpoint the specific target group in regard to age, marital status, residence, school status, gender, and other factors relevant to planned activities (Fee & Youssef, 1993; Kurz et al., 1995). Not only does this process allow a feasible work plan and appropriate strategy, it avoids the trap of reaching a group that is easy to reach — in-school youth — at the expense of more needy out-of-school young people (Hawkins et al., 1992; Senderowitz, 1995a; WHO, in press). For example, the CRUSH project in Kenya, mentioned earlier, found through a midterm evaluation that targeting "youth" in a wide geographic area was unrealistic and likely to result in a poor level of accomplishment. The revised target, out-of-school youth aged 12–18 in specific areas, was more manageable and resulted in successful achievements of their objectives (Chege et al., 1995).

Targeting younger, pre–sexually active teens was a successful strategy for the Peruvian FPA's Futures Youth Center. Before using this approach, the center attracted only those young people who feared they were pregnant. Effective targeting now attracts teens both before and after their sexual debut. This has the great advantage of teaching responsible behaviors before unsafe and unhealthy behaviors become entrenched (IPPF/WHR, 1995).

When resources are scarce, it may be especially important to identify those young people who are most vulnerable and disadvantaged (UNICEF, 1996). UNICEF Manila, for example, has made the most vulnerable, highest risk youth their priority target audience, especially identifying groups such as street youth, the sexually exploited, substance abusers, and those in conflict with the law (UNICEF Manila, 1995).

Among those program analysts assessing AIDS prevention programs for young people, there is a particularly strong view about adapting the messages and intervention so that they can be meaningfully related to the circumstances of various young people's lives. In that respect, it is felt, the more highly targeted a program is, the more effective it will be (Panos Institute, 1996).

C. Needs Assessment

Once a target audience has been identified, it is important to conduct a needs assessment of that specific group in order to plan relevant project activities (IPPF, 1995; Koontz & Conly, 1994; McCauley & Salter, 1995; Themmen, 1996; UNFPA, in press; WHO, in press). WHO, among others, underscores the importance of repeating this process at various times once the project is under way (WHO, in press).

This process was used with significant practical success by Mexfam in designing the Gente Joven project. A survey was done with 100 randomly distributed young people to determine their needs regarding sex education, contraception and youth services (Brandrup-Lukanow et al., 1991).

In HIV/AIDS prevention, understanding the target group's particular needs may be key to designing an intervention that will attract them. For example, a Brazilian project for street children began its design by conducting focus groups and in-depth interviews to understand their high-risk behaviors, especially the role of sex in their lives, and what is important to them. They were then able to build into their plans approaches and messages that realistically related to their lives. In this case, current values and needs were incorporated by emphasizing the link between preserving health (avoiding AIDS) and survival (Merritt & Raffaelli, 1993).

D. Youth Involvement

The involvement of young people in programs designed for them has become axiomatic, yet there is no actual evidence that such a component results in stronger impacts. At the same time, common sense dictates that the target group can best identify its own needs and feel more a part of an effort if it has the chance to be substantively involved.

Adult professionals, however, typically develop and implement projects without youth involvement in designing or carrying out activities. Probably this is a result of scarce time and inexperience and is almost certainly not ill-intentioned. Staff truly believe they know what youth need; as one analyst put it, "Programs are largely mirrors of how adults think these matters should be handled" (Paxman, 1993). A recent cross-cultural study concluded that youth programs suffer from the ambivalence resulting from adults' wanting to help young people to develop, but being unwilling to give up control over that process (MSI, 1995).

Many experts recommend that young people be involved in many, if not all, stages of their projects, including design, implementation, and evaluation (Koontz & Conly, 1994; McCauley & Salter, 1995; Monroy, 1992; MSI, 1995; Themmen, 1996; UNICEF, 1996; Weiss et al., 1996). Many agencies (such as Pathfinder International, WHO, UNFPA, UNICEF, and IPPF) have stressed this programmatic component as one of the important guiding principles in working with youth. The IPPF Task Force on Youth, for example, is adamant on the point, stating that tokenism is not acceptable. The Adolescent Health Programme at WHO is equally committed, concluding that youth involvement ensures project relevance, dedication to the project objectives, and personal development for the young participants (AIDSCAP, 1996; IPPF, 1995; PI, 1993; UNFPA, in press; UNHCR, 1995; WHO, in press; WHO/UNFPA/UNICEF, 1995).

Trends support this growing strategic emphasis on youth involvement. A study of 103 adolescent reproductive health projects, carried out by the International Center on Adolescent Fertility of the Center for Population Options, reported that more than one-half of the projects

involve youth in some significant way, indicating an increasing trend from an earlier study (Barker et al., 1991). An ICRW survey of 52 programs concluded that youth participation is the most commonly reported strategy among adolescent reproductive health projects, with 30 percent using this approach (Peplinsky, 1994).

Several outreach projects have involved youth in significant planning functions. In Honduras, Proyecto Alternativas instituted a Youth Advisory Council to formalize planning and decision-making (WHO/UNFPA/UNICEF, 1995). In a peer facilitator program in the Philippines, young people were involved in the assessment and planning phases of the project. This opportunity generated considerable awareness and interest in acting to meet their own needs (UNICEF Manila, 1995). Some projects, as discussed above, make young people's involvement the centerpiece of the program from beginning to end. Youth for Youth is probably the clearest example of this approach, as young people decide what is to be done and how it should take place. They implement major activities and in some cases are involved in the evaluation of the projects' outcomes (IPPF, 1993).

Increasingly, young people expect to have a voice in programs for their well-being and notice when they are kept out of the planning process. When the ICRW evaluation team talked with members of the Under 20s Club in Grenada, the young people made an important point about the National Youth Council in their country. They noted that this council was established to define adolescent issues, yet it consisted entirely of adults who had never requested input from young people, something the young people viewed as likely to benefit the effort (Kurz et al., 1995).

