



**World Health  
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## **Generating demand and community support for sexual and reproductive health services for young people**

A review of the literature and programmes

Department of Child and Adolescent Health and Development  
World Health Organization  
Geneva, Switzerland – 2009

# ACKNOWLEDGEMENTS

The Department of Child and Adolescent Health and Development (CAH) of the World Health Organization (WHO), would like to thank Amy Kesterton, formerly at the London School of Hygiene and Tropical Medicine (LSHTM), for preparing this review in collaboration with Susannah Mayhew, senior lecturer in Reproductive Health and Policy, LSHTM, UK. The work was supervised by Meena Cabral de Mello, Scientist, CAH/WHO who led and managed the project. Acknowledgments are also due to Hilary Standing, research fellow at the Institute of Development Studies and Director of the DFID funded Realising Rights Research Programme Consortium which funded some of the advisory input into this review. Jane Ferguson, Venkatraman Chandra-Mouli and Bruce Dick, members of the team of Adolescent Health and Development (ADH) in CAH/WHO, provided extensive comments on the various drafts of this document for which they are warmly thanked. Krishna Bose, Paul Bloem and Garrett Mehl of the ADH team also gave many useful inputs and suggestions for improving the document for which they are graciously thanked.

The conceptual framework of this document and its summary findings were presented and discussed in a regional consultation on community-based interventions to improve the use of health services by adolescents in Accra, Ghana, in February 2008. The participants in the consultation are duly thanked for their invaluable insights and feedback. They are (in alphabetical order): Gertrude Ananse-Baiden, Mary Nana Ama Brantuo, Irene Chami, Trovoada Daisy, Bassonon Dieudonne, Alassane Diop, Nafissatou Diop, Ndeye Nagatte Diop, Humphres Evelia, Anta Fall, Jane Ferguson, Theopista John, Gisèle Kaboré, Agnes Odawa Kinyanyi, Elizabeth J. Mapella, Louise Thomas Mapleh, Rose Maina, Hermenegildo Constâncio Mboa, Oppah Midzi, Susan N. Mutungi, Dorothy Mtemeli, Fatou Ndour, Jeanne-Monique Nougbara, Rejoice Nutakor, Silas Quaye, Diop Djibil Salif, Edith Tetteh, and Francis Xoagub.

Kompatibe Nagbandja, Regional Adviser in Adolescent Health for the WHO African Region, provided much guidance and support in the development of this work.

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WHO Library Cataloguing-in-Publication Data

Generating demand and community support for sexual and reproductive health services for young people: a review of the literature and programmes.

1.Reproductive health services. 2.Adolescent health services. 3.Community health services 4.Health knowledge, attitudes, practice. I.World Health Organization. Dept. of Child and Adolescent Health and Development.

ISBN 978 92 4 159848 4 (NLM classification: WA 330)

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Printed in

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**2009**

# CONTENTS

PREAMBLE.....	4
EXECUTIVE SUMMARY .....	6
<b>GENERATING DEMAND AND COMMUNITY SUPPORT FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG PEOPLE.....</b>	<b>6</b>
Evidence from developing countries on what works.....	6
Methodology for reviewing the evidence .....	7
What the review has NOT done .....	8
Summary of findings for interventions aimed at generating adolescent demand for sexual and reproductive health services for young people .....	8
Multisectoral approaches .....	11
Implications for policy-makers, programme development and delivery staff and researchers.....	11
<b>CHAPTER 1. INTRODUCTION .....</b>	<b>14</b>
1.1 The problem: under-utilization of sexual and reproductive health services (SRHS) by young people	14
1.2 Aims and objectives .....	15
1.3 Context.....	16
1.4 Multi-component and large-scale multisectoral approaches .....	17
1.5 Conceptual framework.....	18
<b>CHAPTER 2. METHODS.....</b>	<b>20</b>
2.1 Methodology .....	20
2.2 How to use this review .....	22

<b>CHAPTER 3. GENERATING DEMAND FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY YOUNG PEOPLE: INFORMATION, EDUCATION AND COMMUNICATION INTERVENTIONS .....</b>	<b>23</b>
3.1 In-school education .....	23
3.2 Community-based education .....	32
3.3 Overarching IEC methods .....	47
3.4 Finance interventions .....	57
3.5 Multi-component and multisectoral interventions .....	62
<b>CHAPTER 4. COMMUNITY SUPPORT FOR USE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY YOUNG PEOPLE: COMMUNITY AWARENESS-RAISING, PARTICIPATION AND MOBILIZATION .....</b>	<b>73</b>
<b>CHAPTER 5. CONCLUSIONS AND DISCUSSION .....</b>	<b>92</b>
5.1 Effectiveness of different types of intervention aimed at generating demand: Information, education and communication interventions .....	95
5.2 Effectiveness of interventions aimed at generating community support for use of sexual and reproductive health services by young people .....	99
5.3 Multisectoral approaches .....	102
5.4 What seems to work best in different contexts .....	102
<b>REFERENCES .....</b>	<b>103</b>

## PREAMBLE

Families and communities play a potentially central role in adolescent health and development. Despite recognition of the importance of family and community participation in adolescent programmes and several efforts in developing countries to foster such participation, this component remains weak in programming for adolescent health and development. Even when it is implemented, the link with health services is often overlooked or omitted.

The WHO Department of Child and Adolescent Health and Development (CAH) has worked to develop the evidence base through reviews of the experience of specific projects on adolescent participation and of interventions to support parenting. A review of interventions in developing countries to support parents has been completed, along with an initial paper about young people's health-seeking behaviours. WHO/CAH has also developed indicators for measuring young people's participation. A document entitled *Facts for Adolescents* is aimed at duty-bearers, such as parents, people working in youth organizations, teachers, and even health workers.

A major review was undertaken of the evidence in developing countries of interventions delivered through a variety of settings, including community settings, for the prevention of the human immunodeficiency virus (HIV) among young people (WHO, 2006). One of the evidence-based findings was that "training of health-care providers, making changes in facilities and undertaking activities to obtain community support can increase young people's use of health services...". Some potential for community-based interventions to increase demand for and utilization of services was found. However, it was recognized that there is inadequate knowledge about the impact of specific activities, and further work is needed (Maticka-Tyndale & Brouillard-Coyle, 2006).

The basis of our work on strengthening family and community action has been to address the knowledge gap in order to expand the scope and effectiveness of our work on the adolescent-friendly health services approach. Our focus is on two interrelated aspects: increasing demand by adolescents for sexual and reproductive health services (SRHS), and increasing community acceptance and support for the provision and use of such services.

In order to generate demand, adolescents need to be informed about the availability of services through a range of channels, including youth groups, parents, the media and schools. This information needs to include not only details about the availability of the services (when and where), but also information about why young people should use the services, and information to allay their anxieties about using them.

However, giving information and knowledge to adolescents is not enough. Adolescents' use of health services – especially reproductive health services – remains a sensitive issue in many communities. It is therefore important not only to generate demand but also to contact and inform a range of gate-keepers, from parents to religious and other community leaders, on the importance of service provision and to involve them in furthering the use of the services by young people for their reproductive health.

Despite the importance of these issues, there is a dearth of suitable tools to guide health planners and programme managers in initiating activities and projects in these areas. In order to support the health sector in identifying and implementing a few strategic, do-able, evidence-based interventions to create demand for sexual and reproductive health services by adolescents who need them, and to stimulate community acceptance and support for their provision, WHO plans to develop a tool based on the approaches that have proved to be effective in resource poor settings. The tool will describe the issues that planners and managers in health ministries need to consider for generating demand and community support.

Prior to the development of the tool, this global review of the evidence is being compiled to bring together systematically the evidence from published research and programme/project evaluations, as well as the perspectives of field experts in this area. The review provides assessments of the effectiveness of interventions for generating demand for health services for adolescents, such as: the provision of IEC (information, education and communication) through several different channels; information on health services, where services are available, and under what conditions; the use of referral systems; and the provision of funds/vouchers/subsidies to cover financial costs of services. Similarly, assessments of the effectiveness of interventions for garnering community acceptance and support include interventions such as providing information to influential community members about the need for health services for adolescents through a variety of channels (one-to-one discussions, cultural/social or school events, mass media) and activities to foster community engagement and participation in improving access to health services by adolescents. Such activities include different types of intervention, although several may be combined in one programme. At the community level there is also potential for the use of community saving and micro-insurance schemes, which have not yet been trialled with a specific focus on adolescents.

Community acceptance of adolescent reproductive health services is important in determining the uptake of these services. Young people are most likely to use youth-friendly services in those communities that demonstrate most awareness and approval. A supportive social environment (folk, popular, professional) also results in higher utilization rates. Improving supply side factors such as the friendliness of adolescent services and reducing barriers to access are only part of the picture; education of adolescents and broader social mobilization and community education interventions are also needed.

In February 2008, the WHO Regional Office for Africa, in collaboration with the United Nations Population Fund (UNFPA), hosted an expert consultation in Accra, Ghana, to review existing projects on community involvement, to discuss themes raised by the present literature review, and to build consensus on strategic orientations for improving community support and participation for adolescent reproductive health services. Despite recognition of the importance of community support and several efforts in countries to engender it, this component remains one of the weakest elements in adolescent health programming. Even when it is implemented, the link with health services is weak or non-existent. The regional consultation was thus organized to review all the different experiences to date and to identify the most effective interventions for strengthening the community component of adolescent-friendly health services. There was participation from the United Nations Children's Fund (UNICEF), UNFPA, the London School of Hygiene and Tropical Medicine, WHO headquarters and regional offices, ministries of health, nongovernmental organizations (NGOs) and youth associations of selected countries.

The conceptual framework for creating adolescent demand and community support for adolescent health services, as discussed in the present review, was presented at the consultation along with the main conclusions of the review. The discussion focused on the fact that despite limited data, a few effective actions to increase demand for services have been identified. Moreover, they can influence service utilization and they can also put pressure on the community to accept/support the provision of health services for adolescents. The evidence confirms the importance of engaging parents, adolescents and communities as part of a more comprehensive strategy for improving health service use by adolescents. It also highlights the need for stronger programme design and for the evaluation of projects that work with families and communities on influencing reproductive health behaviour and service use.

Participants in the WHO consultation concluded that activities to generate demand and support for adolescent-friendly health services must be integral components of adolescent health programmes. Programmes can do much more by using the current evidence that is synthesized in this review to strengthen demand and community support for adolescent health services.

## EXECUTIVE SUMMARY

### **Generating demand and community support for sexual and reproductive health services for young people**

#### **Evidence from developing countries on what works**

Approximately 85% of the world's young people live in developing countries. Most will become sexually active before their 20th birthday, and far too little is being done to meet their need for sexual and reproductive health information and services. Rates of early and unplanned pregnancies, unsafe abortions, maternal deaths and injuries, and sexually transmitted infections, including the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) are very high. It is estimated that more than half of all new HIV infections are among young people, while between one quarter and one half of adolescent girls become mothers before they turn 18. Adolescent girls are two to five times more likely to die during pregnancy or childbirth than women in their twenties (UNICEF, 2005).

In 2006 a major review of available evidence on preventing HIV in young people in developing countries was carried out by WHO under the aegis of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Interagency Task Team on HIV and Young People. Despite the constraints imposed by the quality of the data from most of the studies included in this review, it stated that “if countries want to move towards achieving the global goals on HIV and young people, there is sufficient evidence to support widespread implementation of interventions that include elements of training for service providers and other clinic staff, making improvements to facilities, and informing and mobilizing communities to generate demand and community support. These interventions will require careful planning and implementation, and their coverage and quality will need to be monitored. Operations research will also be needed as will a better understanding of the costs” (WHO, 2006).

In response to the recommendations from this report, the WHO Department of Child and Adolescent Health and Development (CAH) supported a further review to look in more detail at interventions specifically seeking to increase demand and support for adolescent sexual and reproductive health (ASRH) services in developing countries. The results are being published in the present document titled *Generating demand and community support for sexual and reproductive health services for young people: a review of literature and programmes*.

The report provides evidence of what works in order to guide national policy-makers, programme planners and donors in deciding how to allocate limited resources for efforts aimed at increasing adolescent demand for services and community support for their utilization and at meeting international commitments in this area. The International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994, called on governments, in collaboration with nongovernmental organizations, to meet the special needs of adolescents. This includes education, counselling and services in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. In addition, this evidence is important for informing progress towards achieving the global goals on young people of the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS) – particularly the goal that, by 2010, 95% of young people should have access to the information, skills and services that they need to decrease their vulnerability to HIV. Paragraph 26 of the Political Declaration



from the 2006 High Level Meeting on AIDS also explicitly states the need to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies for young people.

## Methodology for reviewing the evidence

Studies were identified through searches of electronic databases, web searches, and by looking at the bibliographies of known papers. Studies that met the inclusion criteria outlined in Table ES1 below were then critically reviewed by type of intervention and the evidence on the effectiveness was summarized. In total thirty studies were reviewed. Twenty-nine investigated interventions to increase adolescent demand for services delivered both through schools and in the community, including outreach from health facilities. The cross cutting methodologies of peer education and counselling, life skills approaches and use of the media were also looked at. Finally, finance interventions and multi-component approaches were investigated (chapter 3). Thirteen of these studies were also reviewed in relation to their impact on generating community support for service use, and they were combined with one additional study. The use of targeted community education sessions, festivals and sporting events, the media and broader community mobilization approaches were all reviewed (chapter 4).

**TABLE ES1. Inclusion and exclusion criteria for the review**

INCLUSION CRITERIA	EXCLUSION CRITERIA
<b>Part 1. Youth demand for SRH services</b>	
<p><b>Location</b></p> <p>Programmes/studies carried out in developing countries with sufficient details of intervention content.</p>	<p>Programmes/studies carried out in developing countries with insufficient details of intervention content.</p>
<p><b>Outcomes</b></p> <p>Programmes/studies that attempted to generate demand for and increase utilization of health services by young people.</p>	<p>Programmes/studies that did not attempt to generate demand for and increase utilization of health services by young people.</p>
<p><b>Evaluation design</b></p> <p>Intervention studies using the following designs:</p> <ul style="list-style-type: none"> <li>– randomized controlled trials;</li> <li>– quasi-experimental study designs.</li> </ul> <p>When outcomes measured are particularly relevant, studies using these additional designs were included:</p> <ul style="list-style-type: none"> <li>– data collected before and after (without comparison group);</li> <li>– cross-sectional (after only) when compared with others not exposed to the intervention or presented by level of exposure.</li> </ul>	<p>Interventions that did not use designs enabling the reader to evaluate the impact of the intervention or to make inferences based on statistical tests.</p>

*Continued...*

INCLUSION CRITERIA	EXCLUSION CRITERIA
Part 2. Community support for SRH service use by young people	
<p><b>Location</b></p> <p>Programmes/studies carried out in developing countries with sufficient details of intervention content.</p>	<p>Programmes/studies carried out in developing countries with insufficient details of intervention content.</p>
<p><b>Outcomes</b></p> <p>Programmes/studies that attempted to generate community support for and acceptance of provision of adolescent health services and their use by adolescents.</p>	<p>Programmes/studies that did not attempt to generate community support for and acceptance of provision of adolescent health services and their use by adolescents.</p>
<p><b>Evaluation design</b></p> <p>Intervention studies using the following designs:</p> <ul style="list-style-type: none"> <li>– randomized controlled trials;</li> <li>– quasi-experimental study designs.</li> </ul> <p>When outcomes measured are particularly relevant, studies using these additional designs were included:</p> <ul style="list-style-type: none"> <li>– data collected before and after (without comparison group);</li> <li>– cross-sectional (after only) when compared with others not exposed to the intervention or presented by level of exposure.</li> </ul>	<p>Interventions that did not use designs enabling the reader to evaluate the impact of the intervention or to make inferences based on statistical tests.</p>

## What the review has NOT done

While the report will make an important contribution, it has several limitations. In general, the evidence base in this area (demand and community support for ASRH services) is relatively undeveloped, and the papers that meet the inclusion criteria do not comprehensively cover all groups of young people (such as young migrant workers or soldiers) or all intervention types (such as traditional theatre). Additionally there is difficulty in disentangling the influences of different interventions within multi-component approaches, and studies do not look at the long-term impact of interventions or at the sustainability of changes.

## Summary of findings for interventions aimed at generating adolescent demand for sexual and reproductive health services for young people

**In-school education** interventions benefit from a ready-made audience and there is reasonably strong evidence of the benefits of using curriculum-based participatory and life skills approaches to increase knowledge and awareness. However, there are few evaluations of impact on utilization of services and the data that are available are mixed. The Frontiers studies in Bangladesh, Kenya, Mexico and Senegal found no consistent pattern between the countries, which suggests that effectiveness is highly specific to the context and that the intervention design and the interventions themselves need to be carefully tailored to the local area. Evidence for the potential impact of setting up active referral systems between schools and health facilities is more positive, as shown by Okonofua et al. (2003) in Nigeria. School-based health services, and linkages between schools and nearby services, have proved successful in the USA (Santelli et al., 2003).

**Community-based facilitated education sessions** have the potential advantage of reaching out-of-school young people as well as those in school. The former are often more vulnerable. Sessions can be more informal and relaxed, promoting more open and participatory discussion than in school. As with in-school education, participatory and life skills educational approaches show the greatest potential, but the informal nature of these means that curricula are less commonly used. Sessions within the community may struggle to maintain attendance over a period of time, with other commitments often getting in the way. The use of community members to carry out education in a culturally sensitive way also shows potential, as does the combination of these sessions with wider community mobilization activities. The use of established organizations that already serve young people, such as the scout and guide movements, has been shown to help sustainability. Although there is evidence of such interventions influencing knowledge of ASRH issues and some related behaviours, there is no strong evidence that it influences the uptake of services. Further research is needed into sustaining education sessions in the community and strengthening links to services.

**Youth centres** represent existing youth structures, much like schools do, and provide a ready-made target audience, but they also have the added benefit of involving out-of-school young people. There are many examples of youth centres being set up with an ASRH purpose in mind, and these tend to combine sexual and reproductive health services with recreational activities to attract young people, as well as providing vocational and educational components. There has been some success in promoting youth centres for information, recreation and services but, in general, evidence for encouraging young people to access services is poor. Those that do use the services tend to be older than the target age and often female. In general, the high costs of maintaining centres, compared to the costs of supporting outreach/peer promotion components of interventions, does not seem to be justified (Erulkar & Mensch, 1997; FHI/YouthNet, 2002). There is some evidence of young people's preferences for health facilities or for the private sector (e.g. pharmacies) when seeking commodities and services, and more research into the effect of youth centres on the uptake of other services available in the community would be useful.

**IEC outreach from health facilities** to promote their services can involve IEC (information, education and communication) materials and media, with community educators providing referrals, and this shows potential for increasing uptake of services. These techniques have been used as part of a broad social franchising model. Different versions of this approach can be used by government, not-for-profit and private sector providers. The innovative use of private sector outlets such as pharmacies needs further investigation since these are often the first choice for young people seeking contraceptives and other commodities.

**Peer education and counselling** is a popular and flexible approach that has been used in many different contexts (e.g. schools, universities, youth clubs and the community). Educators themselves seem to benefit the most but there is evidence of some impact on the knowledge and behaviour of recipients. Peer programmes vary considerably in objectives and operations. All provide education, but peers may also act as counsellors or condom distributors, or they may provide referrals to formal health services. These are often not closely monitored, however, and although there is some evidence for their impact on condom use the evidence is weaker for uptake of services. Youth and community participation helps retain and motivate educators, sustain programmes and maintain responsiveness to local needs. Evidence suggests that peer education is most effective as a component of wider interventions.

**Life skills education or broader youth development approaches** grew out of the failure of narrow problem-specific education programmes. The new approaches aim to address the wider determinants of behaviour, placing ASRH behaviour in the broader context of adolescents' lives. Such approaches should increase adolescents' autonomy, mobility, self-esteem and decision-making (WHO, 2005; Reynolds et al., 2006;

Blum, 1999). In many settings, reproductive health and livelihood interventions are beginning to be linked due to the combined needs of communities. These approaches show potential, and are certainly more effective than narrow didactic approaches. However, there has been little long-term evaluation and evidence available suggests that it is difficult to sustain changes after programmes are completed.

*The use of media* covers a wide spectrum of different approaches, from the distribution of IEC materials at health centres, schools, workplaces and other locations to comprehensive mass media campaigns using television and radio. In general, participatory education methods and a holistic approach to adolescent health are being advocated. Although printed IEC materials may be a valuable educational component, alone they are unlikely to produce changes in behaviour. The use of mass media is unique in its ability to reach large numbers of people easily, and this means it can influence social norms and practices and provide population-level sensitization to ASRH issues. Disentangling the impact of media efforts on knowledge and behaviour is difficult and, in general, evidence suggests that they are more effective in influencing the former than the latter. There is only weak evidence that media efforts successfully increase uptake of services, but more research is needed as this is often not adequately monitored. Media programmes seem to be most effective when combined with other complementary activities such as educational materials, entertainment and health services. Social marketing of ASRH commodities and services with focused marketing of branding also shows potential and requires further investigation.

*Finance interventions* and the provision of vouchers for subsidized or free ASRH services shows great potential but there is a lack of rigorously evaluated studies and a need for more research. Voucher schemes can utilize the private sector and give adolescents a choice of services so that they can pick the ones that they feel most comfortable with. The schemes show great potential for targeting adolescents even within a politically conservative context, and of realizing unmet demand for care. Such schemes require careful monitoring, however, and may be labour-intensive to run.

*Education sessions* that involve the wider community rather than just adolescents have the same problem of sustaining interest and attendance. However, they have the advantage of being able to encourage intergenerational dialogue and wider discussion even on taboo subjects, and they help to break down stigma and discriminatory attitudes. Sessions may be ongoing but are commonly concentrated in the first phase of programmes in order to gain support for the implementation of other intervention components, including the provision of services. In some cases it is necessary to make key actors in the community, such as parents and community leaders, an important focus of activities. For example, many parents and community leaders recognize that there is a need for ASRH education, but they usually do not agree to extensive or intensive education on sex or sexuality. They think adolescents will be promiscuous if they learn about sexuality and contraceptives and do not understand the risk of not providing information. Although the evidence is generally weak, there is some evidence of the protective effects of positive attitudes of parents and it has been observed that, in some contexts, it is impossible to address ASRH needs without support from key leaders and constituents. The targeting of key actors, especially at the beginning, is therefore a crucial phase in some interventions.

*Community IEC activities at festivals, celebrations and sports events, and use of media* can reach large numbers of people and have been used to draw attention to ASRH activities. There is no evidence of their impact on increasing uptake of services, and evidence for influencing knowledge and awareness is mixed. There is, nevertheless, potential for them to contribute to nurturing community support for addressing ASRH. These events must be part of a wider intervention and must be sustained rather than one-off in order to have a lasting impact. As mentioned above, mass media techniques can achieve very wide coverage and, if sustained, there is the potential to influence social norms – especially if messages are reinforced through other means.

**Community participation** encompasses a continuum of approaches from inclusive collective action and mobilization to simple community awareness-raising (see above). Community and adolescent involvement in the design, implementation and evaluation of interventions can help ensure that they meet the needs of the population, and also bring a sense of ownership that helps sustain the interventions in the longer term. There is some evidence that dealing with adolescents in isolation is not helpful and that programmes need to involve the adults around them (teachers, parents etc). There is evidence that broader community mobilization activities can help gather even wider support for ASRH programmes and can ease some of the barriers to adolescents accessing services (WHO, 2005). However, most studies are multi-component interventions with the separate components not evaluated.

## Multisectoral approaches

Adolescents are influenced by other individuals, their families, school, and community and societal factors. Thus, multi-component strategies that tackle at least some of these areas may be necessary to sustain changes in behaviour. Youth-friendly services alone do not meet adolescents' sexual and reproductive health needs and an important link with their wider developmental needs has been established. Overall, it seems that a comprehensive approach is most promising. Ultimately young people need relevant information, life skills and access to care when needed. These can be provided in various ways and the best methods probably vary by gender, developmental stage and social setting (Speizer et al., 2003). For example, it is clear that the needs and issues that influence the use of services by unmarried and married young people are very different. Premarital sex remains taboo in many areas of the world, and the sensitization and involvement of the wider community is particularly key if an acceptance of their need for contraceptives and services is to be established.

More large-scale, innovative, integrated, multifaceted research interventions in adolescent sexual and reproductive health are needed. Within these approaches there is the opportunity to incorporate a specific focus on generating community support and increasing adolescent demand for services into the various intervention components. Experiences from the African Youth Alliance indicate that this is possible, and that the impact of different components on service use can be evaluated.

## Implications for policy-makers, programme development and delivery staff and researchers

The sexual and reproductive health needs of adolescents are severely underserved and the provision of youth-friendly services alone is not sufficient to meet them. Supply side intervention needs to be combined with demand side activities to create a more supportive environment for adolescent care-seeking and increased uptake of services, and governments need to work in partnership with civil society and community organizations to reach young people effectively.

The intention was to gauge the strength of evidence for different intervention types and on this basis make recommendations for implementation. However, the limited number of studies explicitly measuring impact on service use and community support, and the prevalence of multi-component approaches, making it difficult to disentangle the effects of individual interventions, means this could not be done as rigorously as hoped. Table ES2 below summarizes the available evidence to inform the potential scaling-up of different intervention types. Individual studies have been highlighted which provide particularly rich information on influencing the outcomes of interest. The weak evidence base means that all intervention types need further investigation and a research agenda is outlined. It is essential that implementation of all interventions should be accompanied by careful monitoring and evaluation, and findings need to be published and made publicly available.