The West African Youth Initiative (WAYI) is placing a major emphasis on youth involvement in its ten community-based peer education projects. The evaluation of WAYI is seeking to isolate and address this variable by assessing young people's ability to identify problems and generate solutions, by determining peers' contribution to changing KAP, and by examining staff attitudes and behaviors related to youth management of the projects (Advocates, 1996).

Preliminary results from the evaluation suggest overall support of youth involvement; nevertheless, some project site staff have not allowed youth a role in financial management, citing their lack of trust in youth concerning money (Lane, 1997a).

E. Community Involvement

As with youth involvement, community involvement has not been measured as a factor leading to programmatic success, but there is wide agreement that it does play a role (Barker & Fontes, 1996; Koontz & Conly, 1994; Moore et al., 1995; Paxman, 1993; Themmen, 1996). Many international donors and implementing agencies, such as Pathfinder International, WHO, UNFPA, UNICEF, and IPPF, have stressed involving community leaders as a key program design feature helping to ensure their support and acceptance (IPPF, 1994; PI, 1993; UNHCR, 1995; UNICEF, 1996; WHO, in press).

Depending on a program's objectives and sensitivities, specific groups are identified for special efforts; these can include, for example, policy makers, health professionals, and religious leaders. At the same time, the community as a whole needs to be engaged to consider harmful gender-related practices (such as forced sex, female genital mutilation, child marriage, and nutrition and education biases) that serve as barriers to improving young adult reproductive health (Moore & Rogow, 1994). An ICRW study on adolescents and AIDS concluded that communities might be

more willing to challenge traditional beliefs that result in holding back necessary information and services from young women if they were made aware of the positive benefits of such activities (Weiss et al., 1996). Using evidence to demonstrate that interventions can (or did) make a difference helps to gain this political support (IPPF, 1994; PI, 1993).

Community involvement is particularly important for outreach programs because they typically move into various locales and seek out one or more youth target groups in places where they live, work, and play (AIDSCAP, n.d.). Several projects reviewed earlier have found effective ways to inform, involve and gain the acceptance of the community — overall, or those sectors most critical to the project's success.

For example, a review of AIDS prevention activities in Haiti concluded that seeking the expert advice of "gatekeepers", or community leaders, before implementing a project helped win gatekeeper ownership, with the sense that they have a stake in the project's success. It can also, in turn, facilitate target audience ownership (AIDSCAP, 1996). An AIDS prevention project in Kenya, CRUSH, gained adult support in each sublocation through meetings with community leaders; this action introduced the project and strengthened the link between the project staff and the community, including the target group. The evaluation points to an interesting indicator of adult support: the high level of female involvement in the project indicated adult support, as girls' participation in public events is often severely limited (Chege et al., 1995).

In the UMATI project in Tanzania, FLE coordinators were trained to work with community leaders to raise their awareness and support of the project; leaders were identified and attended a two-day workshop in each region of the country. This action has been credited with assisting the project's launching and success (WHO, in press). SERVOL, in Trinidad and Tobago, used community meetings also, in order to design "respectful interventions" (WHO, in press). In a Botswana project with a fixed site, community members were invited to visit the center (PI, 1995).

In addition to gaining the support of key leaders, projects sometimes try to change views among the broader public. In the early stages of addressing adolescent reproductive health it may be necessary to foster public discussion in order to break traditional taboos against dealing with it (MSI, 1995). In the Philippines, the project for street youth actually went beyond discussion and leadership support: the community mobilization campaign, which reached far into all sectors of the various participating cities, turned public opinion from viewing street youth as lawbreakers to victims of poverty (WHO, in press).

F. Parental Involvement

Parents are an important subset of the community, whose acceptance and support are viewed as highly valuable to programs. Although this program design area, too, lacks conclusive evaluative data, there is general, but not unequivocal, agreement that parents' support should be gained (AIDSCAP, 1996; IPPF, 1994; Moore et al., 1995; Paxman, 1993; UNICEF, 1996). This is a challenging task; planners must assess the best way to involve parents with their own project culture (WHO, in press). An IPPF report suggests that one way to gain their support is to convince them of the consequences of *not* dealing with adolescent reproductive health (IPPF, 1994).

As a part of the community, parents are generally reached in much the same way as discussed above. Several center-based programs, such as in Tanzania and Botswana, have regular

meetings for parents. The UMATI project in Tanzania concluded that it was especially important for programs like theirs to gain parents' support, because absenteeism on the part of young women is typically caused by household obligations (PI, 1995).

Parents have an additional role as well; if parents are involved and well informed, they can play a direct role in communicating with their children. And young people have indicated a desire that their parents be better informed and, where possible, that they participate in special activities of youth programs (Kurz et al., 1995; MSI, 1995).

Parents themselves sometimes ask to be included, as in Mexfam's Gente Joven Project and in Profamilia's project in the Dominican Republic. In the latter case, parents objected to having their children trained as peer educators; in response, the project was revamped to include parents, which resulted in their active support (Stewart, 1996).

Beyond parental involvement in the peer education project, programs have included complementary parent education projects that train parents to be the primary sex educators of their children (Alexis, 1996). In Zimbabwe, the National Family Planning Council offered a parent education program to help parents educate their adolescent children about sexuality and reproductive health (WHO, in press). In Tanzania, the Parent Education Program developed a manual for trainers to help parents communicate with their children by increasing their comfort level and information base. The evaluation concluded that a high degree of need and interest exists, which was only partially met. The project succeeded in increasing awareness among parents of the need to discuss sexuality with their children, but they had not yet mastered the facility to do so (Binagi & Mbunda, 1993). In Malawi, a parent education project succeeded in helping parents and children to discuss reproductive health issues previously considered taboo (Banda, 1993). And in the West African Youth Initiative, parents asked to be trained as peer educators themselves (Lane, 1997b).

G. Evaluation Design and Monitoring

Evaluation has not been fully embraced by project managers as a critical element of their operations. Too often assessments of a project's activities are done retrospectively, by creative "bean counting" or amassing anecdotal evidence. Furthermore, this sort of exercise may be viewed as an external donor's requirement and not seen for the direct value it provides the project.

In some instances, a barrier to good evaluation is a perception that the answers are obvious and no inquiry is needed. A study in Mexico, Belize, and Peru found that many involved in peer counseling programs felt that they are the ideal, if not the only, way to reach youth. The model was unquestioned and the attraction of peer counselors became the ultimate goal. No need was felt for actually evaluating the effectiveness of the peer counselors (Bartling et al., 1996).

In order to have useful and accurate information about a project's accomplishments and outcomes, an evaluation plan and monitoring mechanisms must be built in from the start (or, technically, before the start, if baseline data are collected) (Bartling et al., 1996). A critical need, often ignored, in adolescent projects is the collection of data on program participants by relevant age groups (UNFPA, in press; WHO; in press). This may require one- or two-year groupings (and certainly not 15–24 or 10–19, as is common), given that adolescent developmental status and needs change so dramatically from year to year.

Among the lessons learned in the Red Cross Jamaica project is the importance of including an evaluation feasibility study prior to a project's implementation and evaluation. It is important to discover early if data collection systems are compatible and not to underestimate the human resources, costs, and time required to carry out adequate impact and outcome evaluations (Kauffman et al., 1996).

That evaluation can play a role in improving projects is increasingly being recognized and addressed, especially in more recently developed AIDS prevention projects (AIDSCAP, 1996). Organizers of the Red Cross prevention project in Jamaica grew to appreciate the benefits of its evaluation: instead of viewing it as personal criticism, they recognized its contribution to improved project design through individual feedback, regular debriefings, and quantitative reports, all part of the evaluation process (Kauffman et al., 1996). Another feature becoming more common is the involvement of young people in evaluation tasks; allowing them to play an active role rather than just being the *object* of the study facilitates the cooperation of young people in providing needed information and also in the resulting activities (Weiss et al., 1996).

Another useful tactic has been acquiring regular feedback from the target audience instead of waiting until the end of the project to assess what was positive or negative. A Brazilian project demonstrated the involvement of young people and also the use of ongoing feedback. The HIV prevention project for street children in Belo Horizonte held monthly meetings for peer educators — to learn from them and for them to learn from each other and from their supervisors. Repeat assessments are also being conducted of youth enrolled in a longitudinal study (Merritt & Raffaelli, 1993).

Positive evaluation findings provide a concrete way to demonstrate the effectiveness of a project and raise public discussion about needed programs for young people. Monitoring and evaluation were priority management concerns for SERVOL, in Trinidad and Tobago, and enabled them to use the findings to promote the organization. For example, an evaluation indicated that employers preferred SERVOL graduates, even compared to jobseekers with superior academic credentials, because of their vocational training and skills (WHO, in press).

Evidence of successful project activities, especially leading to community benefits, also helps projects with longer term funding and sustainability. This was true for SERVOL, which received increased financial support (WHO, in press). Another key impact of demonstrating success is the ability to use tangible evidence to gain or increase the support of policy makers, which is also critical to sustained program operations (PI, 1993).

H. Training

Training of peer promoters and adult counselors and supervisors is a critical element in all young adult programs given the special needs of this age group (Brandrup-Lukanow et al., 1991; IPPF, 1994; McCauley & Salter, 1995). Some analysts suggest that all staff involved in adolescent projects, including administrators, should receive training in order to be better managers, to know what to expect, and to be supportive (Hawkins & Ojakaa, n.d.; Hawkins et al., n.d.; Perry & Sieving, 1991). In projects that have peer promoters, there are many other professionals involved to support them and to follow up their referrals in serving young people.

The amount of training given to peer promoters depends greatly on what tasks and in what types of programs they will be expected to perform. In a study of 21 projects by AIDSCAP study, eight of the 21 projects provided training for peer educators of more than one week and seven

projects had three or fewer days, including two projects that reported training of from three to eight hours (Flanagan et al., 1996). A study of peer programs for WHO's Global Programme on AIDS underscored how the length of training is related to the subject matter to be covered. For example, in a smoking prevention program, sufficient training took only three hours, because the participants were familiar with the topic. On the other hand, a nutrition program required 10 hours of training, because this subject is more complicated and less familiar. The authors conclude that hours of required training depend on the length of the program, the percentage of activities to be led by peers, the difficulty of planned activities, and the knowledge needed to lead those activities (Perry & Sieving, 1991). The Jamaica HIV prevention project provided 27 hours of training in a residential format for its peer educators (Kauffman et al., 1996).

Because of both emerging developments in the field and turnover, training cannot be a one-time action. This is especially true in training peer promoters, given their temporary involvement. Although PROJUVE, in Mexico, started with a good training program, the quality decreased at a time of difficulties for the organization. This had a dramatic effect on the number of peer promoters active in the program, dropping to 20 percent of the previous number (Lobo, n.d.). But even in more stable projects, refresher courses are needed to impart new skills, correct misinformation, and focus on identified priorities.

Obviously, content of the training depends on information peers are expected to understand and use. If the initial training is comprehensive, dropouts are reduced and less retraining and supervision are needed (AIDSCAP, n.d.). In recent years, especially in AIDS prevention programs, more emphasis is being placed on training peers to master skills in order to help young adults not only understand but be able to act on what they learn as prevention strategies. Thus, skills-based training is recommended, involving such areas as risk assessment, negotiation, safer practices, dealing with violence and abuse, and use of services (Fee & Youssef, 1993).

One major task differential, which requires appropriate training differences, is between educators who provide information and referral and counselors who advise and work with individual clients in decision-making situations. Yet sometimes lines between these functions become blurred. In the AIDSCAP study, 12 percent of peer educators expressed the need for additional training in individual counseling techniques. Very often, peers expected to provide counseling are inadequately prepared (Flanagan et al., 1996).

Given that counseling is an emerging professional area, it is not surprising that counseling components in projects for youth are not meeting their needs. This is true for adult counselors as well as youth counselors. In Africa, several studies report this gap between training and performance. For example, in Burkina Faso, a study concluded that counselors need training to be able to deal with adolescents in a discreet and confidential manner without moralizing (Gorgen et al., 1993). In an Ethiopian project, with counseling key to the program, activities are limited because of too few trained counselors (Hawkins et al., n.d.).