TABLE ES2

INTERVENTION	NUMBER OF STUDIES	DOES EVIDENCE SHOW THAT THE INTERVENTION WORKS?	MORE RESEARCH NECESSARY?
Type 1: IEC interventions to increase adolescent demand for ASRH services			
In-school education (not including peer-led)	<b>6</b> 1 highlighted (Nigeria, Okonofua et al.) (1 multi-component [AYA])	Yes, there is some evidence for participatory and life skills approaches having an impact on demand for and use of services. This seems to be most effective when schools and services are linked via a referral system.	Yes, there is particularly a need for more research into referral systems between schools and health facilities.
Community-based IEC (facilitated education sessions)	<b>2</b> Both highlighted (India, Pande et al.)	Yes, some impact on demand for and use of services demonstrated, and the value of a referral system highlighted (as above). There were problems with sustaining interest in education sessions, and the importance of youth and community involvement in intervention design and implementation in combating this is noted.	Yes, research is needed into referral systems and the impact that young people's involvement in programme design and implementation can have on sustaining interest and participation in activities.
Community-based IEC (youth clubs)	<b>3</b> No highlighted studies	Evidence shows that promotion of youth centres (e.g. through media and peer education) can encourage their use but most youth, particularly boys, visit for recreational activities and use of services within them is low.	Yes, research is needed into the potential for information, education and activities provided at youth centres to influence use of sexual and reproductive health services provided elsewhere.
IEC outreach from health facilities	<b>5</b> 1 highlighted (PATH RX, Thailand; Bond et al.) (1 multi-component [AYA])	Yes, intensive outreach from health facilities can promote use. The marketing and branding associated with social franchising shows potential. This can include involvement of the private sector, and the potential for referral between pharmacists and health facilities has been demonstrated.	Yes, further research is needed into the impact of social outreach from health facilities, and in particular social franchising including the role of the private sector.
Peer education	(1 multi-component [AYA]) No highlighted studies	Some evidence of potential for impact on demand for services, but peer education is usually part of a wider multi-component approach, making it hard to disentangle its individual effect. The main evidence available relates to impact on knowledge, with the effect greatest on the educators themselves.	Yes, further work is needed in which peer educators provide more formal links with services and uptake is measured.
Life skills	<b>2</b> 1 highlighted (BLP India, Levitt-Dayal)	Yes, the potential for ASRH issues, with a specific focus on service use, to be integrated into life skills approaches and to have an impact service use has been shown. However, there are large variations in the intensity and focus of life skills approaches, and integration needs further exploration.	Yes, more studies are needed on integrating ASRH service-specific education into life skills programmes and on the potential for setting up referral systems.

Continued...

Use of media	<b>2</b> 1 highlighted (Zimbabwe, Kim et al.)	Yes, there is evidence of the potential for media to influence service use and it is most effective when intensively implemented, with the effect increasing with level of exposure. There is stronger evidence of the impact on knowledge, and use of the media is typically combined with wider intervention components, making it difficult to evaluate its effect.	Yes, more research is needed to identify the specific impact of mass media alone and its potential for sustained change.
Vouchers for ASRH services	<b>2</b> 2 highlighted (Nicaragua, Meuwissen et al.; Kenya, Erulkar et al.)	Yes, there is great potential for using vouchers to increase use of services. This approach has been shown to successfully meet adolescent demand for services within relatively conservative cultures, with high uptake of vouchers achieved.	Yes, voucher programmes need to be trialled in a wide range of cultural contexts and piloted on a larger scale.
Multi-setting and multi-component programmes (community, school and health service)	<b>7</b>	Yes, there is good evidence for the impact of comprehensive multi-component approaches on creating demand and influencing uptake of services. However, resource requirements are high and it is difficult to disentangle the effects of specific components.	Yes, rigorous evaluation is needed of individual intervention components within multi-component approaches.
<b>Type 2: Interventions to increase community support for ASRH services</b>			
Sensitization via multimedia	<b>1</b> 1 highlighted (Zimbabwe, Kim et al.)	Yes, a multimedia approach has been shown to raise awareness and to gather acceptance of ASRH service use, creating a more supportive environment.	Yes, further studies are needed to identify which components of a multimedia approach are most effective and to look into the sustainability of changes after the duration of the campaign.
Community participation and mobilization	<b>9</b> 4 highlighted (Zambia, Mmari & Magnani et al.; Burkina Faso, Yaro et al.; Jamaica, Tiffany et al.; AYA)	Yes, sensitization of the wider community, with a particular focus on key stakeholders, such as parents and church leaders, has been demonstrated to assist in opening dialogue on sensitive ASRH issues. This can have an impact on social norms and lead to a strengthening of support for use of ASRH services. A correlation between acceptance of ASRH services and their use has been shown.	Yes, further research is needed into the most effective approaches to mobilization – in relation to gaining support for services.
Community participation and mobilization, including involvement in intervention design	<b>4</b> 3 highlighted (Nepal, Mathur et al.; India, Pande et al.; Mozambique, Senderowitz et al.)	Yes, more explicit participation in intervention development can also help establish a supportive environment for ASRH service use, and a sense of community ownership of a programme so that it is implemented in a locally acceptable way.	Yes, further work is needed into the key elements of community participation in the design and implementation of interventions for gaining ownership and support specifically for service use.

## CHAPTER 1. Introduction

### 1.1 The problem: under-utilization of sexual and reproductive health services (SRHS) by young people

Approximately 85% of the world's 1.5 billion young people<sup>1</sup> live in developing countries. Most will become sexually active before their 20th birthday, many within the context of marriage. These young people urgently need reproductive health information and services to prevent early and unplanned pregnancies, unsafe abortions, maternal deaths and injuries, and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (UNFPA, 2005).

Adolescent girls are a particular priority in developing countries. Between one quarter and one half of adolescent girls are mothers before they turn 18, and about 14 million adolescent girls (15–19 years) give birth every year. Contraceptive use can mean the difference between early pregnancy and an education. Married adolescent girls are particularly vulnerable to dropping out of school, early childbearing, HIV infection from older husbands, and sexual violence (UNFPA, 2005). Utilization of antenatal care by adolescents is poor, with reasons including an inability to recognize pregnancy, lack of availability or accessibility of services, and coercion and violence during pregnancy. Many women do not deliver in health facilities and are not aided by a skilled birth attendant. In Asia, adolescents appear over-represented in this group. In Africa, there is no difference between adolescents and older women in this group (WHO, 2005; Reynolds, Wong & Tucker, 2006). Adolescent girls are two to five times more likely to die from pregnancy or childbirth than women in their twenties (UNFPA, 2005) and more adolescent girls die from pregnancy and childbirth-related complications than from any other cause (Reynolds, Wong & Tucker, 2006). Adolescents also seek abortion later in pregnancy than other women and they undergo 5 million unsafe abortions every year as a result of unwanted pregnancy – many resulting in permanent injuries and deaths.

HIV and other sexually transmitted infections are also a big problem. It is estimated that 50% of all new HIV infections are among young people (about 7000 young people become infected every day), and that 30% of the 40 million people living with HIV are in the 15–24-year age group. The vast majority of young people who are HIV positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners ((WHO, 2006).

There is a consensus that these problems must be addressed and that they require adolescent-specific designs that include the adaptation of adult information, counselling and services. They also need to take a broader approach to meet adolescents' developmental needs with life skills training – both related to adolescent sexual and reproductive health and more broadly – with linkages to emerging adult concerns such as developing a secure livelihood through job training and income generation (Senderowitz, 2000).

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<sup>1</sup> Young people are defined in this report as those aged 10–24 years; this group combines adolescents – aged 10–19 years – and youth – aged 15–24 years. While providing access to adolescent friendly health services is an integral part of any national prevention programme, provision and use of services remains insufficient. Although adolescents make up a segment of the population that is particularly vulnerable to sexual and reproductive health problems, they are less likely to seek preventive and curative treatments than people aged 20–24 in most countries and they typically have lower access to effective health services. The aim of this Review was initially to focus explicitly on the interventions for generating demand and community support for the use of sexual and reproductive health services by adolescents. However it was frequently impossible for authors to find sufficient age disaggregation in the published reports of the original studies to be able to maintain this focus. It was therefore decided to include interventions that focussed on adolescents and/or youth or young people, and these terms have been used throughout this document as they were referred to in the literature.”



## 1.2 Aims and objectives

The adolescent period shapes powerfully how boys and girls live out their lives in the sexual and reproductive health (SRH) arena with long-lasting consequences on their health, development and well-being. There is an obvious need to address adolescent SRH issues. Health professionals and policy leaders are building on political commitments to formulate and deliver adolescent health programmes – including those targeting sexual and reproductive health. During the past 10–15 years a number of development partners have worked to conceptualize and pilot the adolescent-friendly health services approach in several countries. A review of the experience has made it clear, however, that the provision of adolescent-friendly services alone is not sufficient and does not guarantee the use of these services by those who need them most. It has been increasingly realized that the provision of youth-friendly services needs to be accompanied by activities by the health sector to mobilize demand and community support for the use of these services by adolescents.

In 2006 a major review of available evidence on preventing HIV in young people in developing countries was carried out by WHO under the aegis of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Interagency Task Team on HIV and Young People. Despite the constraints imposed by the quality of the data from most of the studies included in this review, it stated that “if countries want to move towards achieving the global goals on HIV and young people, there is sufficient evidence to support widespread implementation of interventions that include elements of training for service providers and other clinic staff, making improvements to facilities, and informing and mobilizing communities to generate demand and community support. These interventions will require careful planning and implementation, and their coverage and quality will need to be monitored. Operations research will also be needed as will a better understanding of the costs” (WHO, 2006).

The following specific recommendations were made:

### For policy-makers

- The evidence is sufficient to support widespread implementation of interventions to increase young people’s use of health services. However, these interventions should be implemented only if they are carefully monitored and evaluated.
- Interventions to increase young people’s access to health services should be linked to interventions in other settings that aim to improve young people’s knowledge, skills, attitudes and behaviours.

### For programme development and delivery staff

- In order to increase young people’s use of services it is necessary to train service providers and other clinic staff, make facilities more accessible and acceptable to young people, and work in the community to generate demand and community support.
- It will be important to better understand the key components of training programmes for services providers and other clinic staff, the most important improvements to make in health facilities, and the most strategic actions to take in the community. This will require careful monitoring and links with researchers.
- Interventions implemented through health services need to be carefully planned and monitored, and linked to actions in other sectors. In addition, in order to ensure that these interventions have the desired impact, evaluation and operations research should be actively supported.

(WHO, 2006)

The present review builds on these recommendations by looking in more detail at how utilization of health services can be increased through activities aimed at creating demand among adolescents and at generating community support for the provision and use of health services. The review aims to meet requests from countries for recommendations on the most effective methods for intervention in these two areas. It represents the first stage in the development of a tool to support decision-making by programme managers implementing community-level SRH interventions.

The specific aims of this review are:

- to provide an overview of interventions aiming to increase demand for sexual and reproductive health education and services, and to increase community acceptance and support for their provision and use;
- to formulate implications for action and research based on the effectiveness of interventions.

Although some interventions explicitly focus on adolescents or the community, multi-component approaches generally try to address both.

The ultimate objective is to contribute to national efforts to prevent pregnancies that are too early and unwanted, to reduce mortality and morbidity during pregnancy in adolescents, to prevent STIs/HIV, and to provide treatment, care and support to adolescents/young people living with HIV.

### 1.3 Context

Youth sexual and reproductive health activities broadly operate at three main levels: the political level at which policies are developed, the service provision level where care is provided, and the community level which is the focus of the present work.

Community-level interventions include a range of different types. In the present review the two areas of particular focus are community activities to increase demand for services and activities to increase community support for service use by young people. IEC activities are needed to provide young people with the information and skills to make the right decisions about health-related behaviours, including the use of services (WHO, 1999). Education programmes are taking place in schools, with teachers trained in providing sexual and reproductive health education. Youth centres and camps are also common sites for education interventions with a particular emphasis on reaching out-of-school young people. Peer counselling has been found to be a popular methodology, as has the use of the mass media which has achieved wide coverage of messages. Some programmes include wider life skills training, helping adolescents to build social networks and develop emotional and decision-making capacities (Sebastian et al., 2005).

Advocacy and awareness-raising activities can engage and involve the wider community, as well as young people themselves, and can stimulate support for the use of ASRH services. Distribution of IEC materials, group meetings and discussion groups, training of community activists or educators, community events and use of the media are all popular approaches. Such interventions aim to influence social norms and to create environments that are more amenable to healthy behaviour choices. Youth and community members may be encouraged to participate actively in the provision of appropriate information and services and to help ensure that these services are genuinely tailored to adolescents' needs. A spectrum of community involvement exists, with participation possible in any or all the stages of programme design, implementation and evaluation.

It is important to acknowledge that although “community participation” in a project and “community ownership” of the project can be powerful influences, they are not universally necessary or possible. Providing outreach services in the community can still be valuable. In some contexts, particularly where there is conservatism or where groups are marginalized or stigmatized, interventions may successfully operate at the community level, targeting adolescents without requiring the specific involvement of the wider community (e.g. Managua voucher scheme, see page 56). This is especially true in the case of groups such as migrants or sex workers who may be marginalized. Use of the private sector also has good potential because of its existing wide network and “community reach”. Adolescents and others have been found to utilize this sector because it is easier to do so anonymously (Standing, 2004).

## 1.4 Multi-component and large-scale multisectoral approaches

Evidence suggests that the basic provision of adolescent information and services does not guarantee their uptake, and traditional approaches with a narrow focus on specific problem reduction (e.g. prevention of pregnancy and promotion of abstinence and condom use) have failed due to their limited capacity to fully address young people’s sexual and reproductive health needs. Many of the factors that motivate behaviour change and prevent risk behaviours go far beyond the typical remit of health programme managers (e.g. social norms, connectedness with family, school and/or community, and livelihood opportunities (Schutt-Aine & Maddaleno, 2003). A paradigm change has been called for in which policy-makers and programme planners take a holistic approach to adolescent development (Blum, 1999). As a result, peer education, life and livelihood skills development, media campaigns, parental education, and community campaigns and mobilization have all been tried.

Research suggests that programmes which use multisectoral approaches, combining activities at different levels and linking health sector interventions with other types of interventions delivered through other sectors, offer the most promise in sustaining behaviour change (WHO, 1999). This reinforces the WHO, UNFPA, UNICEF country programming framework which calls for programmes to provide support for adolescents in:

- receiving accurate information
- building skills (life and livelihood)
- obtaining counselling
- accessing health services
- living in a safe and supportive environment (WHO, UNFPA, UNICEF, 1997).

This review looks at components that can have a specific impact on uptake of health services, and that could be carried out by the health sector. However, one problem in evaluation is to distinguish, or even disentangle, the effects of individual interventions.

Despite their potential there are relatively few examples of large-scale or national level multisectoral strategies focusing on ASRH, although the African Youth Alliance and Reproductive Health Initiative for Youth in Asia programs are two. These require working at the system level, and may involve shaping policies and institutional changes. Effective collaboration and cooperation is also needed to ensure strong linkage between the components. Public sector partnerships at the very least need to involve ministries of education, health, youth and sports, social welfare and labour. Public–private (including NGOs) partnerships are also possible when a mutual goal is identified. It has been acknowledged that particular attention needs to be given to the building of community partnerships in which adolescents actively participate (UNFPA, 2000; Bond & Magnani, 2000; Bond, 2004). In multisectoral interventions, community-level activities are important for strengthening links between health promotion and service

utilization, and for gaining community approval and support for the provision of ASRH. Adolescents represent a dynamic section of the population, varying in their social environments, economic circumstances, culture, gender and marital status. A uniform approach is therefore not appropriate and intervention must be tailored to the local environment, and particular vulnerable or hard-to-reach groups may need targeting (Schutt-Aine & Maddaleno, 2003).

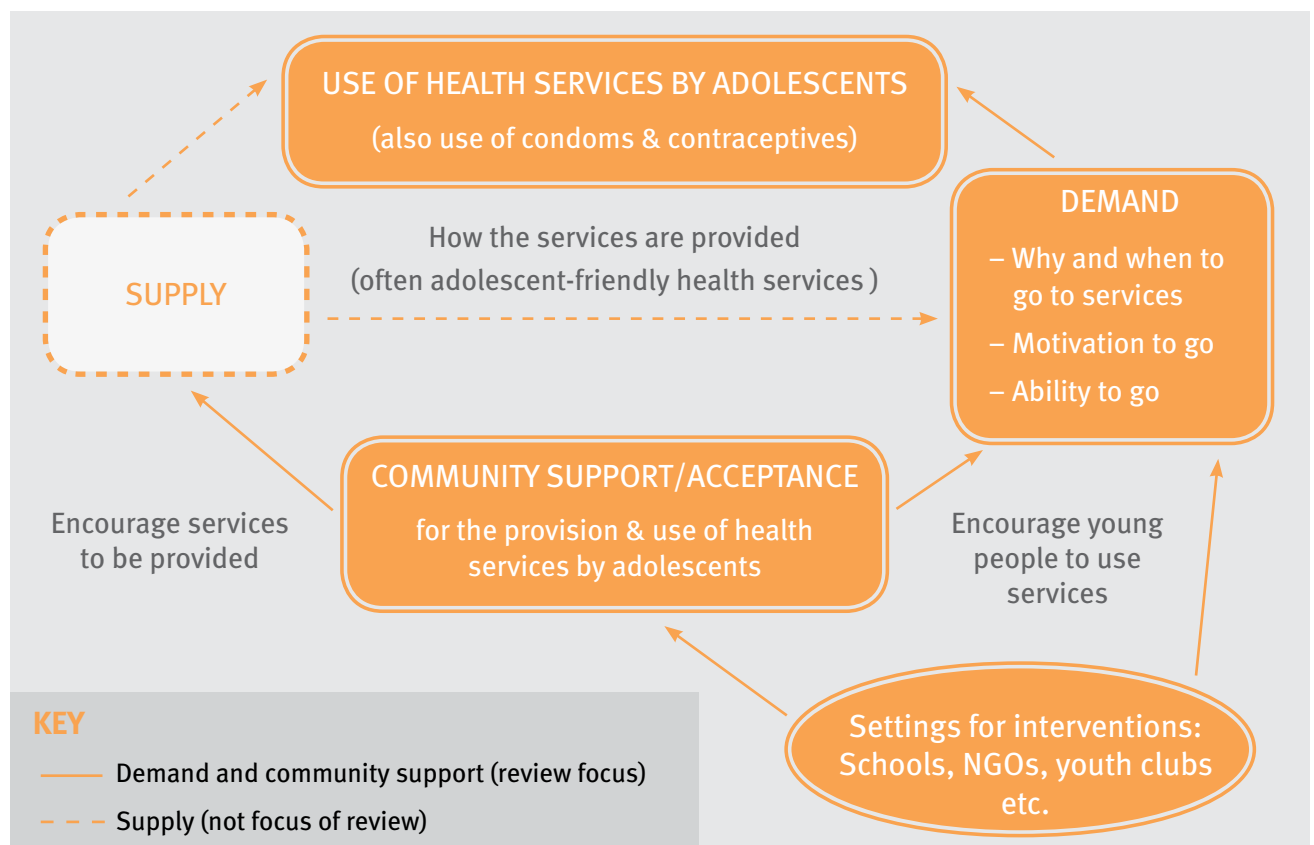
## 1.5 Conceptual framework

Figure 1 depicts the influence of demand and supply sides on the uptake of services and the underlying role of community support. Supply issues have been the focus of attention of WHO and many partners in recent years and have been extensively dealt with in numerous policy and programme documents. They will therefore not be considered in any detail in this document, although it is acknowledged that demand generation and community support factors, the focus of this review, would also have impact on supply side issues (e.g. hold providers to account, push for quality services).

In contexts where adolescent sexual health is a sensitive or taboo subject, or understanding of sexual and reproductive health problems and their need for care is poor, demand for care is often lacking. There is little documented evidence on how best to increase demand in such contexts.

Figure 1 shows that young people are more motivated or able to use youth-friendly services when they know why and when the services are useful and when they are enabled or empowered to go to the services. The services may even be delivered through different channels. In those communities that demonstrate most awareness and approval – i.e. community support for the provision and use of such health services – there is effectively more frequent use by adolescents (Nelson & Magnani, 2000). The definitions of “health services” and “community” as used in this review are provided below, along with the indicators for measuring demand for health services and community support for their provision and utilization.

**FIGURE 1. Conceptual framework**



## Definitions

**Health services:** public or private provision of medical interventions which prevent, diagnose or care for pregnancy; STIs and HIV in health facilities, other sites in the community and pharmacies.

**Community:** individuals living in the geographical vicinity of adolescents, including religious and traditional leaders, parents and teachers, but not health workers.

## Indicators

### *Community support/acceptance of service provision and/or use of services*

- awareness of adolescents' need for health services (*knowledge*);
- approval of service provision and use (*attitude*);
- action taken to improve provision of services to adolescents (e.g. through advocacy in the community) (*behaviour*);
- action taken to improve the use of services by adolescents (e.g. accompanying adolescents to services, providing funds for fees/transport to services) (*behaviour*).

### *Demand for health services for adolescents*

- adolescents know when and why health services should/could be used (*knowledge*);
- adolescents know where health services can be obtained and what the conditions are for their use (*knowledge*);
- adolescents state intention to use services, if needed (*motivation*);
- adolescents feel enabled to use services (*behaviour*).

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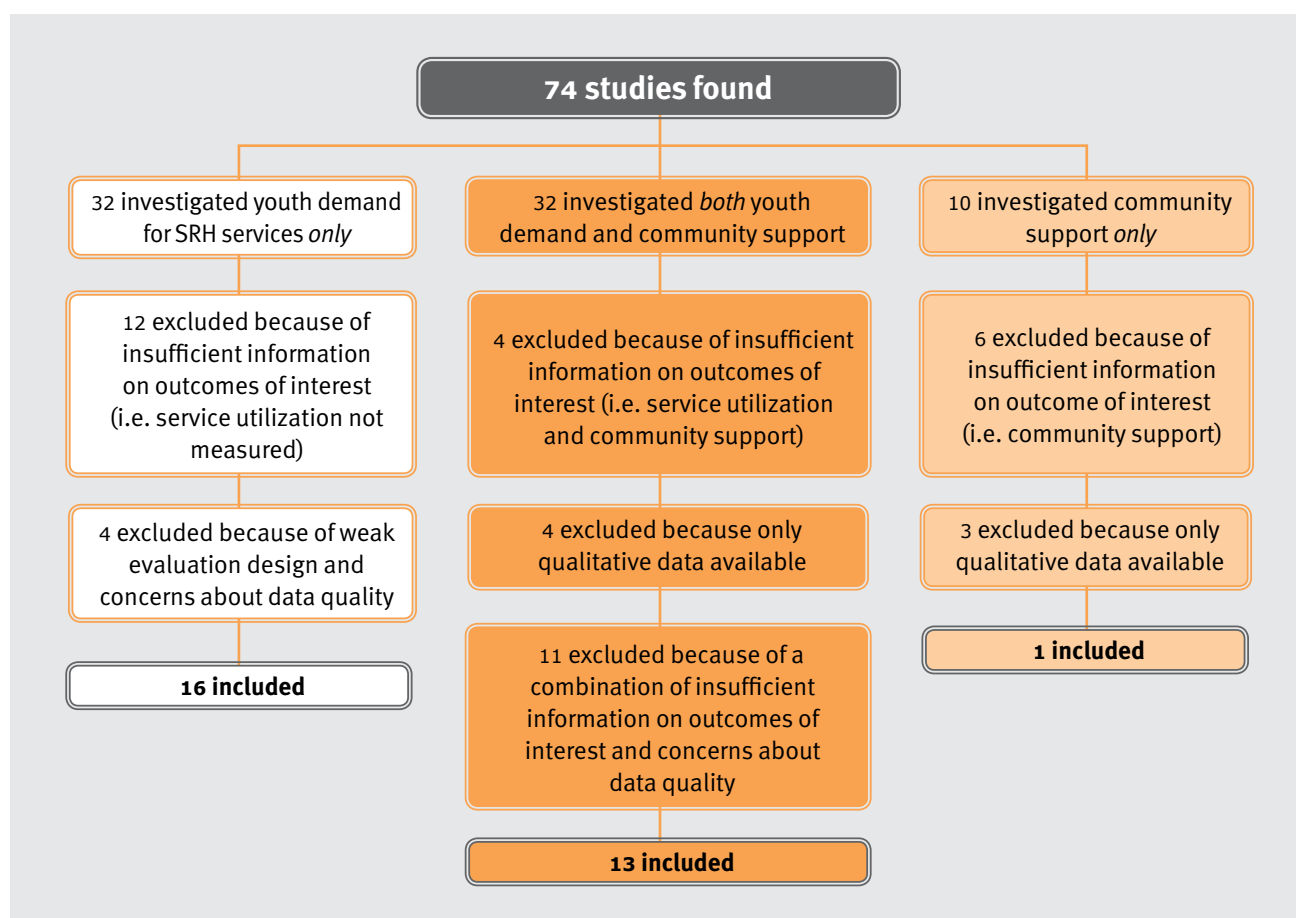


## CHAPTER 2. Methods

### 2.1 Methodology

Studies were identified through searches of the following electronic publication databases: PsychINFO, AIDSLINE, MEDLINE, POPLINE, ERIC, Sociological Abstracts, Social Sciences-Wilson Web, Leeds Sexual Health Database, Eldis and Id21. The search terms used were ‘adolescent reproductive health seeking’, ‘adolescent/youth health’, ‘adolescent/youth & reproductive health’, ‘adolescent/youth & sexual health’, ‘adolescent/youth health service utilisation’, ‘adolescent/youth health community intervention’, ‘adolescent/youth health & community support’. Additionally the web sites of organizations with related programming and research were thoroughly explored, these included AEGIS, AVERT, Core Initiative, Center for AIDS Prevention Studies, Development Gateway, DFID, EUROPEER, FHI, PAHO, UNAIDS, UNFPA, UNESCO, UNICEF, WHO, CEDPA, Alan Guttmacher Institute, EngenderHealth, Population Council, IPPF, MSI, Pathfinder International and PATH. The bibliographies of known conference proceedings, papers and journals with published review articles were also looked at. Finally, consultation with experts, in particular through a meeting organized by the WHO Regional Office for Africa in February 2008, was used to increase coverage of the grey literature.