In a project in Gambia, researchers conclude that there is a need for more training based on the observation that counselors could not answer questions presented by teens. Although the young people were referred to clinics for their answers, very few actually went (PI, 1995). In Kenya, FPAK's youth program, because of inadequate training, clinic staff depend on their own judgment in serving young people. This results in a wide variety of advice and guidance given young clients based on views such as feeling young girls should prove their fertility before receiving contraceptives or that they are too immature before age 18 to do so. In one situation, a

young pregnant girl was not informed about private abortion facilities but rather referred to a "rehabilitation centre" run by the Catholic Church (Hawkins & Ojakaa, n.d.).

Quality training materials appear to be a continuing need, at least for some types of programs. Gender considerations are important concerns in this area. For example, many materials still continue to stereotype genders, depicting women as passive or in family or reproductive roles rather than in work or productive ones (UNFPA, in press). An assessment of resource materials for adolescent reproductive health in English-speaking Africa found that although two training guides are available (from IPPF and WHO), they were not used in the five countries visited by the assessment team. A strong need for a comprehensive training guide was expressed by local and international experts (Themmen, 1996).

I. Selection of Peer Promoters

In general, the characteristics of a good educator or counselor are often overlooked when selecting individuals for these roles. A counselor should be capable of being respectful, nonjudgmental, and confidential (WHO/UNFPA/UNICEF, 1995). Such qualities are especially important when relating to youth, because many young people fear that they will not be respected and that their personal matters will not be treated with confidentiality; these concerns have been shown to keep young people away from reproductive health information and service programs.

Some added characteristics have been advocated when selecting youth as educators and/or counselors for their peers. They should be credible role models for the social competencies they will advocate, admired and respected for their social skills, and acceptable to young people, even if they are not as favored by adults (Fee & Youssef, 1993; Perry & Sieving, 1991).

While many projects have not articulated criteria for peer promoter selection, some have. For example, Mexfam's Gente Joven selects peer promoters according to their ability to establish good relations within a group, be enthusiastic and respectful, demonstrate interest in helping their peers, show commitment and responsibility, work at the community level, and deal with scientific information (Marques, 1993). The Jamaica Red Cross HIV prevention project established the following selection criteria: capacity to appeal to their peers as a group leader, ability to interact and communicate with peers, and ability to be trained as a peer educator. Academic talents and achievements are not taken into consideration, so that projects can draw from a wide range of young people who can relate to the target audience (Randolph, 1996). In Belize, a new project on preventing early, unwanted pregnancies requires that a certain percentage of peer promoters must be teen mothers (IPPF/WHR, 1995).

Some researchers and analysts have also set forth criteria for selection. In one study assessing the peer components of two Latin American projects, PROJUVE and El Camino, the author concludes that peer promoters should be committed to the practice of family planning (and practice it if sexually active), be committed to a high level of training, be able to command respect among peers, and possibly, be slightly older than the target group. Gender concerns should be considered, as well, as the author posits that girls may be more effective as youth promoters with girls, while males seem more willing to distribute contraceptives (Lobo, n.d.)

In a study of 21 peer education projects supported by AIDSCAP in Africa, Asia, and Latin America, the authors reported that project managers look for certain characteristics in their selection of peer educators. They seek young people who are accepted and respected, good at

communication, literate and charismatic, able to understand health problems, interested in self-enhancement, selected by their peers, and willing to be volunteers (Flanagan et al., 1996).

J. Tasks of Peer Promoters

1. Overview

Young people have always sought and received information from their peers. Now, however, with traditional sources of information from within the family and village becoming less available, young people turn to their peers even more (Barker & Rich, 1992). Having peers trained to provide information helps to ensure its accuracy and usefulness. Peers are often better at finding and contacting their own age and social groups (Fee & Youssef, 1993). Furthermore, peers as the transmitters of information may be especially important in reaching the most vulnerable groups, who can be mistrustful of traditional educational approaches (WHO/UNFPA/UNICEF, 1995).

Peer education is becoming a key feature of many programs designed to reach young adults. In a survey of 103 adolescent reproductive health projects conducted by the Center for Population Options, one-third used peer educators (Barker et al., 1991). AIDSCAP surveyed 21 projects to better delineate what peer educators do. They found that all reported undertaking one-to-one activities (such as informal discussions and referral for testing and services) and larger group activities (such as formal discussions, displaying educational materials, and organizing educational sessions). Seventy-one percent talk to 30 or more peers, with eleven percent of the total surveyed, who typically work with large groups, reporting reaching more than 500 each month (Flanagan et al., 1996).

2. Provision of Information and Education

Adolescents often have difficulty talking with adults about sensitive matters and tend to prefer peers, who are similar in age, background, and interests (WHO, in press). When the AIDSCAP survey questioned young people about whether talking to a peer educator is a good way to learn

about HIV/AIDS, 99 percent said that it was; when asked about their preferred source, 81 percent identified peer educators (Flanagan et al., 1996).

Some multiproject studies have found peers to be more effective than adults. Furthermore, this success has occurred in a range of cultures, settings, and risk groups (Paxman, 1993; Perry & Sieving, 1991). For example, young female Thai factory workers, out-of-school youth in Kenya, and young participants (in and out-of-school) in a Ghana YWCA project all preferred peer, over adult, educators (Cash & Anasuchatkul, 1993; Chege et al., 1995; Riley, 1995). A U.S. study comparing peer-led and adult-led AIDS education sessions found both to be equally effective in promoting knowledge gains and attitude changes. However, more questions were asked of the peer counselors, suggesting that AIDS may be seen as more of a personal danger when the topic is presented to adolescents by their own age group (Rickert et al., 1991).