**FIGURE 2. Selection of studies for review**



Through all these routes a total of 74 studies were found. Thirty-two studies investigated both young people’s demand and community support for SRH services, a further 32 looked only at youth demand and 10 focused only on generating wider community support. The studies were then all reviewed against the inclusion and exclusion criteria for investigating firstly, demand for SRH services by young people and secondly, community support for SRH service use. The criteria are outlined in Table 1.

**TABLE 1. Inclusion and exclusion criteria for the review**

INCLUSION CRITERIA	EXCLUSION CRITERIA
<b>Part 1. Youth demand for SRH services</b>	
<p><b>Location</b></p> <p>Programmes/studies carried out in developing countries with sufficient details of intervention content.</p>	<p>Programmes/studies carried out in developing countries with insufficient details of intervention content.</p>
<p><b>Outcomes</b></p> <p>Programmes/studies that attempted to generate demand for and increase utilization of health services by young people.</p>	<p>Programmes/studies that did not attempt to generate demand for and increase utilization of health services by young people.</p>
<p><b>Evaluation design</b></p> <p>Intervention studies using the following designs:</p> <ul style="list-style-type: none"> <li>– randomized controlled trials;</li> <li>– quasi-experimental study designs.</li> </ul> <p>When outcomes measured are particularly relevant, studies using these additional designs were included:</p> <ul style="list-style-type: none"> <li>– data collected before and after (without comparison group);</li> <li>– cross-sectional (after only) when compared with others not exposed to the intervention or presented by level of exposure.</li> </ul>	<p>Interventions that did not use designs enabling the reader to evaluate the impact of the intervention or to make inferences based on statistical tests.</p>
<b>Part 2. Community support for SRH service use by young people</b>	
<p><b>Location</b></p> <p>Programmes/studies carried out in developing countries with sufficient details of intervention content.</p>	<p>Programmes/studies carried out in developing countries with insufficient details of intervention content.</p>
<p><b>Outcomes</b></p> <p>Programmes/studies that attempted to generate community support for and acceptance of provision of adolescent health services and their use by adolescents.</p>	<p>Programmes/studies that did not attempt to generate community support for and acceptance of provision of adolescent health services and their use by adolescents.</p>
<p><b>Evaluation design</b></p> <p>Intervention studies using the following designs:</p> <ul style="list-style-type: none"> <li>– randomized controlled trials;</li> <li>– quasi-experimental study designs.</li> </ul> <p>When outcomes measured are particularly relevant, studies using these additional designs were included:</p> <ul style="list-style-type: none"> <li>– data collected before and after (without comparison group);</li> <li>– cross-sectional (after only) when compared with others not exposed to the intervention or presented by level of exposure.</li> </ul>	<p>Interventions that did not use designs enabling the reader to evaluate the impact of the intervention or to make inferences based on statistical tests.</p>

Thirty studies were included in this review. Twenty-nine have been included in chapter 3, all of them having strong evaluation design and providing useful information on outcomes related to increasing adolescent demand for SRH services. Some multi-component studies are included in more than one intervention section. This is the case when evaluation allows findings relating to a specific component to be elucidated, in addition to the overall impact. Thirteen of the studies included in chapter 3 also provide rich findings relating to the importance of community support for ASRH services and are therefore included in chapter 4 as well. These are combined with one additional study (not in chapter 3), giving a total of 14 studies for chapter 4.

The majority of the studies included use randomized controlled or quasi-experimental trials, which include a control group. The other evaluation designs do not account for the possibility that something other than the programme itself could cause the change in the outcome indicators (lack of a control group) but these have been included when a particularly in-depth investigation of the outcomes of interest has been carried out. Studies that provide the most useful information linking specific intervention types to outcomes of interest have been highlighted in the tables of chapters 3 and 4. Eight such studies have been drawn out from chapter 3 relating to the demand for services, and eight from chapter 4 focusing on community support.

All the studies that meet the inclusion criteria have been reviewed by type of intervention. The key types of intervention that policy-makers need to choose from are outlined with a description of their content and an assessment of their effectiveness in influencing the outcomes of interest. The intention was to gauge the strength of evidence for different intervention types and on this basis make recommendations for implementation. However, the limited number of studies explicitly measuring impact on service use and community support, and the prevalence of multi-component approaches, making it difficult to disentangle the effects of individual interventions, means this could not be done as rigorously as hoped. Instead, as mentioned above, individual studies have been highlighted which provide particularly rich information on influencing the outcomes of interest. The criteria for good evidence include: the quality of the intervention and its implementation; strength of the evaluation design; validity of indicators; rigour of results analysis; transparency in reporting (research design, methods etc); plausibility of the mechanism by which the intervention is linked to reported outcomes; and the feasibility of the intervention in terms of resources, logistics, acceptability etc. In deciding which studies to highlight, these criteria have been considered as far as possible. It is also acknowledged that some types of intervention need stronger evidence than others in order to be recommended. For example those that are more feasible, have lower potential for adverse outcomes, a greater potential size of effect and are more acceptable, in general require a lower threshold of evidence (Ross et al., 2006).

## 2.2 How to use this review

The review has two main chapters. Chapter 3 focuses on interventions that are aimed at adolescents and at increasing their demand for reproductive and sexual health commodities and services. Chapter 4 looks at the wider community and methods of increasing their acceptance and support of these same services. Each chapter describes different intervention designs and includes a discussion of the most promising interventions, followed by an evidence table outlining the studies. In chapter 3, intermediate outcomes are presented before the ultimate outcome of use of services so that the pathway can be seen. The programmes providing the best evidence are highlighted in the table and text, and key messages are drawn out at the end of each section.



## CHAPTER 3

## GENERATING DEMAND FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY YOUNG PEOPLE: INFORMATION, EDUCATION AND COMMUNICATION INTERVENTIONS

Adolescents have educational, informational and broader development needs. It is well acknowledged that adolescent-friendly services need to be supplemented with other efforts. On the most basic level, adolescents need to be informed what services are available. Adolescents may not appreciate why and when it is important to seek help, and education can combat this. It is also important that ASRH should not be divorced from adolescents' wider needs and livelihoods, and life skills education methods provide a more holistic approach. Overall, many different educational methods have been used, targeting in-school and out-of-school youths with a variety of multifaceted or single-pronged approaches.

### 3.1 In-school education

Five in-school programmes are grouped in Table 2, all of which measured their impact on adolescent demand and on service use. In Endo, Nigeria, health professionals (supported by peer educators) led in-school education via clubs and ensured strong links with health facilities. Evidence for an impact on service uptake is strong and findings show great promise for linking in-school education with services when an effective referral system is established (Okonofua et al., 2003). In Bahia, Brazil, the integrated approach based on schools and health clinics used a slightly different methodology. Teachers themselves were trained to provide classroom ASRH education, again combined with peer education. Findings indicated that the project was successful in increasing the flow of sexual and reproductive health information to secondary school students but that it failed to develop a replicable cross-referral system. Evidence for an impact on service uptake is much weaker than in Nigeria. The data do show that adolescents use public sector clinics for family planning purposes, however, which is useful justification for future investment in the clinics. The programme importantly had an impact on adolescents' intentions to use public health clinics in the future, and further work with a longer follow-up period is needed to evaluate the potential of this approach properly (Magnani et al., 2001).

The Frontiers programme led by the Population Council combined school-based education programmes with wider community activities and measured impact on service use. The programmes carried out in Bangladesh, Senegal, Kenya and Mexico all followed a similar evaluation design. Service and community activities were carried out at all intervention sites but only half received the in-school education component. In Kenya and Mexico no impact on service utilization was found. In Kenya the reasons for this included the fact that crucial actors such as school nurses and public health technicians were not involved and there was a lack of interaction between teachers and clinical staff. In Senegal, the site with the school intervention had higher indicators of knowledge and use of contraceptives and services than the other intervention site, although for other indicators the two sites were similar (Diop et al., 2004). The fact that other activities were taking place in the control makes it hard to draw strong conclusions or to link findings directly to the intervention. In Bangladesh the impact on service use was most marked and utilization of services from health facilities doubled in the site with just the service and community components and increased 10-fold with the additional school component. Again, other activities going on simultaneously made it difficult to strongly link the changes to the intervention. However, on the basis of these findings, it was recommended that a combination of reproductive health interventions at the school, community and health facility levels, accompanied by community sensitization, is needed to respond effectively to adolescent reproductive health needs. In the case of constrained resources though, schools and health

facilities should be targeted first for they have existing structures that can be more easily leveraged. In Bangladesh a large majority of adolescents were in favour of introducing reproductive health education in schools and they showed positive attitudes towards health facilities for services and a preference for them compared to pharmacies. This adds to the evidence base on attitudes towards different sources of care, which appears to be very context-specific (Bhuiya et al., 2004).

No clear overall pattern emerged among the Frontiers programmes to indicate that the interventions with school-based components were more effective in changing ASRH knowledge and behaviour than those with only community-based and health service interventions. The intervention sites generally did better than the control sites, but results were mixed depending on the indicator. For example, knowledge of HIV increased at all intervention sites in Bangladesh and Mexico, but declined at an intervention site and the control site in Kenya. No study found strong evidence of impact on demand or utilization of services. The type and intensity of activities that represent the different components appears to vary significantly in different interventions and are implemented in widely varying contexts. It was concluded that monitoring and documenting the progress of implementation and the quality of activities is important to understanding any direct relationship between interventions and outcomes (Maclean, 2006;).

The national multi-component African Youth Alliance (AYA) programme in Botswana, Ghana, Tanzania and Uganda (examined in more detail in section 3.5) included implementation of an in-school “life planning skills” programme, which showed positive impact and potential for scaling up. Separate component evaluations were carried out in the different countries and results of the in-school life planning skills programme in Botswana showed increased use of condoms and services. In 2004, the Ministry of Education adopted the AYA life planning skills manual for nationwide use in secondary schools. In Ghana, an evaluation showed a large increase in the percentage of students who were confident they could negotiate condom use, and who had the intention to do so. In Uganda, extracurricular ASRH activities were carried out in schools and a post-intervention assessment showed an increase in the percentage of participants who could articulate their personal values, talk to a parent, obtain youth-friendly clinical services, and resist pressure to have sex (AYA, 2007).

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**TABLE 2. In-school education programmes**

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES						
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	EFFECT SIZE	
<i>In-school education</i>						
1. Nigeria, Endo (Okonofua et al., 2003) Note: Peer education for adolescents took place in the community as well as in the school.	To improve uptake of ASRH services (for treatment of STIs) by in-school urban youths (high school 14–20 years).	Randomized controlled trial – 4 randomly selected intervention schools (and nearby STI treatment providers); – 8 randomly selected control schools; – pre (n=1896) and post (n=1858) intervention Surveys.	<ul style="list-style-type: none"> <li>In-school health clubs.</li> <li>Specially trained health professionals provided                             <ul style="list-style-type: none"> <li>– IEC material on treatment and prevention of STIs;</li> <li>– discussions, films.</li> </ul> </li> <li>Peer education                             <ul style="list-style-type: none"> <li>– link to services (given list of those providing adolescent-friendly services).</li> </ul> </li> <li>Linked health services                             <ul style="list-style-type: none"> <li>– providers trained (including pharmacists and private practitioners).</li> </ul> </li> </ul>	<p><b>RELATED OUTCOMES:</b> Adolescents</p> <ul style="list-style-type: none"> <li>know when and why health services should be used;</li> <li>know where health services can be obtained;</li> <li>state intention to use services, if needed.</li> </ul> <p><b>Statistically significant improvements in knowledge of sexually transmitted diseases, including symptoms i.e awareness if partner had STI in intervention sites.</b></p> <p><b>Statistically significant increased use of condoms in intervention sites.</b></p>	<p><b>PRIMARY OUTCOME:</b> Use of health services</p>	<ul style="list-style-type: none"> <li>Multivariate logistic regression with Huber's formula to account for school clusters.</li> <li>Treatment by private physicians increased (OR=2.1, 95% CI=1.1–4.0), and treatment by patent medicine dealers or pharmacists decreased (OR=0.44, 95% CI=0.22–0.88).</li> <li>Reported prevalence of STD symptoms in the past 6 months was significantly reduced in the intervention compared to control schools (OR=0.68, 95% CI=0.48–0.95).</li> </ul>

*Continued...*

<p>2. Brazil, Bahia</p> <p>The Strengthening Public Health Project</p> <p>Adolescent Reproductive Health Project</p> <p>May 1997–Nov 1999</p> <p>State Secretariats of Health and Education</p> <p>(Magnani et al., 2001)</p>	<p>To promote responsible sexual and health-seeking behaviours, including the use of public health clinics, among public secondary school students (focus on grades 6 and 8).</p>	<p>Quasi-experimental</p> <p>Matched control group panel design.</p> <ul style="list-style-type: none"> <li>– 6 pilot project secondary schools (4 in Salvador and 2 in interior of Bahia) paired with reference clinics and compared with matched (geographically, socio-economically and school size) control schools;</li> <li>– KAP baseline and endline survey (n=1480) (high loss only 2.6% intervention tracked, 30% control – therefore analysed as independent samples);</li> <li>– service statistics from health facilities;</li> <li>– clinic survey 1998 in 4 clinics (n=385);</li> <li>– teacher survey 1999 (n=34).</li> </ul>	<ul style="list-style-type: none"> <li>• School education <ul style="list-style-type: none"> <li>– inclusion of sex education in different school disciplines by trained teachers;</li> <li>– student peer educators trained;</li> <li>– cross-referral system between secondary schools and health clinics set up (contact between schools/teachers and health providers).</li> </ul> </li> <li>• Linked health services <ul style="list-style-type: none"> <li>– health providers trained (2 per clinic with one exception).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• No significant effect of project found on levels of sexual activity or contraceptive behaviour.</li> <li>• Modest but significant increase in students citing health centre staff as potential sources of reproductive health and sexuality information.</li> <li>• Twice as many students knew about the referral clinics and, of those, 51% could correctly name the clinic, compared to 12% at the baseline.</li> <li>• Information about obtaining a family planning method was the key motivating factor cited by those going to clinics.</li> <li>• Marginally significant increase amongst girls in intention to use STI services in the future.</li> </ul>	<ul style="list-style-type: none"> <li>• 18% of teachers in intervention schools reported having referred at least one student to a reference clinic in the 1999 school year.</li> <li>• In the endline survey <ul style="list-style-type: none"> <li>– 2% of students at intervention schools reported having been referred to a clinic by a teacher and 10% reported having been to a referral clinic.</li> </ul> </li> <li>This compares to the 24.3% who had attended any public health clinic in the previous six months.</li> <li>– Overall no significant evidence of increased use of services related to the intervention.</li> </ul>	<ul style="list-style-type: none"> <li>• Multivariate logistic regression. No increase in use of services amongst males OR=1.23 (95% CI: 0.16–9.7) or females OR=1.05 (95% CI: 0.19–5.76) compared with control.</li> </ul> <p>Three potential sources of bias in estimates highlighted</p> <ol style="list-style-type: none"> <li>1. Schools and clinics chosen in part due to their willingness to participate.</li> <li>2. Before and after groups differ due to high drop-out and reasons for drop out were not collected.</li> <li>3. Logistic regression only controls for chosen variables and other factors may be correlated with the outcomes of interest.</li> </ol>
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<p>3. Bangladesh Frontiers programme 1999–2003 (evaluation over two years, 2000–2002) (Bhuiya et al., 2004)</p>	<p>To improve SRH knowledge, attitudes and behaviour of in-school and out-of-school urban youths.</p>	<p>Quasi-experimental Site A: Intervention – youth-friendly services; – community interventions. Site B: Intervention (test additional effect of school education) – youth-friendly services; – community interventions; – in-school education. Site C: Control – baseline and endline population surveys (~6000 adolescents and 1500 parents) and qualitative interviews and focus groups; – service statistics.</p>	<p>• School education – led by teacher and peer supported; – trained to provide a participatory reproductive health curriculum tailored to in-school youth, and focusing on life skills. • Youth-friendly services – providers trained. • Community – life skills education; – peer education; – sensitization and awareness-raising (sessions with gatekeepers, parents, teachers, leaders).</p>	<p>• Knowledge of acquisition of HIV, acquisition of sexually transmitted diseases, and pregnancy prevention improved in intervention and control sites (greatest increase in Site A, without the in-school intervention). • Adolescents in Site B (with school) were more likely to support use of contraceptives by unmarried adolescents than those in Site A. • Adolescents in site B revealed a more positive attitude towards health facilities for contraceptive and STI services compared with pharmacies. • Use of condoms increased in intervention sites (greater improvement in Site B).</p>	<p>• Approximately one fourth (4,729) of the adolescent population in the intervention catchment areas visited the adolescent-friendly health facilities, including repeat visits. • Utilization of services doubled in Site A and increased 10-fold in Site B compared to the control. Use was 6 times greater in Site B compared with A. • Effect greater amongst in-school adolescents and lower for unmarried sexually active adolescents, many of whom are not in school.</p>	<p>• Significance testing or multivariate logistic regression of changes in use of services was not carried out. • Evidence that increases were due to intervention is weak (i.e. differences in characteristics of intervention and control groups not controlled for and many other ASRH activities going on in the area).</p>
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<p>4. Senegal Frontiers programme 1999–2003 (evaluation over 18 months) (Diop et al., 2004)</p>	<p>To improve SRH knowledge attitudes and behaviour of in-school and out-of-school youths aged 10–19 years.</p>	<p>Quasi-experimental Tested additional effect of school education (as above). Baseline and endline population surveys and qualitative interviews.</p>	<ul style="list-style-type: none"> <li>• School education <ul style="list-style-type: none"> <li>– led by teacher and peer supported;</li> <li>– trained to provide a participatory reproductive health curriculum tailored to in-school youth, and focusing on life skills.</li> </ul> </li> <li>• Youth-friendly services <ul style="list-style-type: none"> <li>– providers trained.</li> </ul> </li> <li>• Community <ul style="list-style-type: none"> <li>– peer education;</li> <li>– sensitization and awareness raising (sessions with gatekeepers, parents, teachers, leaders).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adolescents knowing one or more contraceptive method rose significantly at intervention sites. Better knowledge of ways of using contraceptives, especially condoms, was noted at Site B (with school) and knowledge of health facilities was significantly greater than the control.</li> <li>• Attitudes towards use of these methods improved, greater tolerance among unmarried adolescents.</li> <li>• Knowledge of health facilities increased at Site B and at the control site, but not at Site A, where levels were already relatively high.</li> <li>• Intervention had no effect on use of contraceptives, including condoms (although there was some limiting of sexual activity).</li> </ul>	<ul style="list-style-type: none"> <li>• Visits to health facilities were low before the intervention. There was a significant rise across all three sites but levels remained modest – below 20% (e.g. amongst 15–19 year olds: Site A boys 8%–13% (<math>p&lt;0.05</math>) girls 12–14% (not significant); Site B boys 6–7% (not significant) girls 8–18% (<math>p&lt;0.05</math>); Site C boys 9–12% (<math>p&lt;0.05</math>) girls 8–20% (<math>p&lt;0.05</math>). Only increase at Site B significantly (<math>p&lt;0.05</math>) greater than the control and was more pronounced for older adolescents (15–19).</li> </ul>	<ul style="list-style-type: none"> <li>• Confidence intervals of changes in service use not reported.</li> <li>• Multivariate logistic regression of use of services was not carried out. Evidence that increases were due to intervention is weak. A large proportion of adolescents were found to be receiving ASRH information in the control, implying that intensive activities were also carried out in this area (by other groups) making it difficult to link findings directly to the intervention.</li> </ul>
<p>5. Mexico Frontier 1999–2002 (evaluation over 18 months) (Vernon &amp; Dura 2004)</p>	<p>To improve SRH knowledge attitudes and behaviour of in- and out-of-school youths.</p>	<p>Quasi-experimental Tested additional effect of school education (as above). Baseline and endline population surveys and qualitative interviews.</p>	<ul style="list-style-type: none"> <li>• School education <ul style="list-style-type: none"> <li>– led by teacher and peer supported;</li> <li>– trained to provide a participatory reproductive health curriculum tailored to in-school youth, and focussing on life skills.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Reproductive health knowledge including of contraceptives and services were quite positive to begin with and improved over the course of the intervention.</li> <li>• No increase in utilization of protection during sex.</li> </ul>	<ul style="list-style-type: none"> <li>• No increase in use of health services. In the baseline and endline surveys adolescents were asked if they had visited a nurse or physician in the last 12 months and</li> </ul>	<ul style="list-style-type: none"> <li>• Significance testing or multivariate logistic regression of changes in use of services was not carried out.</li> </ul>

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<p>6. Kenya Frontier 1999 42 months (evaluation over 18 month implementation phase)  (Askew et al., 2003)</p>	<p>To improve SRH knowledge, attitudes and behaviour of in- and out-of- school youths.</p>	<p>Quasi-experimental Test additional effect of school education (as above).  Baseline and endline population surveys (~3700 (1000 boys adolescents) and qualitative interviews.</p>	<ul style="list-style-type: none"> <li>• Community                     <ul style="list-style-type: none"> <li>- peer education;</li> <li>- sensitization and awareness raising (sessions with gatekeepers, parents, teachers, leaders).</li> </ul> </li> <li>• School education                     <ul style="list-style-type: none"> <li>- teacher led and peer supported;</li> <li>- trained to provide a participatory reproductive health curriculum tailored to in-school youth, and focussing on life skills.</li> </ul> </li> <li>• Youth-friendly services                     <ul style="list-style-type: none"> <li>- providers trained.</li> </ul> </li> <li>• Community                     <ul style="list-style-type: none"> <li>- peer education;</li> <li>- sensitization and awareness raising (sessions with gatekeepers, parents, teachers, leaders).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Positive trends that did occur were observed in both the experimental (no significant impact with additional school component) and control groups, suggesting that the improved attitudes and behaviours were due to additional factors other than the project's interventions.</li> <li>• Adolescents who participated in either school or community interventions significantly improved awareness of contraceptives, although as knowledge of some specific methods increased in all sites, it is not clear the intervention had any additional effect.</li> <li>• None of the interventions improved knowledge of how to use a condom.</li> <li>• Use of protection during sex remained low after the intervention, although there was some improvement amongst girls involved in school activities and the control group, and declines in reports of pregnancy amongst unmarried adolescents (suggests general social change affecting or enhancing the project's results).</li> </ul>	<p>the proportion that had declined from 58% to 47%, with a similar decline observed in all three groups. At endline only 6.2% of those that had visited a provider had been for a reproductive health service.</p> <ul style="list-style-type: none"> <li>• No evidence of increased utilization of services with few of the young people surveyed (5%) saying that they had attended a youth-friendly clinic.</li> </ul>	<ul style="list-style-type: none"> <li>• Significance testing or multivariate logistic regression of changes in use of services was not carried out.</li> </ul>
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<p>African Youth Alliance, partnership between UNFPA, PATH and Pathfinder</p> <p>Botswana, Ghana, Tanzania and Uganda (financial constraints meant the programme finished two years early)</p> <p>2000–2006</p> <p>(For more details, see section 3.5)</p>	<p>To improve sexual and reproductive health of young people, aged 10–24 (with emphasis on 10–19), in Botswana Ghana, Tanzania and Uganda.</p>	<p>Baseline surveys (2001–2002), Mid-term assessments (2003), component evaluations (2005–2006) and independent impact survey evaluation (2006–2007).</p>	<ul style="list-style-type: none"> <li>• Policy and advocacy – develop enabling environment for SRH.</li> <li>• Behaviour change communication – including extracurricular SRH activities in schools.</li> <li>• Life planning skills, education and counselling – in and out of schools (including strategies to reach vulnerable subgroups).</li> <li>• Youth-friendly services.</li> <li>• Institutional capacity-building.</li> <li>• Coordination and dissemination.</li> </ul>	<p><i>In-school life planning skills</i></p> <p>Botswana: Increased risk reduction behaviours among those who perceived themselves at risk (e.g. having an HIV test, reducing partners, condom use, and abstinence), increased intention to use condoms, and increased use of condoms.</p> <p>Ghana: Increased awareness of HIV transmission risks and purpose of condom use, and positive change in intention to use condoms.</p> <p>Tanzania: Pre-test and post-test scores (monitoring data) showed that young people's SRH knowledge (including of HIV transmission and condom use) increased an average of 20% after participation in the sessions.</p>	<p><i>In-school life planning skills</i></p> <p>Botswana: Increased risk- reduction behaviours, including accessing services to obtain an HIV test.</p> <p><i>Extracurricular SRH activities in schools</i></p> <p>Uganda: Post-intervention assessment showed an increase in the percentage of participants who could obtain youth-friendly clinical services.</p>	<ul style="list-style-type: none"> <li>• Data on service use not reported in detail or analysed, focus placed on contraceptive use and changes in knowledge.</li> </ul>
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## KEY MESSAGES

### Key findings

#### General

- **ADVANTAGES:** uses existing infrastructure to reach ready audience of young people and teachers; potential to institutionalize SRH education and broaden its impact; teachers are often from local community and can ensure education is culturally appropriate and encourage community support for it.
- **DISADVANTAGES:** high burden on already over-stretched infrastructures; teachers face competing claims on their time; teachers may be too close to local sensitivities to encourage open discussion; lack of funding for teacher training means necessary skills not given.
- **LESSONS LEARNED:** training of teachers is needed to sensitize them to the issues involved and familiarize them with participatory and life skills techniques which seem to show particular potential; use of specialist counsellors or health professionals can help encourage open discussion; curriculum development is necessary to institutionalize and integrate ASRH in schools for sustainability.