In addition to the direct effects on their target groups, peer education programs can reach a wider audience. Whether planned or not, peers reach their own parents and the larger adult community with information about adolescent reproductive health (Lane, 1997a; WHO/UNFPA/UNICEF, 1995). And an additional multiplier factor was noted in the AIDSCAP study, which showed that nine out of ten of the target audience members reached by peer educators reported that they

shared their newly acquired information and skills with family members, partners, friends, and colleagues (Williams, 1996).

3. Provision of Counseling

In spite of all the benefits provided by peer education programs, a recent analysis suggests that its usefulness, in some instances, may have reached a plateau. After surveying 21 peer education projects, AIDSCAP concluded that if limited to a one-way provision of information, this strategy may be useful only in the early stages of the behavioral change process. In many places where basic AIDS information is well known, peers may need to enlarge their roles by broadening their messages, listening and discussing more than informing, and imparting skills for behavioral change (Flanagan et al., 1996). In fact, there is considerable evidence that providing information alone is not sufficient to generate changes in reproductive health outcomes; project interventions need to address communication, behavioral skills, and access to services (Moore et al., 1995).

Some projects are designed to use counselors rather than educators. For counselors of any age, training is essential, especially that focused on matters that adolescents are most concerned with: privacy, confidentiality, and nonjudgmental, respectful treatment (WHO, in press). In a review for WHO of counseling for the adolescent client, effective counseling was defined as "a combination of well trained, skilled and adolescent orientated counselors who use those interventions which recognize the particular developmental needs of the adolescent as expressed within their culture" (Wastell, 1995). Thus, compared to the provision of education, counseling requires more training and the acquisition of more skills. Increasingly, the counselor of young adults must also address related issues, such as sexual abuse and effects of violence, and must know how and where to link the client to needed health and legal services (Brandrup-Lukanow, 1991; MSI, 1995).

While peer counseling might include many of the same informational tasks as peer education, it is more individualized and focused on problem-solving and emotional coping strategies (Perry & Sieving, 1991). For such help, young people are more comfortable with peers, who seem to have fewer objections to their behavior and needs; with them, young people feel that confidentiality will be respected (Fee & Youssef, 1993; Flanagan et al., 1996; MSI, 1995). Yet many peer educators are expected to play a counseling role that they are not prepared for; such circumstances call for training to increase competency in relevant skill areas, as reviewed above (Flanagan et al., 1996).

4. Distribution of Methods/Referral

Peer educators sometimes and peer counselors more often distribute contraceptives. While little evaluation evidence is available about how well peers do with this task, the WAYI evaluation suggests that they are less effective at distributing contraceptives than at the tasks of informing, educating, and motivating youth to use contraceptives or adopt protective measures. A possible explanation involves youth concerns about confidentiality and their desire for anonymity (Lane, 1997a).

The actual acquisition of many birth control methods (other than condoms and foaming tablets) and medication for treatment of STDs is usually done at a health facility, following a referral by the peer promoter. Most successful programs appear to have effectively made the link between information and/or counseling and services (Paxman, 1993).

Many analysts and leading agencies recognize the essential link to services and highly recommend that it be a key aspect of the program, with effective referrals and resources for use by peer educators/counselors (Brandrup-Lukanow, 1991; Fee & Youssef, 1993; IPPF, 1994; IPPF/WHR, 1995; Koontz & Conly, 1994; McCauley & Salter, 1995; Themmen, 1996; WHO/UNFPA/UNICEF, 1995). STD diagnosis and treatment is much more complex than the distribution of preventive methods; thus, the ability to refer and the availability of referral facilities are critical to the peer role in linking the client to needed services. Another condition increasingly observed and requiring adequate referral is sexual abuse (Bruce, 1993). It is important for projects to factor in the needs of those whose sexual activity is nonconsensual (Moore & Rogow, 1994).

Even when peer promoters are well trained to refer for needed services, one of two major obstacles can prevent successful linkages. As is well known, young people do not like to go to health facilities for services. One way to address this difficulty for young people is to have the outreach counselor also present at the clinic at certain times. It is more problematic when available referral clinics will not serve young adults in a sensitive way — or at all. In an FPAK youth project, youth centers were not providing contraceptives; the evaluation of that project called for alternate points of referral even though such services would lie outside the FPAK structure (Hawkins & Ojakaa, n.d.).

K. Key Characteristics of Peer Promotion Projects

1. Defined Responsibilities

An important starting point for a successful peer program is a set of clearly defined responsibilities that are realistic and understood (UNFPA, in press; UNICEF, 1996; UNICEF/Zimbabwe, 1993). When obligations are not clearly agreed upon or if actions are left up to the discretion of the promoters, projects may fall short of their objectives. For example, in the PROJUVE peer promotion program, in which promoters were given a choice of activities with no obligations, larger percentages chose to participate in less controversial capacities, such as project promotion and training assistance, compared to the central tasks of making presentations, distributing contraceptives, and referring adolescents to the clinic (Lobo, n.d.).

The degree of structure and specified responsibilities desired by peer promoters appears to vary, according to one study of three IPPF programs. There was concern at Mexfam and INPPARES that peers might not react positively to a formal structure that would make specific demands on them. Coordinators felt that because peer promoters are volunteers, too much should not be asked of them and they should be able to have a major say in their workload. On the other hand, in the Belize FPA project it was felt that adding structure would address peer counselors' concern with lack of discipline while professionalizing their roles and increasing their pride in their work (Bartling, 1986).

2. Supervision and Support

Another critical element is effective supervision for the peers (Fee & Youssef, 1993; Lobo, n.d.; Paxman, 1993; PI, 1995; UNICEF, 1996), though the amount depends on the types of activities they carry out and the extent of training they have had (AIDSCAP, n.d.). In addition to overseeing their activities and needs as volunteers (or paid staff), supervisors need to provide reinforcements of efforts, perhaps including some sort of rewards or morale boosters (Lobo, n.d.). Care must be given to maintain attention to peers' professional needs throughout their

tenure and not just during the training phase. Refresher courses are often required for this purpose (PI, 1995). Also recommended is the provision of professional support to the peer promoters by health care providers to allow for personal mentoring and effective referrals (Flanagan et al., 1996).