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#### Utilization of services

- Some evidence that linking health services to schools with referral systems shows potential, but few studies in developing country settings.
- Further research is needed into:
  - – setting up effective referral systems
  - potential for linking in-school education to private practice/commercial sources
  - use of peer distribution networks in schools for contraceptives.

## 3.2 Community-based education

### 3.2.1 Facilitated education sessions

Two programmes led by the International Centre for Research on Women (ICRW) in Maharashtra, India, have used education sessions aimed at both adolescents and wider community members to improve understanding of ASRH issues and measured the impact on seeking health care (Table 3). In Maharashtra, ICRW worked with the KEM hospital research centre to provide sexual and reproductive health education, counselling and care for married adolescents. Evaluation showed improvements in knowledge, despite the fact that fewer than half of couples attended the full series of seven education sessions. Qualitative assessments showed work or childcare commitments to be the most common reasons for dropping out. The links to clinical services were strong, however, and the increase in the use of these services was largely due to referrals from the health education sessions. Before the intervention, no sexuality counselling was available to this population and during the intervention almost one third of couples attended a counselling session. It was found that families were more receptive to the fieldworkers (educators and lay counsellors) if they went into the community in husband–wife couples and in this form they were more effective in reaching young couples (Pande et al., 2007).

In the second programme ICRW worked with the Foundation for Research in Health Systems. The evaluation design allowed the impact of social mobilization activities (i.e. addressing demand side constraints which are defined as determinants of use of health care that are not dependent on service delivery or the price of the services), to be compared with the effect of improving the supply side by providing youth-friendly services. It was found that knowledge of ASRH and use of services improved more at the sites that addressed demand constraints than at those that did not. Although it was expected that the site which combined demand and supply activities would perform best for many outcomes, including use of services, the site that focused on social mobilization (demand) alone performed best, possibly due to more intensive activities (Pande et al., 2007).



**TABLE 3. Programmes with facilitated education sessions**

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES						
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS		EFFECT SIZE
				RELATED OUTCOMES:	PRIMARY OUTCOME:	
<i>Education led by trained facilitators (in some cases community members)</i>						
7. India, Pune, Maharashtra (ICRW & KEM hospital research centre) (Pande et al., 2007)	To provide SRH education, care and counselling for married adolescents (14–25 years) and include a broad spectrum of community and family members.	Before and after study (no control) <ul style="list-style-type: none"> <li>– three components were all initiated simultaneously, and adolescents self-selected which to participate in;</li> <li>– baseline survey (114 couples);</li> <li>– process evaluation (qualitative);</li> <li>– endline survey (74 couples).</li> </ul>	<ul style="list-style-type: none"> <li>• Education sessions in the community led by trained volunteers                             <ul style="list-style-type: none"> <li>– group sessions.</li> </ul> </li> <li>• Professional counselling sessions in the community                             <ul style="list-style-type: none"> <li>– one-on-one and couple sessions;</li> <li>– education and counselling aimed at young women, husbands, mothers-in-law and others (community members informally participated in all activities);</li> <li>– education sessions included referral to counselling when needed;</li> <li>– education and counselling components included a referral system for those requiring clinical services.</li> </ul> </li> <li>• Youth-friendly services (provided by KEM)                             <ul style="list-style-type: none"> <li>– health providers trained.</li> </ul> </li> </ul>	<p><b>RELATED OUTCOMES:</b></p> <p>Adolescents</p> <ul style="list-style-type: none"> <li>• know when and why health services should be used;</li> <li>• know where health services can be obtained;</li> <li>• state intention to use services, if needed.</li> </ul>	<p><b>PRIMARY OUTCOME:</b></p> <p>Use of health services</p>	<ul style="list-style-type: none"> <li>• Data not reported for increase in service use and no significance test carried out. No control.</li> </ul>

Continued...

<p>8. India, Maharashtra ICRW and Foundation for Research in Health Systems (FRHS) 2001–2006 (Pande et al., 2007)</p>	<p>Young newly-married couples (where wife is below 22 years) with a focus on the women.</p>	<p>Quasi-experimental Intervention – 1 site only social mobilization (demand); – 1 only youth-friendly services (supply); – 1 both; – 1 control Test supply versus demand approaches. – baseline and endline survey (1866 married girls); – mid-intervention (972 husbands); – 75 mothers-in-law, qualitative interviews); – social mobilization (process evaluation); – health worker/clinic records.</p>	<ul style="list-style-type: none"> <li>• Social mobilization (SM) through existing community-based organizations (addressed low priority communities place on ASRH) <ul style="list-style-type: none"> <li>– strengthened youth and women's groups (mothers-in-law and husbands drawn in to participate);</li> <li>– adolescent and community education;</li> <li>– community involvement in design and implementation.</li> </ul> </li> <li>• Youth-friendly services (addressed the fact that services are not geared towards ASRH) <ul style="list-style-type: none"> <li>– improve quality and accessibility of government services;</li> <li>– sensitize providers to adolescent's needs.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• All intervention sites showed similar increases in awareness of modern family planning methods and spacing. <ul style="list-style-type: none"> <li>• Basic and detailed knowledge of maternal health, contraceptive side-effects and abortion increased most in the social mobilization sites.</li> <li>• The site with only youth-friendly services did not perform better than other sites on most outcomes. Although it was expected that social mobilization and youth-friendly services would be most successful, in many outcomes social mobilization alone performed better (possibly due to more focused efforts).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Sites with social mobilization performed well in terms of increases in service use compared to those without. They performed best on post-natal checkups, contraceptive acceptance, treatment of gynaecological disorders, and treatment of STIs and reproductive tract infections (e.g. treatment for STI/RTI increased 98.2% in SM/YFS site, 79.5% in SM only site, 44.5% in YFS only site and 26.7% in control).</li> <li>• The site with only YFS performed best only on care for high-risk deliveries. Treatment for high-risk deliveries increased 24.2% in SM/YFS site, 22.4% in SM only site, 44.5% in YFS only site and 26.7% in control.</li> </ul>	<ul style="list-style-type: none"> <li>• Data not reported for overall increase in service use and no significance test. Multivariate logistic regression not carried out.</li> </ul>
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## KEY MESSAGES

### Key findings

#### *General*

- **ADVANTAGES:** uses of existing structures and complementary services (e.g. of youth organizations); reaches out-of-school youth, especially the vulnerable groups (street children, refugees etc.); particularly useful in settings where cultural sensitivities limit in-school ASRH education.
- **DISADVANTAGES:** maintaining interest of participants over time is difficult; if there is no in-school education, community-based programmes alone may not reach in-school youth (especially girls).

#### *Utilization of services*

- Few studies measure effect on demand or use of services so evidence of impact on these outcomes is weak. However, there is some evidence from India that out-of-school programmes can influence use of contraceptives and services.
- Some evidence suggests that involving target groups in design and implementation and involving the wider community both help, as can the use of existing organizations serving young people.
- Further research is needed on:
  - how to sustain participation at educational/sessions;
  - the best ways of strengthening links to health services.



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### 3.2.2 Youth clubs

Youth centres, which also provide recreational activities and services, are sometimes used to provide community-based education. Many such programmes have been implemented but few are rigorously evaluated and even fewer measure impact on service use. Three studies have been found that did this, but findings are mixed (Table 4). In Butare, Rwanda, Population Services International (PSI) set up the multipurpose “Centre Dushishoze” to provide recreation, education and services. Outreach activities were carried out in churches, clubs, schools and rural community centres. Access to radio and television is low, so the programme used mobile video unit presentations, billboards, the *Indatwa Z’ejo* (Heroes of the Future) newspaper, posters, and other print materials to motivate young people to visit the centre. Peer educators also helped identify and promote youth-friendly condom sellers in rural areas, and additional activities were carried out for parents and the community. The design of the programme design took into account that many factors – including self-efficacy, perceived social support and risk – impact sexual behaviour and condom use. Evaluation found statistically significant higher utilization of services with increased exposure to risks, but findings are weakened by the lack of pre-intervention data. Analysis suggests that the programme contributed to some, although not all, of the positive changes. Centre Dushishoze in Butare was considered a success overall, and PSI Rwanda opened two new centres in 2005 in Ruhengeri, and Kibungo (Neukom et al., 2003).

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In Gweru, Zimbabwe, there was little evidence of positive impact. The creation of a recreational youth centre to support the provision of reproductive health services was combined with peer education and youth corners in existing clinics, and community sensitization at the beginning to facilitate implementation. Data showed that, although the youth centre was used by young people, few came there to use the reproductive health services (Moyo et al., 2000).

In Togo, the impact of a youth centre on condom use and service use was measured, showing only limited evidence of success. The evaluation found that the clinical and counselling services in the youth centre had little impact on reproductive

health knowledge and practices, although there was some increase in knowledge of and use of condoms. Over time there was also a modest increase in use of services, and some preference over other sources of care. There is some suggestion that referral peer education activities, and particularly the radio and television advertising, had some influence in promoting the centre (Speizer et al., 2004).

Evidence from a Mexfam programme also questions the effectiveness of using youth centres to provide services. Youth services integrated into adult programmes, both at Mexfam centres and private clinics, were found to be reaching more young people than the clinics at Mexfam youth centres (LaVake and Rosen, 2003) (see section 3.2.3 for further details).

**TABLE 4. Programmes focusing on youth clubs**

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES					
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	EFFECT SIZE
<i>Youth centre with peer education</i>					
9. Rwanda, Butare Centre Dushishoze Population Services International 2001–ongoing (Neukom et al., 2003)	Holistic approach to improve sexual behaviour and condom use, i.e. recognize that social support and self-efficacy are influential.	Before and after (cross-sectional surveys) <ul style="list-style-type: none"> <li>– household, Oct–Dec 2000 (n=3111);</li> <li>– school survey, Oct–Nov 2000 (n=1530);</li> <li>– household, March 2002 (n=3109);</li> <li>– school, April 2002 (n=1555).</li> </ul> Examining trends in survey responses after controlling for sample differences and other confounding factors such as education and socioeconomic status and compare by level of exposure – ‘dose response analysis’.	<ul style="list-style-type: none"> <li>• Youth centre                             <ul style="list-style-type: none"> <li>– recreation and social activities;</li> <li>– vocational skills training;</li> <li>– information material;</li> <li>– peer education;</li> <li>– subsidized youth-friendly services (integrated SRH and HIV);</li> <li>– outreach days for parents and community members.</li> </ul> </li> <li>• Peer education                             <ul style="list-style-type: none"> <li>– education and counselling sessions in youth club, churches, schools, rural community centres;</li> <li>– identify and promote youth-friendly condom sellers in rural areas.</li> </ul> </li> <li>• Media campaign (social marketing)                             <ul style="list-style-type: none"> <li>– billboards;</li> <li>– newspaper;</li> <li>– mobile video unit.</li> </ul> </li> </ul>	<p><b>RELATED OUTCOMES:</b> Adolescents</p> <ul style="list-style-type: none"> <li>• know when and why health services should be used;</li> <li>• know where health services can be obtained;</li> <li>• state intention to use services, if needed.</li> </ul> <p><b>PRIMARY OUTCOME:</b> Use of health services</p>	<ul style="list-style-type: none"> <li>• Change in service use related to exposure statistically significant at <math>p \leq 0.05</math> when age, residential area, level of education, school enrolment, socioeconomic status, and number of sexual partners controlled for. Confidence intervals not reported.</li> <li>• No control, analysis of effect of programme exposure suggests programme responsible for some but not all of the changes.</li> </ul>

Continued...

<p>10. Zimbabwe, Gweru Pathfinder International (Moyo et al., 2000)</p>	<p>To improve adolescent uptake of ASRH services</p>	<p>Before and after (no control) – review of clinic data after a year.</p>	<ul style="list-style-type: none"> <li>• Youth centre             <ul style="list-style-type: none"> <li>– recreation and services.</li> </ul> </li> <li>• Peer education.</li> <li>• Community sensitization (initial stage)             <ul style="list-style-type: none"> <li>– community meetings with leaders, parents and teachers.</li> </ul> </li> <li>• Youth-friendly services             <ul style="list-style-type: none"> <li>– youth corners in clinics manned by peer educator.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Improved attitude towards condom use.</li> </ul>	<ul style="list-style-type: none"> <li>• Use of youth centre but not for services.</li> <li>• No increase in use of youth-friendly services (although youth that visited were generally “satisfied” with the service).</li> </ul>	<ul style="list-style-type: none"> <li>• Service use data not reported in detail, no change exhibited so no significance test carried out.</li> </ul>
<p>11. Togo, Lome (Kouwonou &amp; Amegee, 2001; Speizer et al., 2004)</p>	<p>To provide a supportive environment for youth; to improve youth knowledge, attitudes, skills and practices; and to increase service use among youth (10–24 years).</p>	<p>Before/after (panel) – baseline (2083 youth and 1027 adults) 1998; – follow-up, 2000 (1679 youth) and 2001 (1332 youth plus 524 clinic users).</p>	<ul style="list-style-type: none"> <li>• ABTEF youth centre             <ul style="list-style-type: none"> <li>– youth-friendly services (clinical and counselling);</li> <li>– library;</li> <li>– education (literacy and vocational classes);</li> <li>– recreation;</li> <li>– promotion in schools.</li> </ul> </li> <li>• Peer education             <ul style="list-style-type: none"> <li>– outreach education and referral.</li> </ul> </li> <li>• Media             <ul style="list-style-type: none"> <li>– radio and television promotion (discussions and round table discussions).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Some increase in knowledge of condoms.</li> <li>• Media exposure was positively associated with use of the youth centre.</li> <li>• Youth who visited the youth centre over the follow-up period were significantly more likely to be condom users than youth who either never visited the centre or had already visited the centre at observation 1. This suggests that, for contraceptive users, visiting the centre affirms contraceptive use behaviours.</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate (non-significant) increase in use of youth centre, including services, over time (baseline 3.3% reported ever visiting the youth centre (for recreation or clinical services) and by 2001, 10.3% had).</li> <li>• Youth who were ever exposed to a peer educator (Log Reg Co-eff=-1.31 p&lt;0.001) or who lived nearer (Log Reg Co-eff=-2.52 p&lt;0.001) or were exposed to media (Log Reg Co-eff=-0.72 p&lt;0.01) were significantly more likely to have visited the youth centre.</li> <li>• Young people in the target population were more likely to visit the youth centre clinic than the other clinics in the area (Log Reg Co-eff=1.53 p&lt;0.001).</li> </ul>	<ul style="list-style-type: none"> <li>• Use of youth centre for services versus recreation not investigated separately over time.</li> <li>• Some problems encountered obtaining follow-up data i.e. biased compared to baseline representative sample. Follow-up sample are more likely to be male, in-school and more educated, all factors possibly associated with the outcomes of interest (use of the youth centre and contraceptive use).</li> <li>• No control.</li> </ul>



## KEY MESSAGES

### Key findings

#### *General*

- Many youth centres combine educational, vocational and recreational activities with SRH services.
- Relatively low attendance rates are often reported.
- High costs of maintaining centres do not seem justified when compared to lower costs of outreach/peer promotion activities. Quality of evidence for these interventions is poor.

#### *Utilization of services*

- Where recreational facilities are offered, adolescents (especially males) tend to use only these and not the SRH services.
- There is some evidence of impact on knowledge, motivation and use of condoms but little on services.
- More direct promotion of SRH services and reasons to use them may improve uptake but more research is needed.
- Further work is needed on the potential of youth centres to influence uptake of services provided elsewhere (e.g. links with health facilities, pharmacies etc).

### 3.2.3 Outreach from health centres to provide information, education and communication activities in the community

The public and private sectors have been used to promote health service use through outreach from the sources of commodities and care. Utilization and involvement of the private sector has been growing in recognition of their role as primary points of contact for many young people seeking reproductive health advice and care. Social franchising techniques have relatively recently begun to be applied to the provision of SRH services. They draw on commercial franchising techniques to increase access to and use of socially beneficial services and commodities (Table 5). In addition to promotion and marketing, social franchising also typically involves the training of franchisor staff, some kind of quality assurance and standardization of services, information-sharing and referral mechanisms, and a formal business agreement or franchise contract. Although social franchising traditionally uses private sector providers, there is now a range of models, including the use of government providers and community partnerships (LaVake, 2003). Social franchising responds to the fact that clinics are not usually the first choice for young people to access services. Studies show the potential of such techniques for improving not only outreach and accessibility of services but also demand and uptake of them (Murray et al., 2003; FOCUS, 1999; Carranza, 2003; LaVake and Rosen, 2003; Rosen 2001a; Senderowitz and Stevens, 2001).

In Thailand, innovative work is taking place on the use of pharmacies and drugstores to provide services. The RX Gen programme developed by PATH in Thailand includes use of some social franchising principles and was designed to strengthen drugstores and pharmacies as primary points of contact for youth. The programme also aimed to develop demand for referral networks to social and health services, and provide information and promote services to consumers via information booklets, referral cards and radio. Final assessment results were very promising. They showed a significant improvement in the quality of services

in the drugstores (e.g. improved communication, provision of useful advice and respect for privacy) and a significant increase in the number of clients who sought advice on reproductive health from the pharmacists and who accessed government health centres (part of the referral network) (Bond, Firestone and Francis, 2003).



WHO-208711

In Madagascar a private social franchise model was used to provide youth-friendly services. These, along with services for safe sex, were promoted in a more interactive way through face-to-face communication provided by paid full-time peer educators working in the community and combined with a mass media campaign. Clinic attendance records indicated increased utilization by males and females. However, there were no control clinics, and there was no assessment of the impact of separate components (Neukom & Ashford, 2003).

The Mexfam programme Gente Joven used a similar model but involved a wider range of providers, including NGOs and private sector franchises. Services were provided in health facilities and youth centres, and promotion was provided via peer education and community activities, Mexfam staff members provided information on condoms and training in decision-making skills. Links with schools were strong. Improved knowledge and use of contraceptives was found, with peer educators distributing condoms as well as (sometimes) oral contraceptives. This approach increases youth access to contraceptives but has limited quality control. Interestingly, youth services integrated into adult programmes, both at Mexfam centres and at private clinics, were found to be reaching more young people than clinics at Mexfam youth centres. However, data monitoring the specific impact of the programme on service utilization was not found (LaVake and Rosen, 2003).

In Mongolia, the distribution of IEC material to promote an intervention in a government youth-friendly facility was combined with broader community mobilization activities and adolescent involvement in programme development. A statistically significant greater use of services was found. Although the effects of different components cannot be gauged separately, it is thought that the participation of young people and the wider community was influential. Evidence is also weakened by the fact that results were not standardized for differences in catchment populations (WHO, 2003). In the Songjiang district of China a similar programme was initiated, with the provision of counselling and services including free condom supplies. Service use was not measured but knowledge of the availability of services, condoms and their use increased at intervention sites (Chao-Hua et al., 2004). In the AYA multi-component programme, promotion of health facilities took place, as did outreach using non-traditional condom providers (AYA, 2007).

**TABLE 5. IEC activities as outreach by health centres**

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES					EFFECT SIZE
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	
<i>IEC including social franchising (promotion including peer education, media etc.)</i>					
12. Thailand The PATH <i>RX Gen</i> programme PATH Thailand (Bond, Firestone & Francis, 2003)	To improve the quality of ASRH services through training and consumer education.	Before and after – clinic data.	<ul style="list-style-type: none"> <li>Youth-friendly services                             <ul style="list-style-type: none"> <li>– pharmacists and drug sellers trained to improve service quality for youth (meetings and training sessions);</li> <li>– guidelines for youth-friendly services developed (provide information about products, history-taking and referral, and guidance to improve interpersonal communication with young clients);</li> <li>– RX Gen logo shows adhering to guidelines;</li> <li>– establishment of a referral network to social and health services (public counselling, health centres, social services, vocational training centres).</li> </ul> </li> <li>IEC                             <ul style="list-style-type: none"> <li>– information booklets and referral cards distributed at drugstores and in the community at fairs and shopping centres;</li> <li>– information about a web page with links to the ministry of health's service network;</li> <li>– IEC and promotion by radio.</li> </ul> </li> </ul>	<p><b>RELATED OUTCOMES:</b> Adolescents</p> <ul style="list-style-type: none"> <li>• know when and why health services should be used;</li> <li>• know where health services can be obtained;</li> <li>• state intention to use services, if needed.</li> </ul> <p><b>PRIMARY OUTCOME:</b> Use of health services</p>	<ul style="list-style-type: none"> <li>• Detailed service data not reported and no significance test.</li> <li>• No control.</li> </ul>
				<ul style="list-style-type: none"> <li>• After the referral cards were disseminated widely and promotion began, the number of young clients utilizing the services at participating drugstores increased, with an increase in the number of clients who sought reproductive health advice from the pharmacists.</li> <li>• Increase in referrals by pharmacists to counselling services.</li> <li>• Data from government health centres (part of the referral network) indicated a two-fold increase in the number of young clients seeking related services following the establishment of the referral network.</li> </ul>	

*Continued...*

<p>13. Madagascar, Tamatave Province</p> <p>TOP Reseau ("Top quality cool network")</p> <p>Youth-friendly social franchise project</p> <p>Population Services International</p> <p>2000–ongoing</p> <p>(LaVake, 2003; Neukom &amp; Ashford, 2003)</p>	<p>Community-wide intervention aimed at preventing HIV and unplanned pregnancies by motivating sexually active youth (15–24-year-olds) to treat STIs and to use condoms consistently or not have sex.</p>	<p>Before/after (no control)</p> <ul style="list-style-type: none"> <li>– household surveys;</li> <li>– clinic data.</li> </ul>	<p>Youth-friendly services</p> <ul style="list-style-type: none"> <li>– private provider social franchise model (clinics, pharmacies and others);</li> <li>– quality standards;</li> <li>– provider training;</li> <li>– subsidies;</li> <li>– marketing and promotion of services (17 clinics) (e.g. posters, radio spots and mobile video units)</li> </ul> <ul style="list-style-type: none"> <li>• Peer education (paid full-time educators) <ul style="list-style-type: none"> <li>– reach diverse locations via mobile units;</li> <li>– small group and individual counselling sessions;</li> <li>– group discussions;</li> <li>– health films.</li> </ul> </li> <li>• Mass media <ul style="list-style-type: none"> <li>– social marketing, radio and television.</li> </ul> </li> <li>• Community education sessions <ul style="list-style-type: none"> <li>– parents, religious leaders, teachers, school administrators.</li> </ul> </li> </ul>	<p>• Clinic attendance records indicated increased utilization in the first two years</p> <ul style="list-style-type: none"> <li>– 527 first quarter of 2001 to 2202 fourth quarter of 2002 (these were predominantly females (89%), and a subsequent focus has been on increasing male uptake of services). About half of visits were for reproductive health services. No age breakdown is currently available but more detailed tracking is beginning (it is thought that ~60–70% are youth).</li> <li>• Success has led to funding from the Global Fund to expand to three new provinces.</li> </ul>	<ul style="list-style-type: none"> <li>• No significance test of increase in service use.</li> <li>• No control.</li> </ul>
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<p>14. Mexico Mexfam, <i>Gente Joven</i> 1994–ongoing (LaVake, 2003)</p>	<p>Adolescents in communities with high levels of poverty.</p>	<ul style="list-style-type: none"> <li>• Before/after                             <ul style="list-style-type: none"> <li>– surveys;</li> <li>– clinic data.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Joint venture social franchise model. Mexfam joined with private providers and other NGOs as franchisees.                             <ul style="list-style-type: none"> <li>• Youth-friendly clinics                                     <ul style="list-style-type: none"> <li>– provider training;</li> <li>– subsidized services;</li> <li>– franchise agreement;</li> <li>– logo/branding.</li> </ul> </li> <li>• Youth centres                                     <ul style="list-style-type: none"> <li>– recreational activities;</li> <li>– some have clinical services.</li> </ul> </li> <li>• Peer education                                     <ul style="list-style-type: none"> <li>– young people trained as promoters, counsellors, contraceptive distributors, providing school and community outreach.</li> </ul> </li> <li>• Community                                     <ul style="list-style-type: none"> <li>– youth engage support from the community;</li> <li>– youth involved in programme development and management committees;</li> <li>– Mexfam staff provide school outreach.</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Increased contraceptive use at last sex.</li> </ul>	<ul style="list-style-type: none"> <li>• Youth services that are integrated into adult programmes, both at Mexfam centres and private clinics, seem to be reaching more young people than clinics at Mexfam youth centres.</li> </ul>	<ul style="list-style-type: none"> <li>• Detailed service data not reported and no significance test.</li> <li>• No control.</li> </ul>
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<p>15. Mongolia 3-year project (1999–2003) (WHO, 2003)</p>	<p>To increase adolescents' (10–19 years) access to quality health services.</p>	<p>Quasi-experimental (2 rural districts and 3 districts in capital) – assessment after 1 year of application of youth-friendly services criteria and in-school youth survey; – service statistics January–June 2003.</p>	<ul style="list-style-type: none"> <li>• Youth-friendly services <ul style="list-style-type: none"> <li>– quality standards;</li> <li>– train staff;</li> <li>– improve equipment/supplies (including contraceptives);</li> <li>– improve confidentiality.</li> </ul> </li> <li>• IEC <ul style="list-style-type: none"> <li>– IEC materials developed and distributed.</li> </ul> </li> <li>• Community advocacy and mobilization <ul style="list-style-type: none"> <li>– governors, teachers, health workers, parents and adolescents targeted;</li> <li>– adolescents involved in design of education and advocacy material.</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Statistically significant increase in use of services by 10–19 year old males (OR=1.3 p&lt;0.05) and females (OR=1.8 p&lt;0.05) in project sites. Significantly more likely to visit clinic than in control sites.</li> <li>• Evaluation does not allow the impact of IEC activities and wider community mobilization to be gauged separately.</li> </ul>	<ul style="list-style-type: none"> <li>• Significance test carried out but not multivariate logistic regression – results were not controlled for differences in catchment populations.</li> </ul>
<p>16. China, Songjiang district, Shanghai (Chao-Hua et al., 2004)</p>	<p>To build awareness and to offer counselling and services related to sexuality and reproduction of unmarried urban young people aged 15–24 years both in and out of school.</p>	<p>Quasi-experimental (baseline survey n=1220, intervention n=1007, control, follow-up survey 20 months later n=1148, intervention n=894, control).  1 intervention and 1 control community.</p>	<ul style="list-style-type: none"> <li>• Youth-friendly services <ul style="list-style-type: none"> <li>– youth health counselling centre (with contraceptive services);</li> <li>– service providers trained;</li> <li>– free condom supplies.</li> </ul> </li> <li>• IEC <ul style="list-style-type: none"> <li>– information activities and materials about ASRH and availability of services made available in the community;</li> <li>– sex education lectures;</li> <li>– interactive discussions;</li> <li>– videos shown before films in cinema.</li> </ul> </li> <li>• Community sensitization activities <ul style="list-style-type: none"> <li>– meetings for community leaders and parents.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Increase in knowledge of available services (data not reported).</li> <li>• Increase in contraception and condom use at intervention site. (Logistic regression – after adjusting for demographic factors intervention group were more likely (OR=14.58 95% CI 8.55–24.87 p&lt;0.001) to use contraceptives than those from control groups).</li> </ul>		<ul style="list-style-type: none"> <li>• Data for increase in knowledge of available services not reported and no significance test carried out.</li> </ul>