Not much evidence exists about how projects handle compensation, either as salary or as reimbursement for such expenses as meals and transportation. The AIDSCAP study reports that 76 percent of projects surveyed give some type of compensation, including 19 percent that pay salaries and 52 percent that provide travel allowances. They also report differences in perceptions between project managers and the peer educators over what is needed and what is given (Flanagan et al., 1996).

While young adults often prefer peer counselors, they also appear to need the support of more mature and knowledgeable persons to who they can be referred (Chege et al., 1995). In fact, one study found that young people wanted competent, trained people for counseling with knowledge, reliability, and communication skills; they rated such characteristics higher than the age of the counselor (MSI, 1995).

3. Turnover

A major concern with managing peer programs is the high turnover. Aside from the fact of their growing out of the appropriate age range, young adults are busy moving on to other phases of their lives and careers. Thus, tenures are relatively short. For example, peer promoters remain with Gente Joven about six months and with PROJUVE around 19 months (Marques, 1993; PI, 1995). In a St. Lucia peer counseling program, only nine out of 20 were still participating 17 months after the program began (MOH St. Lucia, 1986). An AIDSCAP survey of 21 countries in three regions found that 68 percent of peer educators remained active more than a year (Flanagan, 1996).

In addition to time and broadening interests, another reason for peer promoters' leaving projects is financial. This was the major explanation given by Mexfam peer counselors in exit interviews (Bartling et al., 1996). In many cases, as they got older, young people needed paid jobs or they simply could not afford the unreimbursed costs of their volunteer work. Similar needs were noted at INPPARES, in Peru, but because most of this FPA's peer counselors were university students in psychology or social work, the relevance of the experience provided an incentive for remaining with the program (Bartling et al., 1996).

Experience of the West African Youth Initiative has demonstrated attrition for other reasons, including the treatment, support, and compensation of peer educators. From the peers' perspective, they complained that project staff set unrealistically high performance standards and did not provide adequate information and training. In turn, project staff have blamed peer educators for irresponsibility. A key factor related to this unresolved issue is the need to pay stipends or provide incentives and how this might affect performance (Advocates, 1996).

In Thailand, a successful program using peer counselors changed the counseling emphasis to adults in large part because of turnover reasons (UNFPA, in press). Because of the turnover problem, it has been recommended that more peers be trained than are actually needed so that alternates are in place and absentees or dropouts can be replaced quickly (Flanagan et al., 1996; Perry & Sieving, 1991).

The FPA in Colombia has developed a set of responses to the high turnover problem. These include establishing a more formal relationship with peer promoters, expanding peer responsibilities, increasing supervision, and strengthening peer commitment to promotion activities by creating two new programs. The new programs are: (1) an official agreement with the schools to allow students to fulfill a public service obligation by training other youth in family planning issues and (2) an arrangement with youth groups allowing participating members to retain their group identity while serving as peer promoters (IPPF/WHR, 1995). Contracting with young adults to commit to a minimum of 12–18 months can help minimize attrition (Alexis, 1996).

Although projects understandably regret losing peers from their programs, especially after investing considerable resources in their training, it is interesting to note that young people tend to continue playing the role of peer promoter years after their formal affiliation. In rural Thailand, for example, former peer educators were still providing information on reproductive health five years after leaving a project (UNFPA, in press).

4. Benefits to the Peer Promoters

There are advantages to serving in a peer promotion project (Bartling et al., 1996; IPPF/WHR, 1995). On matters directly related to AIDS and reproductive health, the AIDSCAP study reports that 95 percent of peer educators have made changes in their own life and behavior, 31 percent practiced safer sex and/or used condoms, 20 percent reduced the number of sexual partners, and 19 percent changed their own attitudes (Flanagan, 1995). A positive impact was also found on the attitudes and behavior of PROJUVE peer promoters (Lobo, n.d.). More generally, young people participating in peer education programs gain valuable skills, such as leadership ability, as well as self-esteem and a sense of belonging (Dietz, 1990).

5. Use of Quality Materials and Participatory Approaches

In their work, peer promoters need to use materials to help them educate and motivate their clients. It is important that they use materials that are clear, accurate, interesting, and relevant. Consideration should also be given to meeting the special needs of age, sex, and social context (WHO/UNFPA/UNICEF, 1995). In the reproductive health area, it is also important to relate to what young people want to know: how sexuality affects their relationships and their lives (McCauley & Salter, 1995).

As important as content, especially for young people, is presentation. In imparting information, many agencies believe that teaching techniques should be active and interactive, particularly allowing sufficient time for participants to discuss issues and ask questions (IPPF, 1994; Panos Institute, 1996; Themmen, 1996; WHO/UNFPA/UNICEF, 1995).

Participatory approaches are particularly important in teaching young people skills related to protecting their reproductive health. "Life skills," such as decision-making, personal communication, problem solving, negotiation, and self-awareness, are increasingly thought to be the most valuable lessons for young people to learn (Panos Institute, 1996; Perry & Sieving, 1991; WHO, in press).

Project experiences confirm expert recommendations. For example, in a Kenyan AIDS prevention project for out-of-school youth, the midterm evaluation indicated that participants were bored with the mini-lectures they received. The format was changed to emphasize

discussion and interaction, and the later evaluation showed that participants liked the new approach, preferring it to other sources of information (Chege et al., 1995). A Brazilian project chose to develop materials, such as a video and comic book, in order to stimulate group discussions, role plays, and theater and art activities. These interactive approaches were designed to be entertaining as well as educational (Merritt & Raffaelli, 1993). "Karate Kids," the adventure cartoon, is also designed to provoke discussion and is widely shown in over 60 countries (Connolly, 1992).

An interesting interactive project in Bangladesh developed a culturally specific teaching tool to help adolescent girls learn about their own health and encourage them to delay their age of marriage. The girls were provided with health cards to chart their height and weight at each clinic session; they also included various health education messages (Piper, 1992).

Developing and using skills have been shown to result in improved behavioral outcomes. One skill, ability to communicate with one's partner about sexual issues, is associated with better contraceptive use and safer sex. Although little research has focused on adolescent communication of this sort, one U.S. study found that adolescent women who communicated openly with their partners had the lowest risks of pregnancy and STD (Keller, 1996).

In Haiti, those participants who practiced negotiation skills or were provided with scripts were more successful in partner interactions (AIDSCAP, 1996).

In Zimbabwe, an experimental intervention was carried out to test the finding from developed countries that skills-based, participatory activities are more effective than information-based interventions in changing AIDS-related attitudes and practices. The two interventions compared were an hour-long lecture about HIV and an active 90-minute session that included a condom-fitting demonstration followed by individual practice, large- and small-group personal strategy sessions, demonstrations of assertiveness skills, psychodramas, and a video about a musician with AIDS. The evaluation concluded that the skills-based group was more knowledgeable about condoms and their correct use, perceived fewer barriers to action, reported fewer sexual partners in the previous month, and reported few coital acts without a condom in the previous month (Wilson et al., 1992).

IV. KEY PROGRAM ELEMENTS

Based on evaluative evidence and professional analyses and conclusions, the following elements appear to be valuable and beneficial in improving the design, implementation, and outcomes of outreach programs. The program implementation elements that follow the design and development section are limited to peer programs for several reasons. First, there is very little evidence indicating what elements of youth centers contribute to successful program outcomes. Furthermore, two of the key program offerings of centers, family life education and clinical services, are covered in other papers in this series. This is also true of the youth-oriented NGO activities. Also, these latter projects have not been subjected to rigorous evaluations. Finally, there is considerable and growing interest in the peer promotion model, which accounts for the disproportionate amount of evaluation and other assessments of this approach.

A. Preliminary Actions[1]

1. Program Design & Development

a. Strategic approach

From the earliest stage of program planning, designers should attempt to develop activities that are practically, financially, and politically feasible and will have the most impact. Lessons learned from other projects should be utilized, with care, and available, relevant research should be a starting point for more inquiries and/or project planning. Objectives, measurable wherever possible, should be clearly articulated and achievable. At the same time, building on a solid plan, flexibility should be built-in so that unanticipated opportunities can be seized; project leaders should be able to take some risks.

If the project is designed as a pilot, the feasibility of replication should be considered and expansion planned.

b. Target audience identification

From available or project-associated research, the prime target group should be selected to correspond with strategic objectives. Most often "youth" is broadly identified as the audience. Instead, the selection should be as specific as possible according to the demographic and other variables desired so that plans can be formulated for effective outreach. At a minimum, subgroup characteristics such as age, marital status, whether or not sexually active, gender, residence, in/out-of-school should be considered.

c. Needs assessment

In order to design a relevant and effective project, an assessment should be conducted with representatives of the precise audience targeted for services in view of the vastly different preferences found among groups of young people. This is especially important with marginalized groups who are mistrustful of traditional approaches.

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[1] These actions, which occur prior to project implementation, usually apply to all young adult projects and not just outreach programs. Because they are so crucial to project success, they are presented as part of this paper.

d. Youth involvement

In addition to determining program preferences (as noted above), youth involved in the design stage will also foster their perceived "ownership" of the project, thereby enhancing commitment and participation. To the extent practical and desirable, youth can also be active participants in the implementation and evaluation phases and should certainly, in any case, be provided the opportunity to give feedback as the project proceeds.

e. Community involvement

Inviting the community to become involved at an early planning stage helps to explain the objectives of the project and win their support. This reduces the risk of community opposition later. Depending on the project and the larger context, certain community groups such as policy makers and religious leaders may need to have special activities for their participation.

f. Parental involvement

Parental support (or absence of opposition) is significantly linked to their children's participation in reproductive health activities. Parents can also play an active role, if supportive and educated, by reinforcing positive health messages and practices.

g. Evaluation design and monitoring

The evaluation design should be appropriate to the level and nature of programming and assess not only targets (such as contraceptive use) but also skill acquisition (such as communication). Impact evaluations are very useful but should not be designed beyond the capability of the implementers. (Sometimes a university unit or international NGO can assist in this process.) Well-designed process and formative evaluations can provide useful information.

It is very important that mechanisms for monitoring be built into project design from the start and for an appropriate baseline survey to be conducted if needed for outcome measurements. Staff (and peer leaders, if possible) should be helped to play a role in the evaluation process. Service statistics should be kept by useful age groupings; for adolescents, this would ideally be in one- or two-year cohorts. Feedback opportunities for staff and clients should be established. It is key that administrators view evaluations as a means to learn about projects and improve their operations.

B. Peer Programs Implementation

1. Recruitment and Training

a. Peer selection according to characteristics

Young people to be selected as peer promoters should have certain important characteristics and interests. They should be capable of being respectful and able to hold confidences; credible role models, especially for the behaviors they advocate; admired and respected for their social skills; committed to good reproductive health, including contraception and STD prevention; and good at communication skills. They also need to share characteristics of their target audience (such as age, language, and ethnicity) so they are true "peers" and can relate well.

b. Training to assure competence for tasks

Training of peer promoters is highly predictive of how comfortable they will feel about their tasks and how effectively they will carry them out. The length of training depends on the complexity of the content, the amount of activities the peers will lead, the difficulty of the activities, and the amount of knowledge needed to lead those activities. Training should be participatory, teaching trainees skills they can then teach their peers.

If peers are to be trained as counselors rather than as educators, additional training is required that emphasizes such skills as effective listening, interpersonal communication, problem solving, and decision-making. Also, refresher courses are needed for participants to learn new information and brush up on areas they identify as weak.

2. Peer Promoter Tasks

a. Effective provision of information

Peer educators are the most typical form of peer promoters, imparting information, usually in small and large groups, organizing educational sessions, showing audiovisual materials, demonstrating condom use, and sometimes distributing condoms and foam. They become known as a source of accurate information and are sought out informally by their peers.