<p><b>Multi-component</b></p>	<p>African Youth Alliance (AYA) partnership between UNFPA, PATH and Pathfinder</p> <p>Botswana, Ghana, Tanzania and Uganda (financial constraints meant the programme finished 2 years early)</p> <p>2000–2006 (resources are being mobilized for a second phase)</p> <p>(For more details see section 3.5)</p>	<p>To improve sexual and reproductive health of young people, aged 10–24 (with emphasis on 10–19), in Botswana, Ghana, Tanzania and Uganda.</p>	<p>Baseline surveys (2001–2002), mid-term assessments (2003), component evaluations (2005–2006), and independent impact survey evaluation (2006–2007).</p>	<ul style="list-style-type: none"> <li>• Policy and advocacy</li> <li>• develop enabling environment for ASRH.</li> <li>• Behaviour change communication.</li> <li>• Life planning skills, education and counselling.</li> <li>• Youth-friendly services                             <ul style="list-style-type: none"> <li>– work with NGOs, faith-based organizations, public facilities and non-traditional providers</li> <li>– outreach from health facilities (e.g. peer service providers);</li> <li>– advertising and promotion of facilities (e.g. use of media).</li> </ul> </li> <li>• Institutional capacity-building.</li> <li>• Coordination and dissemination.</li> </ul>	<ul style="list-style-type: none"> <li>• Youth-friendly services, including outreach component evaluations and facility reassessments on a representative sample, determined that the availability of youth-friendly services broadened. The quality of and client satisfaction with youth-friendly services improved, and utilization of the services increased.</li> <li>• Ghana: Non-traditional condom distributors (young barbers, tailors, artisans and shopkeepers) trained to provide confidential sexual and reproductive health information and condoms in their shops. Results showed that these distributors were even more effective in condom distribution than peer providers.</li> <li>• Uganda: Approximately half of the clients seen at AYA-supported clinics are new clients and two thirds of all clients are out-of-school youth. This strongly suggests that the programme's service delivery points are succeeding in reaching disadvantaged youth and are still attracting large numbers of new clients. The number of young people accessing voluntary counselling and testing services has steadily increased while condom distribution through outreach has increased 67%.</li> </ul>	<ul style="list-style-type: none"> <li>• Data on service use not reported in detail or analysed, focus placed on contraceptive use and changes in knowledge.</li> </ul>
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TABLE 6. Programmes focused on peer education and counselling

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES					EFFECT SIZE
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	
<i>Multi-component</i>					
African Youth Alliance, partnership between UNFPA, PATH and Pathfinder	To improve sexual and reproductive health of young people, aged 10–24 (with emphasis on 10–19), in Botswana, Ghana, Tanzania and Uganda.	Baseline surveys (2001–2002), mid-term assessments (2003), component evaluations (2005–2006), and independent impact survey evaluation (2006–2007).	<ul style="list-style-type: none"> <li>Policy and advocacy               <ul style="list-style-type: none"> <li>– develop enabling environment for SRH of adolescents.</li> </ul> </li> <li>Behaviour change communication               <ul style="list-style-type: none"> <li>– including peer education and peer service provision;</li> <li>– health talks, counselling, behaviour change sessions, film shows and debates;</li> <li>– provision of non-prescription contraceptives and referral to services;</li> <li>– mobilize and sensitize young people for health services.</li> </ul> </li> <li>Life planning skills, education and counselling.</li> <li>Youth-friendly services.</li> <li>Institutional capacity-building.</li> <li>Coordination and dissemination</li> </ul>	<p><b>RELATED OUTCOMES:</b></p> <p>Adolescents</p> <ul style="list-style-type: none"> <li>know when and why health services should be used;</li> <li>know where health services can be obtained;</li> <li>state intention to use services, if needed.</li> </ul> <p><b>PRIMARY OUTCOME:</b></p> <p>Use of health services</p>	<ul style="list-style-type: none"> <li>Data on service use not reported in detail or analysed, focus placed on contraceptive use and changes in knowledge.</li> </ul>
Botswana, Ghana, Tanzania and Uganda (financial constraints meant the programme finished 2 years early)				<p>Peer education Uganda: (focus on vulnerable sex workers and street adolescents)</p> <ul style="list-style-type: none"> <li>Activities had a positive influence on vulnerable young people's SRH knowledge (including condom and service use).</li> <li>Attitudes towards health centres improved.</li> <li>Increased use of condoms.</li> </ul>	<ul style="list-style-type: none"> <li>Increased use of voluntary counselling and testing, treatment for STIs and other sexual and reproductive health services.</li> </ul>
2000–2006 (resources are being mobilized for a second phase)					
(FOR MORE DETAILS SEE SECTION 3.5)					



## KEY MESSAGES

### Key findings

#### *General*

- A range of outreach activities from health facilities show the potential to reach adolescents in the community – especially peer education, condom distribution (including non-traditional outlets) and specific promotion of services (see below).

#### *Utilization of services*

- Promotion of health facilities, including the private sector (clinics, pharmacies etc.) particularly through social franchising (including branding, marketing, use of mass media) appears to be particularly important. Most countries have a significant existing network of private services and there is evidence that young people show preference for private providers (particularly because of the relative anonymity).
- Mobilization of the wider community as part of outreach seems to contribute to uptake of services. Evidence is still limited and further research is needed to evaluate properly which outreach models are most effective (see chapter 4).

## 3.3 Overarching IEC methods

### 3.3.1 Peer education/counselling

A very wide array of evaluations of peer programmes addressing SRH in schools, universities, clinics and the community, and also focusing on particular vulnerable groups, have been carried out but they have been of variable quality and result. While programmes based in schools or health facilities have been looked at in corresponding sections of this review, most programmes also operate in the community and many are based there. Many programmes show a greater effect on the educators themselves than on the intended audience, but there are also programmes that have shown effects on the intended target audience (FHI/Youthnet). However, while many programmes include the provision of information on services and commodities, or even provision of the latter, the impact on uptake of services is not typically measured.

Peer education is also commonly part of large multi-component programmes. The comprehensive AYA programme (implemented in Botswana, Ghana, Tanzania and Uganda) worked with public health facilities, NGOs and faith-based organizations to improve both clinic and outreach services. This programme has made the best attempt to measure the specific impact of peer education on service utilization. Experiences in Uganda demonstrate approaches used to reach vulnerable and marginalized groups. One partner focused on promoting SRH to adolescent street children and young commercial sex workers in five divisions of Kampala district. Given the challenge of reaching this target audience, consultative meetings were held with community leaders, brothel owners and managers of commercial places where commercial sex workers were found. The trained peer service providers who work with these groups were selected from among those young people who had formerly been part of the groups. The approach of using peer service providers to mobilize and sensitize young people for health services worked well. Awareness and use of condoms and services improved and the fact that the peer providers enjoyed good relationships with their young clients and gained recognition in their communities as role models was considered important (AYA, 2007).

## KEY MESSAGES

### Key findings

#### *General*

- Peer education by young people is popular and widespread. Activities vary but can include counselling, referral and distribution of contraceptives as well as individual and group education sessions.
- It is a flexible approach that can be used in a wide variety of settings (schools, youth centres, community) and tailored to different contexts.
- Programmes often have a greater impact on the educators themselves but have been shown to influence knowledge, attitudes and condom use in a wider group of peers.
- *Utilization of services*
- Peers are commonly reported as a primary source of sexual and reproductive health education, they can help to ensure that more accurate knowledge is passed on and that the use of services is promoted. The potential for their impact on service use has been seen.
- Reliable evaluation tools to assess programme impact, including on use of services, are only recently being applied. Few studies currently measure service outcomes, and peer education is commonly part of multi-component programmes making it hard to assess their specific impact.



### 3.3.2 Life skills approaches

Life skills approaches include the development of psycho-social competencies such as communication, negotiation, problem-solving, decision-making and emotional coping skills. They can also incorporate broader livelihood approaches such as the development of employment opportunities. This section looks at programmes that have focused on the development of life skills and included education specifically on applying these skills to behaviour relating to sexual and reproductive health (e.g. the ability to negotiate condom use, delay sex, or seek services when needed). This approach can be used in many settings (Table 7) and has been mentioned above as a popular methodology for school education (e.g. Frontiers in Bangladesh and Senegal). In India there has been a lot of work in which the development of life skills is the core objective. Out-of-school adolescents are typically the target, and education takes place in the community. Although few programmes relate their activities directly to service use, two have been found.

Bhartiya Grameen Mahrasangh initiated the Better Life options Programme (BLP) in 1987 with support from the Centre for Development and Population Activities (CEDPA). The programme aimed to address the numerous concerns and needs of adolescents. In particular, it proposed to develop a cadre of adolescents who were educated, healthy, economically empowered and capable of making autonomous decisions through life and livelihood education carried out in village training centres. Reproductive and sexual health education was one component of the curriculum and knowledge about reproduction and contraceptive use improved as a result. BLP alumnae were also more likely to have used prenatal, delivery and postnatal care in their last pregnancy. In getting this care more BLP girls had gone to a health centre alone in the last six months, compared with controls. This demonstrates the positive influence of setting ASRH education within a broader approach to improve empowerment and autonomy (Levitt-Dayal & Motihar, 2000).

Another example is the Swaasthya programme run by ICRW in Tigri. This involved a similar youth development approach but without the livelihoods element, and focused on unmarried adolescents. It also included wider IEC activities (fieldworker education in the community and television and video promotion) and development of a social support network. Again this holistic approach, which was aimed at building girls' understanding of self and increasing their capacities and life skills to deal with real life situations in both social and health spheres, showed promise in influencing key SRH outcomes. Participation in a skills-building module was the intervention component that was most consistently effective in influencing the intermediate outcomes. These included knowledge of reproductive and sexual health; perceptions of support from key gatekeepers such as mothers-in-law for information and access to reproductive health services; and improvement in girls' positive perspective on life. Contact with community fieldworkers who helped educate and disseminate information to girls, was also quite effective. Girls who participated in the social support group networks experienced improvements in their reproductive and sexual health knowledge but not in their support perceptions or life perspectives. The programme was replicated in a slum area called Naglamachi but outcomes were weaker there. The more conservative social environment in which girls were allowed less freedom to attend the programme may have contributed to these weaker results. People were also less receptive since, unlike in Tigri, Swaasthya had not worked in Naglamachi previously (ICRW, 2005, Pande, 2007).

**TABLE 7. Programmes using life skills approaches in relation to sexual and reproductive health**

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES					EFFECT SIZE
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	
<i>Trained facilitator-led education with a focus on life and livelihood skills and community involvement</i>					
17. India Better Life options Programme (BLP)	Youth development approach (holistic empowerment model) to tackling the numerous concerns and needs (health, economic, education) in married and unmarried adolescents (12–20 years).	Quasi-experimental Post-test only, after 3 years of intervention. Structured survey n=1693 girls (858 controls and 835 BLP alumnae).	<ul style="list-style-type: none"> <li>Life and livelihood education – non-formal, participatory education in village training centres run by local literate women.</li> <li>Holistic empowerment model focusing on youth development               <ul style="list-style-type: none"> <li>reproductive and sexual health;</li> <li>vocational skills;</li> <li>literacy;</li> <li>basic skills for living (nutrition, self-protection from violence);</li> <li>family life skills;</li> <li>leadership skills;</li> <li>personality development;</li> <li>challenging gender inequalities;</li> <li>recreation.</li> </ul> </li> <li>Community               <ul style="list-style-type: none"> <li>community involvement in development of programme.</li> </ul> </li> </ul>	<p><b>RELATED OUTCOMES:</b></p> <ul style="list-style-type: none"> <li>Adolescents know when and why health services should be used;</li> <li>know where health services can be obtained;</li> <li>state intention to use services, if needed.</li> </ul> <p><b>PRIMARY OUTCOME:</b></p> <p>Use of health services</p>	<ul style="list-style-type: none"> <li>Confidence intervals for change in service use not reported and no multivariate logistic regression carried out.</li> <li>Post-test only.</li> </ul>
1996–1999 (Levitt-Dayal & Motilhar, 2000)			<ul style="list-style-type: none"> <li>Improved knowledge about reproduction and contraceptives.</li> <li>Increased literacy, employment, communication and autonomy (e.g. about spending what they earned).</li> <li>More likely to discuss family planning with their husbands and to use contraceptives (and greater intention to use them in the future).</li> </ul>	<ul style="list-style-type: none"> <li>Compared with those in the control group (21%), significantly (<math>p &lt; 0.001</math>) more BLP girls (68%) had travelled outside their village and went to a health centre alone in the last 6 months.</li> <li>Compared to controls, the BLP alumnae were more likely to have used prenatal, delivery and postnatal care in their last pregnancy.</li> </ul>	

*Continued...*

<p>18. India, Delhi</p> <p>“Swaasthya” programme</p> <p>ICRW</p> <p>April 1998–April 2001 (Tigri pilot)</p> <p>July 2003–July 2006 (Naglamachi slum-replicative study)</p> <p>(ICRW, 2005, 2007; Pande, 2007)</p>	<p>To enhance the sexual health and decision-making of adolescent girls (targeting unmarried girls aged 12–22 in Tigri (an area with many economic migrants from surrounding states) and both married and unmarried girls in the Naglamachi slum</p>	<p>Before/after surveys (no control)</p> <p>Tigri (n=401) and Naglamachi (n=295 baseline, 365 endline) and qualitative interviews with community members and Swaasthya staff members</p> <ul style="list-style-type: none"> <li>– analysed by intervention component exposure.</li> </ul> <p>Sustainability study in December 2005 (to see if changes were sustained after Swaasthya withdrew in April 2001), Tigri.</p>	<ul style="list-style-type: none"> <li>• Life skills education, participatory approach. Holistic youth development model                             <ul style="list-style-type: none"> <li>– 7 skills-building modules; reproductive and sexual health was one module.</li> </ul> </li> <li>• Development of a social and peer support network (including supportive adults)                             <ul style="list-style-type: none"> <li>– women’s groups for adolescent girls and their mothers to increase understanding between them;</li> <li>– involved community elders and boys as well as mothers.</li> </ul> </li> <li>• IEC dissemination                             <ul style="list-style-type: none"> <li>– one-on-one interaction with Swaasthya female health worker;</li> <li>– television programmes and videos on community and adolescent issues (Tigri only, as not found to be effective).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Improved knowledge of reproductive and sexual health including contraceptive use and availability and use of services. Tigri: high knowledge of SRH issues 57.7% in participants, 53.9% in non-participants. Naglamachi: 62.2% in participants, 43.3% in non-participants.                             <ul style="list-style-type: none"> <li>• However, overall effects were weaker in Naglamachi than in Tigri. The former has a more conservative environment with girls having less freedom to attend programmes. Earlier work in Tigri by Swaasthya may also have made people more receptive.</li> <li>• The sustainability study showed that the community did not sustain all the components of Swaasthya, and that knowledge of sexual and reproductive health decreased, suggesting that consistent input is needed to maintain knowledge.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Use of services not measured, no significance test of change in knowledge of services.</li> <li>• No control.</li> </ul>
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## KEY MESSAGES

### Key findings

#### *General*

- Poor success of individual risk reduction interventions (e.g. condom promotion) led to broader approaches being developed. Life skills education responds to this by focusing on the development of underlying negotiation, communication and other psycho-social development skills to help with positive SRH decision-making by young people (WHO, 2005; Reynolds et al., 2006; Blum, 1999).

#### *Utilization of services*

- The two studies demonstrate the potential of life skills approaches in increasing awareness and use of services, but it is rarely measured.
- Very few programmes directly relate the SRH component to services, and to date none have measured uptake. Until more programmes are implemented and evaluated, the evidence base remains very limited.

### 3.3.3 Use of media

Information, education and communication materials such as leaflets, posters, billboards and magazines may be made available to adolescents in many different places (work sites, youth clubs, health facilities and in the community). Information on the availability and recommended use of services is a component of many of the education programmes described in this review (Table 8). For example, as part of the national Youth Now programme in Jamaica (see section 3.5 and chapter 4), various educational materials have been developed, including a series of fact sheets for use in schools and clinics and by Youth Now advocates in the parishes. In contexts where there is access to them, radio and television are useful in reaching a large number of people quickly. Evidence suggests that the provision of materials alone is not sufficient to change behaviour. Ideally, it should be combined with more interactive approaches. With the mass media this is possible through radio chat shows and the promotion of counselling phone lines.

Only one study in Zimbabwe was found that included the impact of a media campaign on use of services. Radio programmes, drama performances, and a hotline were combined with peer educators, the distribution of print material at schools and the training of family planning service providers in clinics. These all referred young people to clinics. A statistically significant increase in the use of contraceptives and SRH facilities was found in the intervention area. Launch events, leaflets and drama were the most influential campaign components. The more components respondents were exposed to, the more likely they were to take action in response. However, there was contamination in control sites which weakens the strength of evidence (Kim et al., 1998, 2001).

In Burkina Faso mass media and was also used as part of a very comprehensive approach involving youth friendly services, peer education and community activities (Yaro et al 2003). In Kenya, a finance component was also included (see section 3.4). Awareness of health services and knowledge of and use of condoms increased significantly, and in Kenya a national survey showed that over half of youth (and 40% of adults) had listened to the Youth Variety Show and 40% of both listened to the drama, demonstrating the potential for high coverage (Erukhar et al 2004).

Gennadiy Ratushenko/World Bank



TABLE 8. Use of media in programmes

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES					
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	EFFECT SIZE
<i>Mass media activities with peer education</i>					
19. Zimbabwe (Kim et al., 1998, 2001)	To promote sexual responsibility among youth aged 10–24 years living in cities or in the centres of small towns in rural areas	Quasi-experimental (before/after n=1400). 5 intervention and 2 control areas.	<ul style="list-style-type: none"> <li>• Media               <ul style="list-style-type: none"> <li>– radio;</li> <li>– launch events;</li> <li>– drama events;</li> <li>– hotline;</li> <li>– promotion of services.</li> </ul> </li> <li>• Peer education               <ul style="list-style-type: none"> <li>– including referral.</li> </ul> </li> <li>• Information material distributed at schools.</li> <li>• Youth-friendly services               <ul style="list-style-type: none"> <li>– trained family planning providers.</li> </ul> </li> </ul>	<p><b>RELATED OUTCOMES:</b> Adolescents</p> <ul style="list-style-type: none"> <li>• know when and why health services should be used;</li> <li>• know where health services can be obtained;</li> <li>• state intention to use services, if needed.</li> </ul> <p><b>PRIMARY OUTCOME:</b> Use of health services</p>	<ul style="list-style-type: none"> <li>• Multivariate logistic regression of impact on service use but confidence intervals not reported and contamination of control weakens evidence.</li> </ul>

Continued...



<p>20. Burkina Faso                  Advocates for Youth and Pacific Institute for Women's Health                  4-year programme 1998–2002                  (Yaro et al., 2003 &amp; 2007)</p>	<p>Community mobilization to help identify and tackle local priorities (includes use of services and communication regarding ASRH)</p>	<p>Before/after (no control) – survey.</p>	<ul style="list-style-type: none"> <li>• Media                         <ul style="list-style-type: none"> <li>– folk and modern.</li> </ul> </li> <li>• Peer education                         <ul style="list-style-type: none"> <li>– discussions;</li> <li>– home visits;</li> <li>– role plays.</li> </ul> </li> <li>• Community                         <ul style="list-style-type: none"> <li>– awareness projects for parents and other community members;</li> <li>– community involvement in developing, implementing and evaluating programme.</li> </ul> </li> </ul> <p>Local organizations serving young people worked with community members in 20 villages to develop action plans based on local needs.</p> <ul style="list-style-type: none"> <li>• Youth-friendly services                         <ul style="list-style-type: none"> <li>– providers trained;</li> <li>– adjusted operating hours;</li> <li>– special youth area.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Knowing how to use a condom correctly (up from 52% to 84%).</li> <li>• Aware of where to obtain health services (up from 62% to 78%).</li> <li>• Increased proportion of sexually active youth reporting current condom use (up from 51% to 73%).</li> </ul>	<ul style="list-style-type: none"> <li>• No significance testing.</li> <li>• No control.</li> </ul>
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## KEY MESSAGES

### Key findings

#### *General*

- The use of media covers a wide spectrum of different approaches, from the distribution of IEC materials at health centres, schools, workplaces and other locations, to comprehensive mass media campaigns using television and radio.
- IEC materials, while a valuable educational component, are unlikely to produce behaviour change (including increased use of services) when used on their own.
- Mass media have wide community audiences and seek to influence social norms and cultural practices, often in combination with peer education approaches.
- Although there is some evidence of behavioural changes, there is no strong evidence of the direct and consistent effect of media campaigns. Changes do not appear to survive the campaigns. There is no consensus (or evidence) on how long they need to be sustained (FHI/YouthNet, 2002, 2006).
- Evaluating media activities is difficult. The strength of evidence is weakened because media activities are almost always part of wider interventions. Evaluations rarely make it possible to disentangle the different effects.
- Evidence suggests that media programmes become more effective with increasing exposure. They are also more effective when combined with other complementary activities (e.g. peer education) so that messages are reinforced through a variety of means.
- *Utilization of services*
- The strongest evidence is for impact on knowledge and attitudes, but behaviour change may be promoted by encouraging adolescents to go to a clinic or call a hotline. Hotlines also often provide referrals to services, although data on uptake is rarely collected (FOCUS, 1999).
- Only one study looks specifically at impact on service use. More research is needed as this is often not adequately monitored.

### 3.4 Finance interventions

The cost of services has been recognized as an obstacle to adolescents accessing them. It is therefore an important issue to address (Table 9). In doing this, two main approaches have been used. The first involves helping adolescents or community members to save money or generate income (microfinance) so that the cost of services is more manageable. The second involves earmarked transfers or subsidies, typically via vouchers, entitling beneficiaries to free or subsidized services, thereby removing or minimizing cost as a barrier to uptake.

Microfinance involves the provision of group-based services in the form of small loans, savings and other financial products such as insurance, along with training in business skills to enhance the possibility of success (IPPF, 2006). However, little rigorous evaluation of these approaches has taken place in general, and even less specifically relating to adolescents who are noticeably absent from services provided by many microfinancing institutions. The inclusion of young women is sometimes part of programme objectives but there is a lack of clarity about what this means and how it is measured. Anecdotes and stories remain the main source of evidence to support the assumption that microfinance and wider livelihood approaches are effective strategies for improving adolescent SRH (IPPF, 2006). Broader livelihood approaches that include a reproductive health component often include the building of relevant skills (as seen in section 3.3.2) but in some cases they are more specifically targeted at income-generation and saving. In Bangladesh, for example, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) attempted to evaluate more rigorously the impact of life skills training with a community savings scheme. A quasi-experimental evaluation design was used in one intervention group, and an education programme and youth-friendly services were implemented. In the other, this was combined with life skills training and a community savings scheme. However, high attrition and subsequent problems with evaluation made it impossible to draw firm conclusions (Huq et al., 2005). The Bangladesh Rural Advancement Committee (BRAC) took a broader approach, involving the whole community in its credit scheme. The aim was to build trust in the community by meeting its needs with the programme, while combining it with monthly reproductive health sessions integrated into the school curriculum. Knowledge of services improved and, it is thought, so did use, although this was not measured quantitatively. Evaluation does not make it possible to link the savings scheme to this directly (Barkat et al., 1999; Kahn & Ahmed, 1996). A collaborative project between the Population Council and Care India included group saving formations as part of a livelihood approach integrated into a reproductive health intervention. It is not possible to identify the impact on service use (Sebastian et al., 2005). No studies were found that meet the inclusion criteria for this review. More rigorous research is beginning, however. These approaches show potential and more work is needed to evaluate them.



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An alternative intervention is the use of demand side financing, which has been shown to promote competition and choice. It allows the targeting of social sector resources to specific populations through the

transfer of earmarked funds (Standing, 2004). A limited number of interventions have been trialled with the aim of addressing this constraint. Two met the inclusion criteria and are described below.

### 3.4.1 Vouchers for SRH services

A small number of programmes have used competitive voucher schemes to encourage the use of SRH services by young people. The Safe Motherhood Project of Indonesia (Knowles and James, 2000) and a programme in the slums of Kolkata in India (Mookherji, 2003) have shown the potential of this approach. However, the best evaluated programme is that carried out in Managua, Nicaragua. Knowledge and use of condoms and services were significantly higher among voucher recipients. While utilization of vouchers was higher among sexually active youth, in general young women who received vouchers made greater use of sexual and reproductive health services than those who do not receive them (34% versus 19%). Girls who benefit most from the vouchers are those who are at school, younger, or less well educated. This study showed that many girls are motivated to protect themselves against the risks of sexual intercourse once they have access to reliable information and confidential health services. It was concluded that the need for adolescent SRHS can be met through a relatively simple programme that uses existing health facilities, even within a conservative political climate (Meuwissen et al., 2006a & 2006b).

The Friends of Youth Health Project in Kenya included the use of vouchers as part of a wider programme of demand-creating activities, including peer education and community involvement. The peer educators or “friends of youth” distributed the vouchers to adolescents. The vouchers were given out in a more targeted way than in the Managua project – specifically to adolescents who it was felt were in need of services. The services were not free but subsidized, and the cost was shared between the beneficiary (i.e. the young person), the implementing organization (the Family Planning Association of Kenya) and the youth-friendly service providers (public and private). Because only young people in need of the services received a voucher, and because there was a mechanism to follow up young people if they did not go for the services within a reasonable period of time, virtually 100% of the 2800 vouchers distributed were used. This strong referral and follow-up network provided by the community-based peer educators proved highly successful, although it was a labour-intensive approach that might be more difficult on a very large scale (Erulkar et al., 2004; Gorter et al., 2003).



**TABLE 9. Finance interventions**

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES					EFFECT SIZE
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	
<i>Finance vouchers</i>					
2.1. Nicaragua, Managua and the departments of Rivas and Chinandega Instituto Centro Americano de la Salud (ICAS) and the London School of Hygiene and Tropical Medicine (Meuwissen et al., 2006a & 2006b)	Aimed at all poor female adolescents aged 12–20 years of age to increase their utilization of sexual and reproductive health services and overcome obstacles to seeking care	Quasi-experimental – community-based survey of voucher recipients (904) and control (2105).	<ul style="list-style-type: none"> <li>Youth-friendly services – 28 711 vouchers distributed in disadvantaged neighbourhoods, at markets and in schools directly by ICAS and through a network of youth NGOs; – the vouchers offered free access to sexual and reproductive health services in 20 health centres in Managua.</li> <li>Provision contracted to public, NGO and private providers. Services included counselling, family planning, pregnancy tests, prenatal control, and diagnosis and treatment of STIs according to the needs of the adolescent.</li> </ul>	<p><b>RELATED OUTCOMES:</b> Adolescents</p> <ul style="list-style-type: none"> <li>know when and why health services should be used;</li> <li>know where health services can be obtained;</li> <li>state intention to use services, if needed.</li> </ul> <p><b>PRIMARY OUTCOME:</b> Use of health services</p>	<ul style="list-style-type: none"> <li>No randomization but multivariate logistic regression carried out.</li> </ul>

Continued...

<p>22. Kenya  “Friends of Youth” Health Project  Family Planning Association of Kenya and the Population Council  1997–2001  (Erulkar et al., 2004)</p>	<p>Community-wide intervention aimed at improving SRH knowledge, attitudes and behaviour in urban and rural youth aged 10–24 years in and out of school.</p>	<p>Quasi-experimental (Baseline survey 1997, endline survey 2001).</p>	<ul style="list-style-type: none"> <li>• Media.</li> <li>• Peer education (Friends of Youth).</li> <li>• Community sensitization and involvement.</li> <li>• Youth-friendly services <ul style="list-style-type: none"> <li>– service provision was contracted out to private and public service providers, skills of the providers were updated, and staff received training in “youth friendliness”;</li> <li>– no written contract was entered into with providers.</li> </ul> </li> <li>• Finance <ul style="list-style-type: none"> <li>– use of vouchers (2800 distributed) for subsidized youth-friendly services;</li> <li>– peer educators distributed vouchers directly to adolescents in need.</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Most of the 2772 vouchers used were for STI services (55%), followed by family planning (15%) and male circumcision (15%).</li> <li>• Voucher recipients were followed up and encouraged to use, meaning high rate of service use compared with control areas.</li> </ul>	<ul style="list-style-type: none"> <li>• No comparison of service use made between intervention area and control – high uptake in intervention area due to follow up of voucher recipients.</li> </ul>
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## KEY MESSAGES

### Key findings

#### *General*

##### ADVANTAGES OF COMPETITIVE VOUCHER SCHEMES:

- Distributing vouchers to disadvantaged and poor groups removes cost barriers (thanks to the vouchers) and quality barriers (through competition) to the uptake of service. These improvements lead to greater equity.
- Competitive tender, productivity-based remuneration (shifting public resources away from inefficient providers), use of existing institutional structures, greater use of the private sector, and event-based programme monitoring and evaluation all increase efficiency.
- Inviting known quality providers to tender fosters competition for clients. Including quality specifications and compulsory training in provider contracts, and allocating resources only to evidence-based and cost-effective interventions, can improve effectiveness.
- Competitive voucher schemes avoid the need for and cost of setting up special services. Experience has shown that this is extremely difficult to do successfully through supply side interventions.
- More general evidence on competitive voucher schemes suggests that their impact depends very much on the system design. If properly designed, these schemes can reach groups that are otherwise almost impossible to reach, which makes the schemes valuable in the area of adolescent health.

##### DISADVANTAGES:

- The programme may lead to the subsidizing of existing users of private services. Vouchers aimed at disadvantaged groups may be obtained by those less disadvantaged.
- Services may become either fragmented or monopolies. Setting up schemes may be complex with high administrative and monitoring costs.
- These programmes may mean less funding for public sector services and less control over providers. There is a risk that providers may compromise quality to lower prices and raise profits.
- From a patient's perspective vouchers may be stigmatizing and recipients may lack reliable information to choose between providers.
- Competitive voucher schemes are not a substitute for health systems that can offer a comprehensive range of high quality services to entire populations.
- Potential pitfalls include vouchers not being used either because of disbelief that they actually entitle people to services, or cultural or logistic barriers to seeking care (which means that they are insufficient incentive). A black market may develop where vouchers are sold to people who are better off. This can only be avoided by careful system design.

#### *Utilization of services*

- Vouchers represent a useful way of removing financial barriers to accessing services.
- If voucher distribution is combined with education and awareness-raising activities, it can also play a role in increasing demand more widely. Further research is needed.
- Little evaluation evidence exists for adolescent-focused schemes. Small-scale trials and research projects testing voucher schemes could help to produce a badly needed body of empirical evidence with which to assess their true potential.

(Gorter et al., 2003)

### 3.5 Multi-component and multisectoral interventions

Most SRH interventions for young people involve more than one component and this can make it difficult to distinguish the effects of different activities. Earlier in this review, conclusions have been drawn, as far as possible, for different intervention types – such as in-school education, peer education, and use of media. However, there has been a move more recently towards large-scale programmes implemented in multiple settings and including many different strands of activities (Table 10). Some of these have been mentioned earlier where it has been possible to draw pertinent findings relating to one component, but they will now be looked at briefly as a whole. In many cases the overriding approach is that of community mobilization and the impact of this is examined in more detail in the next chapter.

For example, outreach education in the community is often part of wider multi-component programmes. Although evaluation does not normally allow the individual effect to be gauged, it has contributed to increasing the demand for services. In the Jamaica national Youth Now programme, activities include working with the YMCA in Kingston to provide street boys with reproductive counselling and education as well as condoms – as part of a wider plan to support peer leadership and parenting education (Tiffany et al., 2003). Save the Children worked with the scouts organization to provide life skills education in Bhutan, Malawi, Nepal, and Viet Nam (Save the Children, 2005).

Youth centres have also been incorporated into wider programmes. In Ethiopia, SRH clubs were formed in schools and in the community by Save the Children US. These clubs train members to implement youth-focused activities that involve and educate their peers, as part of a much wider community mobilization approach (Gebregiorgis & Mwebesa, 2005). Similarly, as part of wider intervention in Bangladesh, Bhutan, Malawi and Nepal, Save the Children US opened youth information centres which provide an informal space for young people to discuss issues that are important to them and to access information and counselling. The individual impact of the youth information centres has not been measured but they have contributed to improvements in knowledge, motivation and use of commodities and services.

Several multi-component interventions also have IEC outreach components operating from health facilities. Jamaica's national Youth Now programme includes use of public health centres with regular outreach to nearby schools and communities to provide information and encourage people to use youth-friendly services (Tiffany et al., 2003). The AYA programme in Botswana, Ghana, Tanzania and Uganda worked with public health facilities, NGOs and faith-based organizations to improve their clinic and outreach services. In each country different innovative approaches were used. In Uganda, for example, AYA worked with

faith-based health providers and non-traditional condom distributors, including peer service providers. Component evaluations, including facility reassessments on a representative sample, determined that the availability of youth-friendly services broadened, the quality of and client satisfaction with youth-friendly services improved, and utilization of the services increased (AYA, 2007).

Peer education and life skills approaches are also common. Save the Children US worked with the Scouts to provide life skills education in Bangladesh, Bhutan, Malawi and Viet Nam, and in the AYA countries life planning skills curricula were used in schools (see section 3.1). Training in life planning skills was also delivered through vocational education centres. These were chosen





as the existing structure with the greatest reach and most potential to institutionalize such integration since they have a large attendance of young people. In each country, AYA worked with public and or private institutions to train instructors in life planning skills to and integrate SRH into their curriculum. For example, in Zanzibar, Tanzania, vocational education policy was changed to include training in life planning skills, guidance and counselling in their programmes. Life planning skills were a cornerstone of the behaviour change communication component, and it was supported by other activities such as drama, debates, activities at festivals and sports events, peer education, youth clubs, and parent-child communication sessions. Evaluations and process data from this component demonstrated improvements in SRH knowledge, perceptions, attitudes and behaviours among students who received training in life planning skills. Utilization of services was just one of the behaviour changes exhibited.



WHO-217078

TABLE 10. Multi-component and multisectoral interventions

PART 1. INTERVENTIONS TO INCREASE YOUTH DEMAND FOR SRH SERVICES					
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION	FINDINGS	EFFECT SIZE
<i>Multi-component, large-scale, all settings</i>					
23. Jamaica Youth Now Adolescent Reproductive Health Program (in collaboration with YMCA and others) 2000–ongoing USAID-funded (Tiffany et al., 2003 mid-term evaluation; Russell-Brown, 2003)	To implement ASRH policies and create a supportive social environment to improve ASRH outcomes.  To test a variety of approaches to ASRH information and service provision (traditional health centres shunned due to lack of privacy).	Before/after (national, no control) – surveys – 2000 baseline, 2001 and 2002 follow up; – clinic data; – process evaluation; – qualitative data.	<ul style="list-style-type: none"> <li>School and community education and counselling               <ul style="list-style-type: none"> <li>– peer educators, school nurses, girl guide leaders and coaches provide education, counselling, condom distribution and referral.</li> </ul> </li> <li>Media campaign               <ul style="list-style-type: none"> <li>– included promotion of a helpline.</li> </ul> </li> <li>Parenting education.</li> <li>Intensive work with the church               <ul style="list-style-type: none"> <li>– workshops, consultation and training.</li> </ul> </li> <li>Youth-friendly services (NGO and public)               <ul style="list-style-type: none"> <li>– providers trained</li> <li>– health centres linked to schools.</li> </ul> </li> <li>Advocacy and policy development               <ul style="list-style-type: none"> <li>– parish and national level.</li> </ul> </li> </ul>	<p><b>RELATED OUTCOMES:</b> Adolescents</p> <ul style="list-style-type: none"> <li>know when and why health services should be used;</li> <li>know where health services can be obtained;</li> <li>state intention to use services, if needed.</li> </ul> <p><b>PRIMARY OUTCOME:</b> Use of health services</p>	<ul style="list-style-type: none"> <li>No significance tests, detailed data not available.</li> </ul>

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<p>24. Mozambique Geração Biz, government programme UNFPA, Pathfinder Started in 2 districts (Maputo and Zambezia), expanded to 6, and aims for national coverage 1999–ongoing (Senderowitz et al., 1997; Hainsworth 2002)</p>	<p>In-school and out-of-school 15–24-year-old youths.</p>	<p>Before/after. KAP surveys (knowledge, attitudes and practice) and clinic data. Community mapping exercises.</p>	<ul style="list-style-type: none"> <li>• School                             <ul style="list-style-type: none"> <li>– peer education (films, drama, group debates);</li> <li>– teachers trained, national curriculum being developed;</li> <li>– links to youth-friendly services;</li> <li>– life skills education.</li> </ul> </li> <li>• Community                             <ul style="list-style-type: none"> <li>– outreach education, including</li> <li>– peer education (films, drama, group debates);</li> <li>– advocacy work to explain need for ASRH services to community members;</li> <li>– support for HIV-positive youth.</li> </ul> </li> <li>• Media                             <ul style="list-style-type: none"> <li>– community radio programmes.</li> </ul> </li> <li>• Youth centres                             <ul style="list-style-type: none"> <li>– receive counselling, condoms, referral to services.</li> </ul> </li> <li>• Youth-friendly services                             <ul style="list-style-type: none"> <li>– providers trained;</li> <li>– peer education.</li> </ul> </li> <li>• Youth involvement in designing and implementing programme.</li> </ul>	<ul style="list-style-type: none"> <li>• Condom use increased by an average of 28% in the two initial districts.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of adolescents aged 15–19 visiting clinics for counselling and services increased more than 10-fold in Maputo (1173 at baseline in 1999, 11 726 in 2000). Number of young men served almost doubled from 10% to 19% in 2000.</li> <li>• In Zambezia service statistics not available for 1999, but in 2000 number rose to 11 669. A larger proportion of clients were male (39%) than in Maputo.</li> <li>• Counselling and contraception reported as the two most popular services in both areas.</li> <li>• Adolescents were concentrated in the older age groups and more females than males visited. School students were also well represented, demonstrating the impact of school links with youth-friendly services. There was a delay in implementation of outreach activities, which resulted in weaker community links.</li> </ul>	<ul style="list-style-type: none"> <li>• No significance testing.</li> <li>• No control.</li> </ul>
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<p>25. Ethiopia, Addis Ababa and Oromia regions</p> <p>Initiative to Save Young Generation's Health Today (INSYGHT)</p> <p>Save the Children, October 2003 to September 2006 (school programme has been under way in Addis Ababa since 1997)</p> <p>USAID-sponsored (Gebregiorgis et al., 2005)</p>	<p>In- and out-of-school youths including primary school age (under 11)</p>	<p>Before/after evaluation.</p> <p>Process evaluation of ASRH clubs (surveys and interviews).</p> <p>Evaluation of utilization of youth-friendly services (document review, key informant interviews, clinic records).</p>	<ul style="list-style-type: none"> <li>• In-school and out-of-school ASRH clubs (primary and secondary) <ul style="list-style-type: none"> <li>– peer education;</li> <li>– songs, literature, assemblies, audio/visual media;</li> <li>– home visits to married youth by out-of-school club members;</li> <li>– youth action kit (IEC materials).</li> </ul> </li> <li>• Community <ul style="list-style-type: none"> <li>– outreach community activities and events by peer educators to reach community and religious leaders, government representatives, elders, shopkeepers and parents (dialogue with stakeholders for involvement in programme);</li> <li>– parent training, with active interested parents trained as peer educators;</li> <li>– orientation sessions with school principals;</li> <li>– community events;</li> <li>– radio programmes.</li> </ul> </li> <li>• Youth-friendly services <ul style="list-style-type: none"> <li>– increase availability, accessibility and quality of health services.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Improved knowledge of family planning.</li> <li>• Improved knowledge of sources of family planning, counselling, and STI/HIV services and what to do in case a medical consultation is needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Service statistics show uptake of family planning and reproductive health services including voluntary counselling increased.</li> </ul>	<ul style="list-style-type: none"> <li>• No significance test.</li> <li>• No control – other ASRH activities taking place in the area.</li> </ul>
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<p>26. Bhutan, Malawi, Nepal, and Viet Nam Save the Children, USA (Save the Children, 2005) 1999–2004 (ongoing activities in various forms)</p>	<p>To improve access to quality services, empower adolescents (10–25 years) to make positive life decisions. To build social and political capital for ASRH with a focus on changing community norms.</p>	<p>Before/after. Quantitative and qualitative evaluation (group discussions and semi-structured interviews).</p>	<ul style="list-style-type: none"> <li>• Participatory approach                             <ul style="list-style-type: none"> <li>– youth and community involvement in planning, implementing and evaluating activities.</li> </ul> </li> <li>• Peer education and youth action teams.</li> <li>• Youth clubs/information centres                             <ul style="list-style-type: none"> <li>– youth forums;</li> <li>– peer education;</li> <li>– IEC and counselling.</li> </ul> </li> <li>• Life skills education                             <ul style="list-style-type: none"> <li>– integrating into scout programme.</li> </ul> </li> <li>• Media                             <ul style="list-style-type: none"> <li>– newsletter;</li> <li>– magazine.</li> </ul> </li> <li>• Youth-friendly services                             <ul style="list-style-type: none"> <li>– availability and quality;</li> <li>– dialogue between youth and health service providers;</li> <li>– clinic and outreach.</li> </ul> </li> <li>• Community mobilization                             <ul style="list-style-type: none"> <li>– parents, religious leaders education;</li> <li>– community gatherings;</li> <li>– street theatre.</li> </ul> </li> <li>• Policy advocacy                             <ul style="list-style-type: none"> <li>– work with governments.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Improved knowledge of contraceptives and condoms for preventing HIV and pregnancy. Increased knowledge of available services.</li> <li>• In Malawi statistically significant differences (<math>p &lt; .05</math>) in sexual behaviour among young men and women exposed to the programme emerged. Approximately 22% of young women in the exposure group mentioned having changed their behaviour since hearing about HIV, by avoiding multiple partners, compared to 15% of those in the non-exposure group. 21% of exposed males mentioned that they had begun to use condoms, compared to 12% of non-exposed males.</li> <li>• In Nepal need for more youth-friendly service centres identified by adolescents.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased uptake of condoms and ASRH services. E.g. In Malawi improvements in services and an increased awareness of risks and treatment contributed to an increase in the number of female STI clients between April 2002 and April 2004.</li> </ul>	<ul style="list-style-type: none"> <li>• Detailed service uptake data not reported and no significance testing carried out.</li> <li>• No control.</li> </ul>
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<p>27. African Youth Alliance, partnership between UNFPA, PATH and Pathfinder Ghana, Tanzania, Uganda and Botswana (financial constraints meant the programme finished 2 years early)</p> <p>2000–2006 (resources are being mobilized for a second phase)</p>	<p>Seeks to improve sexual and reproductive health of young people, aged 10–24 (with emphasis on 10–19 age group), in Botswana, Ghana, Tanzania and Uganda</p>	<p>Baseline surveys (2001–2002), mid-term assessments (2003), component evaluations (2005–2006) and independent impact survey evaluation (2006–2007).</p>	<ul style="list-style-type: none"> <li>• Policy and advocacy           <ul style="list-style-type: none"> <li>– develop enabling environment for ASRH.</li> </ul> </li> <li>• Behaviour change communication           <ul style="list-style-type: none"> <li>– first stage highly participatory to increase awareness of ASRH in communities (e.g. work with religious groups);</li> <li>– extracurricular ASRH education in schools;</li> <li>– peer education;</li> <li>– mass media (e.g. in Ghana the "Challenge Cup" used the appeal of football to promote youth-friendly sexual and reproductive health information and services).</li> </ul> </li> <li>• Livelihood programme           <ul style="list-style-type: none"> <li>– life planning skills, education and counselling, both in and out of schools (including strategies to reach vulnerable subgroups).</li> </ul> </li> <li>• Youth-friendly services           <ul style="list-style-type: none"> <li>– partnering with facilities (static and outreach) to improve quality;</li> <li>– work with NGOs, faith-based organizations, public facilities and non-traditional providers (including peer service providers);</li> <li>– including outreach and promotion.</li> <li>– Institutional capacity-building.</li> </ul> </li> <li>• Coordination and dissemination.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in condom use by females (first sex, last sex, ever use, always use) in all countries.</li> <li>• Significant increase in modern contraceptive use by females (first sex, last sex) in all countries. Condom use (first sex, always use, ever use) and modern contraceptive use (first sex) increased among males in Tanzania (no impact in Ghana).</li> </ul>	<ul style="list-style-type: none"> <li>• Youth-friendly services clinic and outreach utilization increased. E.g. in Tanzania emerging trends show more girls are accessing services. E.g. in Uganda approximately half of the clients seen at AYA-supported clinics are new clients and two thirds of all clients are out-of-school youth.</li> <li>• Heterogeneity of young people is also evident in their preferences for service provision. Data across all countries showed that more females visited clinics for counselling, more males obtained condoms through outreach. Variation also exists among age groups. Increasing utilization of services requires multiple approaches to match diversity of youth. Outreach work is essential to create demand for clinical sexual and reproductive health services, especially among men (reduce stigma).</li> <li>• In general, a large increase in demand for ASRH education, information and services has begun in all countries, fuelled by AYA's multiple strategies of behaviour change and communication.</li> </ul>	<ul style="list-style-type: none"> <li>• Data on service use not reported in detail or analysed, focus placed on contraceptive use and changes in knowledge.</li> </ul>
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<p>28. RHIYA Funded by European Union (EU), UNFPA-led, with many local partners 2003–2007 (following on from the EU-UNFPA Reproduction Health Initiative 1998–2002) Being implemented in seven Asian countries (Bangladesh, Cambodia, The Lao People’s Democratic Republic, Nepal, Pakistan, Sri Lanka and Viet Nam). (EU/UNFPA, 2006, 2007)</p>	<p>To improve the sexual and reproductive health (behaviour, practices and awareness) of young people, aged 10–24, including utilization of services.</p>	<p>Before/after (no control). Clinic and youth centre attendance data.</p>	<ul style="list-style-type: none"> <li>• Advocacy                             <ul style="list-style-type: none"> <li>– increase political and community support for adolescent sexual and reproductive health.</li> </ul> </li> <li>• Behaviour change communication                             <ul style="list-style-type: none"> <li>– partnering with young people and communities to increase awareness and to improve sexual and reproductive health among adolescents and youth.</li> </ul> </li> <li>• In-school education                             <ul style="list-style-type: none"> <li>– e.g. teachers trained</li> </ul> </li> <li>• Peer education                             <ul style="list-style-type: none"> <li>– e.g. in school, in community, including life skills workshops;</li> <li>– e.g. bar workers trained in adolescent reproductive health and life skills.</li> </ul> </li> <li>• IEC materials                             <ul style="list-style-type: none"> <li>– e.g. distributed in village development committees.</li> </ul> </li> <li>• Youth clubs                             <ul style="list-style-type: none"> <li>– e.g. become youth information centres and provide peer education, counselling, clinical services and vocational training.</li> </ul> </li> <li>• Counselling                             <ul style="list-style-type: none"> <li>– e.g. telephone counselling.</li> </ul> </li> </ul>	<p>Overall impact</p> <ul style="list-style-type: none"> <li>• Significant improvements in awareness and knowledge of STIs across all RHIYA countries. This was identified as a particular problem at the start of the programme.</li> <li>• Improvements in knowledge of condom use.</li> <li>• An overall narrowing of gender gaps in sexual and reproductive health knowledge and behaviour across RHIYA countries.</li> <li>• Strong and significant improvement in contraceptive use, particularly condom use (e.g. Viet Nam where 24% used before intervention, and 48% after).</li> </ul>	<ul style="list-style-type: none"> <li>• Demand for and utilization of health services reported to have increased in many countries. Examples:                             <ul style="list-style-type: none"> <li>• In Bangladesh utilization of health services increased since the beginning of the project but challenges remain to make the service accessible to all.</li> <li>• In Nepal utilization of services in health facilities and youth information centres has increased.</li> <li>• In Viet Nam it has been acknowledged that youth corners could benefit from increased publicity (being addressed in Phase II), plus plan to make youth-friendly services available on a broader scale as part of public health facilities.</li> <li>• In Pakistan youth attendance was low at first. Further outreach and sensitization was carried out and the centres’ operating hours were adjusted, and young men gradually started attending the male centres. Girls, however, still faced restrictions on their mobility. To address this, further door-to-door outreach was done to contact parents and motivate them to allow their daughters to participate in RHIYA activities.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Detailed service uptake data not reported and no significance testing carried out</li> <li>• No control</li> </ul>
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<p>29. Nepal 12–24 months of intervention (November 2000 to March 2003) (Mathur et al., 2001)</p>	<p>To improve ASRH health of urban people, and rural young test influence of youth and community participation in programming.</p>	<p>Quasi-experimental – baseline and endline surveys (households, adolescents and service providers); – mystery client survey; – qualitative data collected at baseline and endline.</p>	<p>Intervention site (greater youth and community participation throughout design and implementation) • Youth clubs. • Livelihood training. • Community education – adult education; – street theatre.  Control site • Peer education • Teachers trained to provide education. • Youth-friendly services.</p>	<ul style="list-style-type: none"> <li>• Improved articulation of specific reproductive concerns (e.g. side-effects of contraception, symptoms of reproductive tract infections and STIs).</li> <li>• The understanding of service options available and how to use them was greater in the intervention areas.</li> <li>• Clear male/female differences. Strong evidence for gains in young women’s knowledge, and reduction in sexual activity among rural young men. A moderate negative effect on knowledge of rural young men and sexual behaviour of urban young men.</li> <li>• Higher demand for reproductive health information and services (adults and youth) and in-depth understanding of issues in the intervention areas.</li> </ul>	<ul style="list-style-type: none"> <li>• Delivery in medical facility increased at both sites but was much more substantial at the study site (Control – increase from 11.8 to 22.5%, Study – increase from 17.4 to 45.0%).</li> <li>• The proportion of young women seeking prenatal care for a first pregnancy increased substantially at the study site but in contrast the control showed a slight decline (Control – decrease from 41.2 to 36.6%, Study – increase from 4.8 to 66.7%).</li> </ul>	<ul style="list-style-type: none"> <li>• No significance test conducted.</li> <li>• No multivariate logistic regression.</li> </ul>
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## KEY MESSAGES

### Key findings

#### *General*

- Multi-component and multisectoral interventions are able to use a combination of approaches to reach adolescents in different and mutually reinforcing ways. Evidence suggests that the cumulative impact of multiple intervention components can be great.
- Rigorous evaluation is needed of the impact of different components within a comprehensive approach. Attempts should be made to determine the added value of the synergy between different kinds of activity.
- Policy-level advocacy can help to provide an enabling environment for intervention. Community activities can generate demand and contribute to a more amenable local context. Supply side interventions can ensure that services are acceptable to young people.
- It is crucial to remember that young people in different age groups and circumstances (e.g. vulnerable groups) may need different approaches and services. A true multi-component approach should be able to cater for this.
- *Utilization of services*
- Comprehensive approaches have been shown to have an impact on service utilization if this is explicitly promoted and measured as part of the different intervention components.