They should be able to provide accurate, relevant information and know how and where to refer if more or other types of information or services are needed.

b. Responsive counseling

Counselors require more training and are expected to perform more and more complex tasks. It is a more personalized activity than the provision of information, usually focused on problem-solving and emotional coping strategies.

c. Effective referral

Linkage to services is a critical aspect of effective adolescent reproductive health programs. Peer educators and counselors must know what resources exist and how referrals can be made to them, trying to assure that the client will follow up.

Referrals for certain circumstances are especially difficult, including HIV testing and follow-up and care for people who have been sexually abused or violated. Project managers must arrange for referral mechanisms and train peer promoters in effectively making use of them.

3. Key Characteristics of Peer Programs

a. Clearly defined responsibilities

Peer promoters need a clear understanding of what is expected of them. If managers hope to achieve a certain level of accomplishment, specific objectives and tasks must be identified and agreed upon by peer promoters.

b. Effective supervision and support

Peer promoters require close supervision of their activities and reinforcement of their efforts. This oversight must continue throughout the life of the project. Supervisors must work with peers to identify their task-related needs and areas for upgrading — and then address those gaps.

c. Participant access to adult professionals

Adult professionals should be available within programs when young adult participants indicate a need for this. Some young people prefer more mature counselors to meet certain types of needs.

d. Minimization of/planning for turnover

Young people will naturally grow older, leaving the age range appropriate for peer programs. But they also will move on to other pursuits faster than adults, given their need to establish personal lives and careers. Thus, turnover is predictably high.

While no solution fully addresses this problem, projects can minimize turnover by well supervising and rewarding their peer promoters to lengthen their tenure and by planning for an inevitable need for replacements. One approach is by training more promoters than needed to provide alternates for absentees and/or dropouts.

e. Use of relevant materials

Materials that peer educators use with their peers should be accurate, clear, interesting, and relevant. It is especially important for this age group to better understand how sexuality fits into their relationships and lives.

Young people are easily bored, so presentation of the materials should allow for participation and interaction, such as question-and-answer periods, group discussions, drama presentations, and role-playing.

f. Emphasis on skills-building

Beyond content, young people need to learn skills to protect and promote their reproductive health. These are critical "life skills" and usually include decision-making, personal communication, problem solving, negotiation, and self-awareness.

V. CRITICAL RESEARCH QUESTIONS

Very little high-quality research has been done on reproductive health outreach activities for young adults. In order to make basic decisions, therefore, about which models to design to achieve specific objectives, program planners are in a virtual wasteland. Furthermore, there is scant evidence beyond testimonials and expert opinion about effects of individual project characteristics, various training approaches, and actions to link clients to services. On peer promotion projects, in particular, little assessment has been carried out on the effects of selection criteria, supervisory procedures, salaries or other forms of payments, and support systems for these young project implementers.

At the same time, it is important to underscore that findings on these programmatic situations will vary from country to country (and possibly within countries), so that application of future research must be done with caveats and care. Nevertheless, some general answers and guidance would be helpful to program planners at the most basic stage of their design tasks. It is also true that a considerable burden must rest with the individual projects, for it is the needs assessment, conducted with the actual target group, that will help define the most relevant programmatic characteristics likely to be effective.

With those limitations in mind, the following are suggested as broad research areas to better define the types and characteristics of outreach projects that could improve reproductive health among young adults.

A. Role of "baby fathers" and families in centers for pregnant and parenting young women

What kind of involvement is possible or desirable for "baby fathers"? For parents? For extended family? What effects do various types of involvement have on the young woman's continuation in the program? On returning to school? On delaying the next pregnancy? On improving parenting skills?

B. Components of multiservice youth centers

What is the minimum constellation of services (educational, psychological, social, medical, and recreational) necessary or desirable to attract young adults to a multiservice center? Which are particularly needed or desired by out-of-school and highest risk youth? What are the relative costs of diverse components? What are the measurable outcomes of diverse components?

C. Overall effectiveness of peer promoter model

How effective are peer promoters/counselors in: (a) providing accurate reproductive health information; (b) making effective referrals; (c) providing contraceptives to those who need them (where appropriate); (d) providing effective counseling (where appropriate); (e) assisting programs to be more responsive to youth needs and concerns?

How much does it cost to recruit, train, supervise, provide ongoing/follow-up training to peer promoters/counselors? How do these costs compare to costs of other forms of promotion and counseling? How does their effectiveness compare to other forms of promotion and counseling?

What effect does their work as peer promoters/counselors have on these young people themselves, especially in terms of their own sexual and reproductive health?

D. Selecting peer educators

What selection criteria are associated with the effective participation of peer educators? With duration of involvement?

E. Training of peer educators/counselors

What minimum curriculum is necessary to train peer educators to perform basic tasks? What performance/competency-based standards should be used to assess adequacy? What additional curricular components are required to train peer counselors? Are certain skills-development approaches more effective than traditional approaches? What types of follow-up training are needed to maintain/improve performance?

F. Supervision and support of peer promoters

What types of supervisory procedures are effective in overseeing and providing support to peer promoters? What channels/mechanisms of feedback from peer promoters and access for peer promoters to the professional staff enhance competence and performance?

G. Increasing tenure of peer promoters

What conditions (training, allocation of tasks, supervision and support, compensation/reward, other) are associated with longer tenure of peer promoters?

H. Possible support of peer promoter "graduates"

Are there feasible "graduate programs" for peer promoters to keep them active in providing education to young adults following formal tenure with a project? Can they serve as role models? Can "graduates" play a useful role in training or mentoring recruits?

I. Linkage of outreach projects to services

What are effective mechanisms for linking outreach workers with needed services at fixed locations? What reproductive health services can outreach workers effectively provide in the field?

J. Couple communication

Can outreach workers effectively enhance couple communication on reproductive health matters? With what project activities? How is couple communication associated with improved protection against pregnancy and STD?

K. Protocols for cost comparison studies

What formulas and what standards are useful for comparing program costs of outreach projects?

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