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## CHAPTER 4

**COMMUNITY SUPPORT FOR USE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY YOUNG PEOPLE: COMMUNITY AWARENESS-RAISING, PARTICIPATION AND MOBILIZATION**

It is well established that many factors are related to adolescent SRH behaviour other than their own sexual and reproductive health knowledge, their attitudes and their access to contraceptives. Community support and acceptance of providing services for adolescents, and the use of such services, are important. In many countries, cultural practices discriminate against young people and create informal barriers to their accessing social support, information and services. Community norms typically place young people low in the family, and these social hierarchies determine whether and how families address young people's health needs (Pande et al., 2007). Married adolescents often lack the autonomy to access health services even in pregnancy; their mobility may be restricted and they do not have their own financial resources. The decision as to whether they should seek care is largely made by parents, spouses, in-laws and other gatekeepers (WHO, 2005; Pande et al., 2007). For unmarried adolescents, access to contraceptive services is commonly difficult (Bond, 2004). There is often a large gap between sociocultural norms and realities. For example, premarital sex is considered inappropriate in many cultures and religions, and there is little acknowledgement that young people are increasingly sexually active before marriage. Community members need to recognize these changes and address the needs of young people rather than stigmatizing them. (Schutt-Aine & Maddaleno, 2003; Hardee, Pine & Wasson, 2003). Close relationships and connectedness with teachers, neighbours, family and particularly parents can be highly protective, and have been found to be related to delayed sexual initiation and safer sexual behaviour (Blum, 1999).

One approach, therefore, is to involve the wider community in activities and to seek to change social norms rather than focusing solely on individual adolescents (Table 11). Community awareness-raising, participatory and mobilization techniques are now commonly used in adolescent programming (FHI/YouthNet, 2007). Many examples have already been seen in chapter 3. The concept of community participation spreads along a continuum, according to the degree of control and decision-making that community members have and the different activities they are involved in. At the least involved end of the spectrum, community members are simply exposed to awareness-raising activities, using IEC techniques similar to those used to target adolescents. This is often essential even to make implementation of SRH interventions possible and to generate a climate in which they can be introduced. Awareness-raising may, for example, involve tackling the stigma and discrimination surrounding adolescent sexual activity, or opening up discussion on SRH and challenging norms. An enabling policy environment is advantageous, but local community traditions, norms and attitudes to adolescents and their health needs are crucial to determining receptivity to interventions. At the most involved end of the spectrum, there is community mobilization or collective action, where community ownership and involvement are high (Maclean, 2006).

It is also important to consider who is involved. Communities are not homogeneous, and community members will not participate equally. The involvement of particular individuals or organizations may be necessary to the success of an intervention. This commonly includes the people who are intended to benefit from the intervention, and several SRH interventions have noted the importance of enabling young people to "drive" the process (e.g. Weissman, 2002; Hainsworth, 2002) so that their issues, priorities and perceptions inform the process. Parents and community leaders are also influential actors, and it is particularly important to sensitize them to adolescents' needs. Parents can be an important source

of information and education, although there is no evidence of systematic action to promote this (WHO, 2007).

The wider community may be reached through the mass media, festivals and events. In Zimbabwe a multimedia approach was found to be a very effective broad-based approach for reaching the community and increasing acceptance of the provision and use of services for adolescents (Kim et al., 1998, 2001).

Interventions may use focused orientation or sensitization sessions to raise awareness and educate key stakeholders. Most commonly, a multi-pronged approach is used to mobilize the community. In Lusaka, Zambia, participatory methods were used to sensitize communities to SRH issues, and a participatory needs assessment was carried out at the beginning with involvement of young people, community leaders and parents. A multi-component programme involving youth-friendly services, peer education and continued community involvement was then implemented, encompassing a broad range of participatory learning activities. Overall, the programme led to more non-pregnant youth seeking services. Although no significant relationship was found between the different models of youth-friendliness in clinics and the rate of service utilization by youth, young people were more likely to use youth-friendly services in those communities that demonstrated most awareness and approval of the programmes. Though making services youth-friendly was deemed important, it was concluded that other factors may have a more profound impact on adolescent health-seeking behaviours. Therefore, before projects relating to youth-friendly services are designed, health-seeking behaviours and beliefs (not only of young people but also of adults who influence their decision-making) should first be examined. Any behaviours or beliefs that are found to conflict with project objectives should be addressed at the community level as part of the project (Nelson & Magnani, 2000; Mmari and Magnani, 2003).



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Community mobilization approaches are becoming very popular in the large-scale national multi-setting and multi-component programmes. In the Jamaican national Youth Now project, core groups of individuals – including clinical providers, parents and people working with groups of parents, pastors, peers, and men – have undergone intensive training with a major focus on coming to terms with their own sexuality so that they are able to cope with issues raised by adolescents. Subsequently, those trained have been reaching out to their own constituencies and sharing information and education. Many have been listed in a local directory of trainers. Pastors in particular have been responsible for promoting and gaining acceptance for service provision and use. The YMCA in Kingston is supporting parenting education to help parents with the knowledge they need to provide their children with informed, useful advice (Tiffany et al., 2003).

In the comprehensive AYA programme implemented in Botswana, Ghana, Tanzania and Uganda, increased involvement of communities was set as a cross-cutting objective. Young people participated in all programme components – planning, implementing and evaluating programme activities – and secured representation on national, district and community-level decision-making committees. AYA identified and sensitized local stakeholders such as government, religious and traditional leaders, media, parents and youth, engaging them in defining the SRH response and encouraging community involvement and ownership of interventions. The programmes were national so it was not possible to use controls. However, evaluation showed that capacity-building among young people resulted in youth-led organizations securing new funding and sustaining SRH programming, and it led the young people to

found new organizations and networks. Community involvement played a significant role in policy change, implementation and enforcement. It also contributed to creating a supportive and accepting environment for services, as demonstrated by the various new initiatives that developed (African Youth Alliance, 2007). Similarly, the RHIYA programme, implemented in seven Asian countries, used a mixture of approaches to promote discussion and openness around youth SRH issues, and ultimately worked towards gaining some acceptance of the provision of SRH services. The issue of premarital sex and provision of contraceptive services to unmarried young people remains sensitive in many countries (EU/UNFPA, 2007).

In the Frontiers programmes implemented in Bangladesh, Kenya, Mexico and Senegal, the quasi-experimental evaluation design did not separately assess the community component (implemented at all intervention sites). However, greater detail is given than in many reports. Although overall positive progress was made towards a more open climate for people's SRH interventions, findings demonstrate the importance of the local cultural context and the variations in community attitudes and receptivity, and in the level of community participation that could be achieved. From focus group discussions in Bangladesh, it was found that parents generally approved of reproductive health information being provided at school and agreed it should be included in the curriculum since they found it difficult to discuss reproductive health issues at home. Religious and community leaders expressed the belief that risk-taking behaviour will decrease if adolescents have correct reproductive health information, which is the opposite of what is found in some conservative environments. Specific attitudes towards service use are not clear but the involvement of service providers was deemed essential (Bhuiya et al., 2004). In Senegal, parents were initially found to lack confidence in providing their children with information, but over the course of the intervention approval grew along with knowledge and communication between parents and their children. Among parents, approval for provision of SRHS was high at the beginning, but the programme did not have a clear impact. Wider community members endorsed the idea of improving youth reproductive health but had mixed beliefs about adolescent sexuality. Religious leaders believed parents should discuss reproductive health issues openly with their children (Diop et al., 2004).

In Kenya, communities were very receptive to information and dialogue about adolescent reproductive health. Community and religious leaders conducted 60 outreach meetings attended by over 7000 parents. The involvement of numerous influential stakeholders – including religious leaders, teachers, young people, and national, regional and district government representatives – was critical to increasing community discussion of adolescent reproductive health. Community members were very receptive to adolescent SRH interventions, and a more open climate for discussion was generated that included better communication between parents and children. However, the issue of premarital sex remained sensitive and there was little impact on approval in this area. It was concluded that programme managers should inform and involve a diverse network of community groups to enhance local support (Askew et al., 2003). In Mexico, Mexfam placed a “young people coordinator” in each of the experimental cities. These coordinators trained community volunteers (multipliers), and with their help disseminated information on sexual and reproductive health through community events. Over 14 000 students, parents, and teachers attended these events. Results showed that community stakeholders had quite positive attitudes at the beginning of the project regarding the delivery of information and services to adolescents. These attitudes often improved over time. However, with changes observed in both the experimental and control groups, the programmes' impact was questionable (Vernon & Dura, 2004).

Some programmes have more explicitly involved the community in the design and development of activities. In Burkina Faso, for example, a participatory approach was deemed crucial for nurturing changes in community attitudes towards service provision for adolescents (Yaro et al., 2003 & 2007). In India, the Foundation for Research in Health Systems (FRHS) used a similar methodology to some of the broad community mobilization approaches described in Jamaica and Zambia but also included young people and other community members in the design of the intervention. As in Zambia, this Indian study compared the impact of addressing demand, including community support, and supply constraints to

service utilisation. The social mobilization approach focused on generating family and community support for young married women's reproductive health outcomes. This was in recognition of the fact that young married women's families and communities often place a low priority on the young woman's reproductive health needs and yet it is typically the husband, mother-in law or grandmother who makes decisions about what care the mother can seek. In the supply approach, FRHS worked with the government health system to train health workers in young people's SRH. As in Zambia, the study found that knowledge of adolescent reproductive health and use of services improved more in the sites that addressed wider community constraints than in those that did not. The social mobilization approach had some success in creating a supportive environment for young women's health needs. Qualitative data showed improvements in the support of mothers-in-law for young women's care-seeking. Ironically one key limitation is that a result of the success at the community level is that representatives of the control area started implementing their own education sessions and some degree of contamination is therefore likely (Pande et al., 2007).

With such a range of community involvement and approaches available, there is a need to evaluate rigorously what components are most effective and at which stages involvement is most key. To date, a study in Nepal has done this most effectively, seeking to evaluate the extent to which participatory approaches yield improved results in developing countries. In two control sites, traditional reproductive health research and interventions were carried out. A more limited needs assessment was conducted on the basis of current knowledge and standard practice in the reproductive health field. A set of three interventions was implemented: adolescent-friendly services, peer education and counselling, and teacher training. In the study site a participatory approach was used for research, intervention, monitoring and evaluation. An extensive needs assessment was carried out and the community helped to design the programme. Young people and adult community members at the study sites identified a broader set of eight integrated interventions that addressed not only the specific sexual and reproductive health needs and concerns of young people, but also the broader social context that defines those needs and concerns. The eight interventions were: adolescent-friendly services, peer education and counselling, an information and education campaign, adult peer education, youth clubs, street theatre addressing social norms, efforts to improve livelihood opportunities, and teacher education. The overall intervention period ranged from 12 to 24 months.

The evaluation reveals that the participatory approach, which also yielded a greater variety of interventions, did indeed yield more positive results. Although the effect is only marginally more positive in terms of basic indicators of youth reproductive health (e.g. SRH knowledge, condom use), it is substantially more positive in terms of the broader contextual factors that influence SRH – such as social norms, capacity-building, empowerment, and sustainability. Of interest for this review is the fact that the participatory approach was found to mobilize the community, increasing the demand for reproductive health information and services by adolescents and the community. It was concluded that participation should be strategic, not all-encompassing. Participation of key people at key points maximizes the use of the community, the skills of the implementing agency, and resources and time. Both community members and the project organizers should be involved in decision-making. Strategies are needed to enable adequate participation of disempowered groups within the community. Participation requires the custom-tailoring and adaptation of existing tools and mechanisms to local needs, rather than the creation or reinvention of new tools and mechanisms (Mathur et al., 2001).

**TABLE 11. Interventions aiming to promote community involvement and support**

PART 2. INTERVENTIONS TO INCREASE COMMUNITY SUPPORT FOR SRH SERVICE USE BY YOUNG PEOPLE					
STUDY LOCATION AND DATES	TARGET POPULATION AND OBJECTIVE	EVALUATION	DESCRIPTION/ SETTING	FINDINGS	EFFECT SIZE
<i>Community sensitization via multimedia</i>					
1. Zimbabwe (Kim et al., 1998, 2001)	To promote sexual responsibility among young people aged 10–24 years living in cities or centres of small towns in rural areas	Quasi-experimental (before/after n=1400). 5 intervention and 2 control areas.	<ul style="list-style-type: none"> <li>• Multimedia                             <ul style="list-style-type: none"> <li>– radio;</li> <li>– drama events;</li> <li>– hotline;</li> <li>– promotion of services (information material distributed in schools).</li> </ul> </li> <li>• Peer education                             <ul style="list-style-type: none"> <li>– including referral.</li> </ul> </li> <li>• Youth-friendly services                             <ul style="list-style-type: none"> <li>– family planning providers trained.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Traditionally, aunts, uncles and other members of the extended family provided sexuality-related information to young people. However, as urbanization increases the distance between family members, parents are taking greater responsibility in this area. Many parents feel uncomfortable in this role. As a result of the campaign, 80% of respondents had discussions about reproductive health with friends (72%), with siblings (49%), with parents (44%), with teachers (34%) or with partners (28%).</li> <li>• Concluded that a multimedia approach is an effective way to build community support for behaviour change. It helps to ensure that young people find approval for their actions and have access to services. Decentralizing management to local committees that included representatives from local government, religious, educational, health and business groups; designing activities to reach a secondary audience of family, friends and teachers, and to prompt discussion of reproductive health issues; and by involving providers in campaign preparations and launches, all contributed.</li> </ul>	<ul style="list-style-type: none"> <li>• Limitation: contamination of control weakens evidence.</li> </ul>

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<i>Community participation/mobilization</i>				
2. Zambia, Lusaka	Quasi-experimental – 8 intervention sites and 2 control sites – qualitative interviews (peer educators, service providers, young people etc); – service statistics.	Varying degrees of community participation  • Community mobilization (sensitization) – “participatory learning for action” activities carried out to varying levels (e.g. use of role plays, debates and small group work).	• Mobilization activities led to fewer negative beliefs (e.g. belief that family planning services are for married adults). • Positive correlation between community acceptance of the provision of ASRH services and their use (Spearman’s Rank Order Correlation: family planning (0.43), outpatient visits (0.41), and reproductive health services (0.35)), but not significant at 95% level (low statistical power – 22%). In contrast, only one of the correlations between youth-friendliness and service use was positive (family planning 0.32). • While some barriers to service use can be tackled through supply side interventions, the family, social, peer and community influences on care-seeking are very important.	• Significance testing carried out but statistical power limited because of the small number of clinics and respondents, meaning relatively high risk of failing to detect significant relationships when they existed. • Not possible to control for unobserved differences amongst clinics that may have predisposed some to attract higher levels of clients or unobserved community level factors that may have differentially predisposed youth to using clinic services in some communities. • Non-probability sampling methods were used to select the clinics.
Lusaka District Health Management Team, with Care, UNICEF and John Snow International	All clinics in intervention sites improved their youth-friendliness and to varying degrees involved the community in activities (degree of friendliness and level of acceptance of provision of ASRH services measured).	• Peer education – chosen either by the programme, by young people or by neighbourhood health committees.  • Youth-friendly services – trained providers; – improved privacy, confidentiality etc.		
1994–ongoing (Nelson & Magnani, 2000; Mmari & Magnani, 2003)				

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<p>3. Jamaica Youth Now Adolescent Reproductive Health Programme (in collaboration with YMCA and others)</p>	<p>To implement ASRH policies, to create a supportive social environment to improve ASRH outcomes, and to test a variety of approaches to ASRH information and service provision (traditional health centres shunned due to lack of privacy).</p>	<p>Before/after (national, no control) – surveys – 2000 baseline, 2001 and 2002 follow up; – clinic data (national, no control); – process evaluation; – qualitative data.</p>	<p>School and community education, counselling and mobilization – peer educators, school nurses, girl guide leaders and other coaches provided education, counselling, condom distribution and referral; – intensive work with the church (workshops, consultations and training).  • Media campaign – included promotion of a helpline. • Parenting education.  • Youth-friendly services (NGOs and public) – providers trained. – health centres linked to schools.  • Advocacy and policy development – parish and national level.</p>	<ul style="list-style-type: none"> <li>• Achieved good community awareness of the programme.</li> <li>• Partnership with all community influencers considered essential to gain acceptance and to change community values, attitudes and norms in support of adolescent reproductive health.</li> <li>• Improvements in the traditionally negative attitudes towards adolescent sexual activity that affects access to information and services (e.g. pastors' and church leaders' awareness was raised concerning the tension between theological theory and realities of adolescents lives, leading them in turn to train other church members; church leaders promoted adolescent services and encouraged their use).</li> </ul>	<ul style="list-style-type: none"> <li>• Qualitative data supporting changes in community acceptance – quantitative survey data not available for indicators of community acceptance.</li> </ul>
<p>2000–ongoing USAID-funded (Tiffany et al., 2003, mid-term evaluation)</p>					

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<p>4. Geração Biz, Mozambique, government programme UNFPA, Pathfinder Started in 2 districts, expanded to 6, aiming for national coverage 1999–ongoing (Senderowitz et al., 1997; UNFPA and Pathfinder International)</p>	<p>In-school and out-of-school 15–24-year-olds</p>	<p>Before/after. KAP surveys (knowledge, attitudes and practice) and clinic data. Community mapping exercises</p>	<p>Youth involvement in designing and implementing programme.</p> <ul style="list-style-type: none"> <li>• Community <ul style="list-style-type: none"> <li>– outreach education, including peer education (films, drama, group debates);</li> <li>– advocacy work to explain the need for ASRH services to community members;</li> <li>– parents trained as community activists.</li> <li>– support for HIV-positive youth.</li> </ul> </li> <li>• School <ul style="list-style-type: none"> <li>– peer education (films, drama, group debates);</li> <li>– teachers trained (national curriculum being developed);</li> <li>– links to youth-friendly services;</li> <li>– life skills education.</li> </ul> </li> <li>• Media <ul style="list-style-type: none"> <li>– community radio programmes.</li> </ul> </li> <li>• Youth centres <ul style="list-style-type: none"> <li>– provide counselling, condoms, referral to services.</li> </ul> </li> <li>• Youth-friendly services <ul style="list-style-type: none"> <li>– providers trained;</li> <li>– peer education;</li> <li>– dialogue between young people and health service providers.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Increased understanding of need for ASRH services among community members through outreach education and sensitization.</li> <li>• Improved parent-child communication</li> <li>• Community support for implementation of the programme was established. Involving parents as community activists helped to create a supportive environment for the provision of sexual and reproductive health services and information, and helped facilitate communication between parents and their children.</li> </ul>	<ul style="list-style-type: none"> <li>• Anecdotal and qualitative evidence.</li> </ul>
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<p>5. African Youth Alliance, partnership between UNFPA, PATH and Pathfinder</p> <p>Ghana, Tanzania, Uganda and Botswana (financial constraints meant the programme finished 2 years early)</p> <p>2000–2006 (resources are being mobilized for a second phase)</p>	<p>To improve sexual and reproductive health of young people, aged 10–24 years (with emphasis on 10–19 years), in Botswana, Ghana, Tanzania and Uganda.</p>	<p>Baseline surveys (2001–2002), mid-term assessments (2003), component evaluations (2005–2006), and independent impact survey evaluation (2006–2007).</p>	<ul style="list-style-type: none"> <li>• Behaviour change communication                             <ul style="list-style-type: none"> <li>– drama, debates, festivals, sports events, peer education, extracurricular ASRH education in schools, mass media, youth clubs and parent–child communication sessions;</li> <li>– first stage, highly participatory to increase awareness of ASRH in communities (e.g. work with religious groups).</li> </ul> </li> <li>• Livelihood programme                             <ul style="list-style-type: none"> <li>– life planning skills, education and counselling;</li> <li>– in school and out of school (including strategies to reach vulnerable subgroups).</li> </ul> </li> <li>• Policy and advocacy                             <ul style="list-style-type: none"> <li>– develop an enabling environment for ASRH.</li> </ul> </li> <li>• Youth-friendly services                             <ul style="list-style-type: none"> <li>– partnering with facilities (static and outreach) to improve quality.</li> </ul> </li> <li>• Institutional capacity-building.</li> <li>• Coordination and dissemination.</li> </ul> <p>Cross-cutting objectives: partnerships, youth participation, gender, community involvement, sustainability and scaling-up.</p>	<ul style="list-style-type: none"> <li>• Improved knowledge and supportive attitudes of young people and stakeholders towards ASRH intervention, including services.</li> <li>• Behaviour change communication.</li> <li>• Tanzania: The media partnership programme reached millions and resulted in increased awareness of ASRH, increased leadership support for ASRH issues, more openness in public discussions on sexuality and condoms, and increased youth participation in activities.</li> <li>• Ghana and Tanzania: Football has provided an entry point for promotion of ASRH issues and for involving the community.</li> <li>• Botswana: Interactive local dramas, dance troupes (led and managed by young people), radio shows and mass media campaigns contributed to fostering of community awareness and positive community change (e.g. support and praise from leaders, teachers and parents). They also helped young people to feel more comfortable to talk about ASRH issues with their parents, teachers and service providers.</li> <li>• Non-traditional condom distributors (e.g. young barbers, artisans and shopkeepers).</li> <li>• Ghana: These distributors contributed to creating more positive views in the community toward ASRH information and service provision.</li> <li>• Increased commitments and actions supportive of ASRH and use of services by stakeholders.</li> <li>• Uganda: The Mufti of Uganda announced that Muslim couples should use condoms in marriage to prevent HIV and other STIs. The Anglican Church signed a declaration supporting ASRH and revised pre-nuptial counselling guidelines to include voluntary counselling and testing.</li> <li>• Botswana: Religious leaders supported discussion of ASRH issues and provision of services, and encouraged community support for them. Support from leaders, teachers and parents helped make young people more comfortable when talking about ASRH issues with them and with service providers.</li> <li>• Challenges of tackling the sensitivity of ASRH, fostering ownership and reaching diverse segments of the population acknowledged.</li> </ul>	<ul style="list-style-type: none"> <li>• Qualitative evidence.</li> </ul>
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<p>6. RHIYA Funded by EU, UNFPA-led, with many local partners 2003–2007 (following on from the EU-UNFPA Reproduction Health Initiative 1998–2002)  Being implemented in seven Asian countries (Bangladesh, Cambodia, Laos, Nepal, Pakistan, Sri Lanka and Vietnam).  (EU/UNFPA, 2006, 2007)</p>	<p>To improve the sexual and reproductive health (behaviour, practices and awareness) of young people, aged 10–24 years, including utilization of services.</p>	<p>Before/after (no control).  Clinic and youth centre attendance data.  Qualitative data.</p>	<ul style="list-style-type: none"> <li>• Advocacy <ul style="list-style-type: none"> <li>– increase political and community support for ASRH.</li> </ul> </li> <li>• Behaviour change communication <ul style="list-style-type: none"> <li>– partnering with young people and communities to increase awareness and to improve ASRH.</li> </ul> </li> <li>• In-school education <ul style="list-style-type: none"> <li>– e.g. teachers trained.</li> </ul> </li> <li>• Peer education <ul style="list-style-type: none"> <li>– e.g. in school, in community, including life skills workshops;</li> <li>– e.g. bar workers trained in adolescent reproductive health and life skills.</li> </ul> </li> <li>• IEC materials <ul style="list-style-type: none"> <li>– e.g. distributed in village development committees.</li> </ul> </li> <li>• Youth clubs <ul style="list-style-type: none"> <li>– e.g. become youth information centres and provide peer education, counselling, clinical services and vocational training.</li> </ul> </li> <li>• Counselling <ul style="list-style-type: none"> <li>– e.g. telephone counselling.</li> </ul> </li> <li>• Community sensitization <ul style="list-style-type: none"> <li>– e.g. sensitization workshops and support groups formed</li> <li>– community health communication sessions. Parent, teacher and community leader groups set up with regular meetings, plus meetings of stakeholder group; e.g. street theatre.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Country variation in attitudes towards sexuality and sexual health.</li> <li>• Bangladesh and Viet Nam: ASRH issues are still widely considered sensitive and private issues that should not be discussed openly. Adolescents' sexual and reproductive rights remain poorly understood. Changing these norms and involving youth actively in decision-making will take time and sustained effort.</li> <li>• Pakistan: The sensitivity of ASRH issues led to recognition that an effective coalition at the community level would be needed for the programme to get off the ground.</li> <li>• Country variation in community support for the provision of education and services.</li> <li>• Pakistan: Extensive community mobilization and gradual consensus among the major gatekeepers allowed the youth centres (providing services) to be established. Sensitivity surrounding the mobility of girls remained a problem and further outreach to parents was needed. The community and all the key gatekeepers are now demanding the continuation of this programme, and district politicians are ready to support it.</li> <li>• Increase in the level of discussion of ASRH issues between the young and their spouses/partners, with peers, relatives including parents and with health professionals.</li> <li>• Nepal: In general, parents and adults were reluctant to educate their children on sexual and reproductive health, fearing the sensitivity of the topic. However, in 2003–2004, the project was able to establish a supportive environment through the formation of support groups and sensitization workshops on ASRH issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Qualitative data on community acceptance.</li> </ul>
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<p>7. Bangladesh Frontiers programme 1999–2003 (Bhuiya et al., 2004)</p>	<p>To improve ASRH knowledge attitudes and behaviour of in-school and out-of-school young people.</p>	<p>Quasi-experimental (baseline and endline population surveys (~6000 adolescents and 1500 parents) and qualitative interviews and focus groups).  Test additional effect of school education  Site A – youth-friendly services; – community.  Site B – youth-friendly services; – community; – in-school education.  Site C – control.</p>	<ul style="list-style-type: none"> <li>• Youth-friendly services             <ul style="list-style-type: none"> <li>– working to improve access to quality youth-friendly SRH services</li> <li>– e.g. “condom cafes” at work.</li> <li>– e.g. youth-friendly services at government health centres, in some cases separate male and female centres.</li> </ul> </li> <li>• Institutional capacity-building             <ul style="list-style-type: none"> <li>– developing the technical, planning and managerial capacity of government and local civil society organizations to meet the SRH needs of young people.</li> </ul> </li> <li>• Community             <ul style="list-style-type: none"> <li>– sensitization and awareness raising in the community (sessions with gatekeepers, parents, teachers, political and religious leaders and service providers) carried out before starting the in-school intervention;</li> <li>– community events organized by peer educators;</li> <li>– life skills education for adolescents;</li> <li>– peer education for adolescents.</li> </ul> </li> <li>• Participatory life skills school education (led by teacher) and peer education.</li> <li>• Youth-friendly services             <ul style="list-style-type: none"> <li>– providers trained.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Pre-intervention focus group discussions found almost all gatekeepers recognized the necessity of reproductive health education and believed that in schools reproductive health information should be started from the eighth grade. Religious and community leaders believe that risk-taking behaviour will decrease if adolescents have correct reproductive health information.</li> <li>• Baseline survey found most parents (62–95% depending on site, with fathers slightly more in favour than mothers) approved of providing reproductive health information (including in schools) at the start of the intervention because they found it difficult for them to discuss reproductive health issues with their children.</li> <li>• Concluded that linking services with community resources and gaining their support for SRH information is key to utilization of services for adolescents – support from schools, community and clinics led to a positive enabling environment.</li> </ul>	<ul style="list-style-type: none"> <li>• Community acceptance very high at baseline, change therefore not measured.</li> </ul>
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<p>8. Senegal Frontiers programme 1999–2003 (Diop et al., 2004)</p>	<p>To improve ASRH knowledge, attitudes and behaviour of in-school and out-of-school urban youths.</p>	<p>Quasi-experimental (pre-survey, post-survey, and qualitative). Test additional effect of school education (as above).</p>	<ul style="list-style-type: none"> <li>• Community           <ul style="list-style-type: none"> <li>– education sessions led by peer educators were also used to reach parents;</li> <li>– sensitization and awareness-raising (parents, religious and administrative leaders attended conferences and meetings convened by the project);</li> <li>– IEC agents of the Ministry of Health and Ministry of Social Affairs led discussion groups and contacted organizations such as women's groups.</li> </ul> </li> <li>• Participatory life skills school education (led by teacher) and peer education.</li> <li>• Youth-friendly services           <ul style="list-style-type: none"> <li>– providers trained.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Parental approval of adolescents being able to receive services was high at the start of the intervention (all above 70%). Women's approval was higher than men's. The impact of the programme was unclear with approval among women increasing at both the control site (non-significant) and the intervention site without school education (significant <math>p &lt; 0.05</math>), but decreasing (significant <math>p &lt; 0.05</math>) at the other intervention site.</li> <li>• Community members strongly endorsed the goal of improving ASRH and this remained true through the intervention (but did not dramatically improve) although it varied according to topic. Contraception was the most sensitive topic with approval levels between 52% and 72% at endline. One significant positive change was in the site with the in-school intervention where approval of providing information about contraception increased from 53% to 66% (<math>p &lt; 0.05</math>). Approval of all other topics (anatomy, sexuality, early/unwanted pregnancy, STI/HIV) reached 90% or more for mothers and fathers in all study sites with few significant changes between surveys.</li> <li>• Parents traditionally lack confidence to talk openly to children about these sensitive issues but wanted to get more information so they could play a bigger role. Communication was found to improve over the course of the intervention, with adolescents more likely to seek information from adults and other qualified sources than from their friends. Nevertheless, a family atmosphere conducive to communication remained lacking, although adolescents' expectations of more open communication had risen.</li> <li>• Religious leaders believed parents should discuss reproductive health openly with their children.</li> </ul>	<ul style="list-style-type: none"> <li>• Significance tests for some changes but no confidence intervals reported.</li> <li>• No multivariate logistic regression.</li> <li>• Qualitative data.</li> </ul>
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<p>9. Mexico Frontiers programme 1999–2003 (Vernon et al., 2004)</p>	<p>To improve SRH knowledge, attitudes and behaviour of in-school and out-of-school youths.</p>	<p>Quasi-experimental (pre-survey, post-survey, and qualitative). Test additional effect of school education (as above).</p>	<ul style="list-style-type: none"> <li>• Participatory life skills school education (led by teacher) and peer education.</li> <li>• Youth-friendly services – providers trained.</li> <li>• Community                             <ul style="list-style-type: none"> <li>– peer education;</li> <li>– sensitization and awareness-raising (sessions with gatekeepers, parents, teachers, leaders);</li> <li>– Mexfam placed a “young people coordinator” in each of the experimental group cities to train community volunteers (multipliers), and with their help disseminated SRH information through community events.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Results showed that community stakeholders had quite positive attitudes at the beginning of the project regarding the delivery of information and services to adolescents. These attitudes often improved over time, but changes were observed in both the experimental and control groups so improvement cannot be linked directly to the programme.</li> <li>• Post-intervention surveys showed an increase in the proportion of adolescents who spoke with their mothers and fathers about reproductive health issues, with differences in characteristics of study groups controlled for. However, this change was only statistically significant (<math>p &lt; 0.05</math>) for communication with fathers (not mothers) and only in the control group (OR=1.667) and intervention group with in-school education (OR=1.910. Changes can therefore not be attributed to the intervention.</li> </ul>	<ul style="list-style-type: none"> <li>• Quantitative data statistical significance to change calculated but 95% confidence intervals not reported.</li> <li>• Qualitative data.</li> </ul>
<p>10. Kenya Frontiers programme 1999–2003 (Askew et al., 2003)</p>	<p>To improve SRH knowledge, attitudes and behaviour of in-school and out-of-school youths in rural Kenya.</p>	<p>Quasi-experimental (baseline and endline population surveys (~3700 (1000 boys adolescents) and qualitative interviews). Test additional effect of school education (as above).</p>	<ul style="list-style-type: none"> <li>• Community                             <ul style="list-style-type: none"> <li>– peer education;</li> <li>– sensitization and awareness-raising by community development assistants and peer educators (briefing and outreach sessions with gatekeepers, parents, teachers, leaders). Religious and community leaders then went on to assist peer educators in organizing briefings and outreach events.</li> </ul> </li> <li>• Participatory life skills school education (led by teacher) and peer education.</li> <li>• Youth-friendly services – providers trained.</li> </ul>	<ul style="list-style-type: none"> <li>• Communities were very receptive to the information and dialogue about ASRH. The support and involvement of influential stakeholders (including religious leaders, teachers, young people and government representatives) was critical to increasing community discussion of ASRH and support for the programme.</li> <li>• Parent–child communication improved significantly at the intervention site that did not include the school education intervention (<math>p &lt; 0.05</math> percentage discussing SRH with at least one parent increased from 28–35%), but did not improve at the site where school education was included. It is not clear if this was due to the greater number of peer educators and community development assistants in the former, or a tendency to talk to teachers about SRH in the latter.</li> <li>• Surveys showed disapproval of both premarital sex and childbearing, particularly for females was high to begin with, and the interventions (especially in the intervention site without school component) reinforced these attitudes and failed to liberalize these attitudes.</li> </ul>	<ul style="list-style-type: none"> <li>• Significance testing only reported for changes in parent-child communication and OR’s and confidence intervals not included.</li> <li>• Qualitative data.</li> </ul>

*Community participation/mobilization included in intervention development*

<p>11. Nepal Engender-Health and ICRW 12-24 months of intervention (November 2000 to March 2003) (Mathur et al., 2001)</p>	<p>To improve SRH of urban and rural young people and test the influence of youth and community participation in programming.</p>	<p>Quasi-experimental – baseline and endline surveys (households, adolescents, adult and service providers); – mystery client survey; – qualitative data collected baseline and endline.</p>	<p>Intervention (1) • Participatory approach – greater youth and community participation throughout design and implementation. • Youth-friendly services. • Peer education and counselling. • IEC campaign. • Adult peer education. • Youth clubs. • Street theatre on social norms. • Efforts to improve livelihood opportunities. • Teacher education.  Control (2 sites – 1 urban, 1 rural) Traditional interventions. • Peer education. • Teacher training to provide education. • Youth-friendly services.</p>	<p>• Effects of the participatory intervention (1) were only marginally more positive on basic indicators of youth reproductive health (knowledge, attitudes and behaviour) than traditional interventions (2). However, (1) was substantially more positive in terms of the broader contextual factors such as marriage norms, empowerment, capacity-building, and sustainability. In the long term these would be expected to lead to improved reproductive health outcomes, but not at the time of the study. • Participatory intervention had greater effect on whether adolescents discussed reproductive health problems with their parents, this increase was greatest amongst rural males (25.6% to 51.0%) and urban females (39.4% to 72.5%) • The participatory approach was found to mobilize the community, increasing understanding of reproductive health issues and demands by adolescents and the community for information and services.</p>	<p>• Significance testing of adolescent behaviour change not carried out and changes in adult attitudes not reported in detail.</p>
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<p>12. Burkina Faso Advocates for Youth and Pacific Institute for Women's Health 4-year programme 1998–2002 (Yaro et al., 2003 &amp; 2007)</p>	<p>Community mobilization to help identify and tackle local priorities (includes use of services and communication regarding ASRH). Rural adolescents.</p>	<p>Before/after (no control) - KAP (knowledge, attitudes and practice) survey.</p>	<p>Community involvement in developing, implementing and evaluating the programme. Local organizations serving young people worked with community members in 20 villages to develop action plans based on local needs, including:</p> <ul style="list-style-type: none"> <li>• Community             <ul style="list-style-type: none"> <li>– awareness projects for parents, and other community members.</li> </ul> </li> <li>• Peer education             <ul style="list-style-type: none"> <li>– discussions;</li> <li>– home visits;</li> <li>– role plays.</li> </ul> </li> <li>• Media             <ul style="list-style-type: none"> <li>– folk and modern.</li> </ul> </li> <li>• Youth-friendly services             <ul style="list-style-type: none"> <li>– providers trained;</li> <li>– adjusted operating hours;</li> <li>– special youth area.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Community participation in the programme was high (70% of those interviewed had participated in at least one component). The community identified infrequent use of reproductive health services and the need to improve parent–adolescent communication as priorities.</li> <li>• The percentage of adolescents reporting that they felt able to talk to their parents about sexuality issues rose up from 36% to 55%.</li> <li>• It was felt that the participatory approach helped create an enabling environment that will encourage young people to take charge of their own reproductive and sexual health, including seeking services.</li> </ul>	<ul style="list-style-type: none"> <li>• No significance testing of behaviour changes.</li> <li>• Anecdotal evidence.</li> </ul>
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<p>13. India, Maharashtra (ICRW and FRHS) 2001–2006 (Pande et al., 2007)</p>	<p>Young newly-married couples (where wife is below 22 years) with a focus on the women.</p>	<p>Quasi-experimental Baseline survey (1866 married girls), mid-intervention (972 husbands in quantitative survey, 75 mothers-in-law in qualitative interviews). Social mobilization (process evaluation). Youth-friendly services (health worker/clinic records). To test the relative effectiveness of addressing supply (youth-friendly services) versus demand (social mobilization) constraints to improving reproductive health. Intervention – 1 only social mobilization; – 1 only youth-friendly services; – 1 both. 1 control.</p>	<p>Community (young people and others) involvement in intervention design and implementation. • Social mobilization through existing community-based organizations to address the low priority that communities place on ASRH – strengthen youth and women’s groups (mothers-in-law and husbands drawn in to participate); – adolescent and community education. • Youth-friendly services (address the fact that services are not geared towards ASRH) – improve quality and accessibility of government services; – sensitize providers to adolescent’s needs.</p>	<p>• The survey of husbands showed that most husbands are now aware of basic maternal care issues, such as the need for antenatal care, and that they are willing to allow their wives to seek treatment for problems during pregnancy and childbirth. Only a minority of husbands actually accompany their wives when they seek care. • Qualitative data show that mothers-in-law, who are often the primary gatekeepers for young married women’s health seeking, are now more likely to be supportive of the young woman’s desire to seek care than they were prior to the intervention. • In general, social mobilization was more influential than the provision of youth-friendly services in improving ASRH outcomes.</p>	<p>• Detailed quantitative data not reported. • One limitation is that the health education sessions in the social mobilization intervention were so popular that representatives in the control arm started implementing them. This caused some contamination of the control findings.</p>
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<p>14. India, Maharashtra (ICRW and KEM) (Pande et al., 2007)</p>	<p>To provide SRH education, plus care and counselling for married adolescents (14–25 years) and to include a broad spectrum of community and family members.</p>	<p>Quasi-experimental Baseline survey (114 couples), process evaluation (qualitative), endline survey (74 couples).</p>	<p>Participatory (community involvement in design and implementation)</p> <ul style="list-style-type: none"> <li>• Education sessions in the community.</li> <li>• Counselling sessions in the community                             <ul style="list-style-type: none"> <li>– education and counselling aimed at young women, husbands, mothers-in-law and others (community members informally participated in all activities);</li> <li>– interested teachers trained as educators/counsellors;</li> <li>– education and counselling components included a referral system for those requiring clinical services.</li> </ul> </li> <li>• Youth-friendly counselling and care services (provided by KEM)                             <ul style="list-style-type: none"> <li>– health providers trained.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A range of community members were involved in the design of the intervention and informally participated in education activities (school teachers, health-care providers, key community members etc). This feedback was considered crucial for acceptance of the activities, including referral to services.</li> <li>• After a period of implementation, it was found that fieldworkers were more accepted and more successful at reaching young couples if they went into the community as husband-and-wife couples themselves.</li> <li>• Qualitative data suggests that couple communication increased where husbands and wives had previously been reluctant to discuss sexuality and reproduction with each other.</li> <li>• The community's support for the intervention was clear from their request for KEM to start a programme with unmarried girls. This showed that they appreciated that girls need sexual health information before they are married.</li> </ul>	<ul style="list-style-type: none"> <li>• Qualitative data.</li> </ul>
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## KEY MESSAGES

### Key findings

#### *Community sensitization via multimedia (IEC material, events, mass media)*

- Cultural and social events, such as festivals and sports competitions, bring large numbers of people together and it is therefore useful to link SRH activities to them.
- Events have been shown to have some influence in fostering community awareness but there has been very little evaluation of their specific influence on community support for adolescent SRH services. Evidence suggests the linking of adolescent SRH to events needs to be sustained rather than one-off, and should be part of a wider multi-component intervention in order to have any lasting impact.
- By actively targeting many different groups (e.g. service providers, community leaders and parents as well as adolescents) and by presenting adolescent SRH as a topic for discussion, and thereby showing that it is acceptable, media activities can influence the social norms and cultural practices that are key to creating a supportive environment for SRH service provision and that have a strong influence on the behaviour of young people.

#### *Broader community mobilization and participation*

##### *Group education sessions*

A first step in fostering an enabling environment is to break existing taboos that surround adolescent SRH and to increase discussion of these sensitive issues by raising them publicly in the community. Small group education sessions using participatory rather than didactic methods have been successfully used to do this (e.g. Weiss & Gupta, 1998). Such sessions can include improved dialogue between parents and children.

- Sessions may be ongoing but are commonly concentrated in the first phase of programmes in order to gain support for the implementation of other components of the intervention, including the provision of services.
- A focus on sensitizing key stakeholders such as parents, religious and community leaders and government officials is common. Focused awareness-raising efforts and discussion sessions are often combined with wider exposure to SRH messages via the mass media. Sensitization of key stakeholders and gaining their support has facilitated implementation of wider SRH interventions.
  - Parents play a key role in influencing adolescents' health and access to services. They may oppose, or avoid talking about, sex education. They may control access to services (sometimes legally if the law specifies that certain services are available to adolescents only with parental consent). Interventions therefore try to involve and educate parents on these sensitive topics.
  - Community and religious leaders are key figures in influencing social norms and in determining and leading a community's response to adolescent SRH. They can prohibit or assist with the provision of services for adolescents. Interventions have sought to work sensitively with these groups.

### *Community participation*

- Community and adolescent involvement in the design, implementation and evaluation of interventions is very valuable. It can help nurture community support for programmes, ensure they meet the needs of the population, and bring a sense of ownership that helps sustain interventions in the longer term.
- Participation does not need to be all-encompassing but should focus on strategic people at strategic points (Mathur et al., 2001).
- Broad community mobilization activities can help gather wide support for ASRH programmes and can ease some of the barriers to adolescents' access to services (WHO, 2005).
- In societies where stigma and conservatism towards ASRH exist to a degree that makes community mobilization unrealistic, approaches that specifically target adolescents to encourage them to access services may be necessary (e.g. the voucher scheme in Managua, Nicaragua).

### *General*

- Anecdotal evidence from a wide range of projects and research studies frequently states that it is important to involve the community in building an enabling environment that fosters positive youth choices and behaviours in SRH.
- Most interventions do not specify objectives of community participation or empowerment and therefore do not develop indicators to evaluate this participation. There is therefore little evidence of the true effectiveness of these approaches.
- The quality of evaluation is improving, and several studies provide strong evidence for the value of strategic adolescent and community participation (e.g. Mathur, 2001), though more studies are needed.

## CHAPTER 5. Conclusions and discussion

In investigating community-based SRH interventions that aimed to increase uptake of services by adolescents and community support for their provision, the lack of rigorously evaluated studies makes it difficult to estimate accurately the relative merits of different approaches. Those that are evaluated are typically small-scale interventions carried out over a short period of time, with little evidence about the long-term effects on behaviours or on scaling up and evaluating long-term programmes. There are two further problems. First, the two outcomes of interest are often not specifically measured. For instance, demand for and utilization of services are not always seen as priorities in monitoring broader community-based interventions. Knowledge and attitudinal changes are more commonly the focus, while community support is often mentioned without being a specific objective and therefore indicators are not set to measure it. Second, a further problem is that, in multi-component interventions, the design of the evaluation rarely allows the impact of the different components to be measured accurately. A total of 30 programmes have been reviewed, and although the majority have been classified as a particular intervention type according to their focus, most involve multiple components and this fact influences the extent to which specific conclusions can be drawn.

From the evidence available, it is clear that programmes generally seem to be more effective in influencing knowledge and attitudes than in changing behaviour related to health service use. This is not surprising as it is widely understood that behaviours are less malleable and are influenced by many factors additional to those that affect knowledge. Nevertheless, although available evidence does not point to a ‘magic bullet’, there is evidence of the potential to increase adolescent’s service use, and of the important role community members can play in this. An overview of findings from the different intervention types are given below, and summarized in Table 12. Finally, some key findings are drawn out from the studies highlighted in chapters 3 and 4 as providing the best evidence linking specific intervention content and outcomes.



**TABLE 12. Overview of findings from different intervention types**

INTERVENTION	NUMBER OF STUDIES	DOES EVIDENCE SHOW THAT THE INTERVENTION WORKS?	MORE RESEARCH NECESSARY?
<b>TYPE 1: IEC INTERVENTIONS TO INCREASE ADOLESCENT DEMAND FOR SRH SERVICES</b>			
In-school education (not including peer-led)	6 1 highlighted (Nigeria, Okonofua et al.) (1 multi-component [AYA])	Yes, there is some evidence for participatory and life skills approaches having an impact on demand for and use of services. This seems to be most effective when schools and services are linked via a referral system.	Yes, there is particularly a need for more research into referral systems between schools and health facilities.
Community-based IEC (facilitated education sessions)	2 Both highlighted (India, Pande et al.)	Yes, some impact on demand for and use of services demonstrated, and the value of a referral system highlighted (as above). There were problems with sustaining interest in education sessions, and the importance of youth and community involvement in intervention design and implementation in combating this is noted.	Yes, research is needed into referral systems and the impact that young people's involvement in programme design and implementation can have on sustaining interest and participation in activities.
Community-based IEC (youth clubs)	3 No highlighted studies	Evidence shows that promotion of youth centres (e.g. through media and peer education) can encourage their use but most youth, particularly boys, visit for recreational activities and use of services within them is low.	Yes, research is needed into the potential for information, education and activities provided at youth centres to influence use of sexual and reproductive health services provided elsewhere.
IEC outreach from health facilities	5 1 highlighted (PATH RX, Thailand; Bond et al.) (1 multi-component [AYA])	Yes, intensive outreach from health facilities can promote use. The marketing and branding associated with social franchising shows potential. This can include involvement of the private sector, and the potential for referral between pharmacists and health facilities has been demonstrated.	Yes, further research is needed into the impact of social outreach from health facilities, and in particular social franchising including the role of the private sector.
Peer education	(1 multi-component [AYA]) No highlighted studies	Some evidence of potential for impact on demand for services, but peer education is usually part of a wider multi-component approach, making it hard to disentangle its individual effect. The main evidence available relates to impact on knowledge, with the effect greatest on the educators themselves.	Yes, further work is needed in which peer educators provide more formal links with services and uptake is measured.
Life skills	2 1 highlighted (BLP India, Levitt-Dayal)	Yes, the potential for ASRH issues, with a specific focus on service use, to be integrated into life skills approaches and to have an impact service use has been shown. However, there are large variations in the intensity and focus of life skills approaches, and integration needs further exploration.	Yes, more studies are needed on integrating ASRH service-specific education into life skills programmes and on the potential for setting up referral systems.

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Use of media	2 1 highlighted (Zimbabwe, Kim et al.)	Yes, there is evidence of the potential for media to influence service use and it is most effective when intensively implemented, with the effect increasing with level of exposure. There is stronger evidence of the impact on knowledge, and use of the media is typically combined with wider intervention components, making it difficult to evaluate its effect.	Yes, more research is needed to identify the specific impact of mass media alone and its potential for sustained change.
Vouchers for SRH services	2 2 highlighted (Nicaragua, Meuwissen et al.; Kenya, Erulkar et al.)	Yes, there is great potential for using vouchers to increase use of services. This approach has been shown to successfully meet adolescent demand for services within relatively conservative cultures, with high uptake of vouchers achieved.	Yes, voucher programmes need to be trialled in a wide range of cultural contexts and piloted on a larger scale.
Multi-setting and multi-component programmes (community, school and health service)	7	Yes, there is good evidence for the impact of comprehensive multi-component approaches on creating demand and influencing uptake of services. However, resource requirements are high and it is difficult to disentangle the effects of specific components.	Yes, rigorous evaluation is needed of individual intervention components within multi-component approaches.
<b>Type 2: Interventions to increase community support for SRH services</b>			
Sensitization via multimedia	1 1 highlighted (Zimbabwe, Kim et al.)	Yes, a multimedia approach has been shown to raise awareness and to gather acceptance of SRH service use by young people, creating a more supportive environment.	Yes, further studies are needed to identify which components of a multimedia approach are most effective and to look into the sustainability of changes after the duration of the campaign.
Community participation and mobilization	9 4 highlighted (Zambia, Mmari & Magnani et al.; Burkina Faso, Yaro et al.; Jamaica, Tiffany et al.; AYA)	Yes, sensitization of the wider community, with a particular focus on key stakeholders, such as parents and church leaders, has been demonstrated to assist in opening dialogue on sensitive ASRH issues. This can have an impact on social norms and lead to a strengthening of support for use of ASRH services. A correlation between acceptance of SRHS and their use has been shown.	Yes, further research is needed into the most effective approaches to mobilization – in relation to gaining support for services.
Community participation and mobilization, including involvement in intervention design	4 3 highlighted (Nepal, Mathur et al.; India, Pande et al.; Mozambique, Senderowitz et al.)	Yes, more explicit participation in intervention development can also help establish a supportive environment for ASRH service use, and a sense of community ownership of a programme so that it is implemented in a locally acceptable way.	Yes, further work is needed into the key elements of community participation in the design and implementation of interventions for gaining ownership and support specifically for service use.



## 5.1 Effectiveness of different types of intervention aimed at generating demand: Information, education and communication interventions

### In-school education

Interventions in schools benefit from a ready-made audience and there is reasonably strong evidence of the benefits of using of curriculum-based participatory and life skills approaches. These methods have been shown to increase knowledge and awareness but there are no long-term evaluations that measure sustained effects and relatively few data on behaviour change or utilization of services. The data that are available are mixed. The Frontiers studies in Bangladesh, Kenya, Mexico and Senegal used a strong quasi-experimental design to test the effect of a school-based education component in addition to community and service interventions. However, the studies found no consistent pattern between countries regarding the influence on many indicators, including uptake of services. This suggests that effectiveness is highly specific to the context and the intervention design (as intensity and detail of components varied a little between countries) and interventions need to be carefully tailored to the local area. The potential for setting up active referral systems between schools and health facilities was more positive, as shown by Okonofua et al. (2003) in Nigeria. School-based health services, and linkages between schools and nearby services, have proved successful in the USA (Santelli et al., 2003) but further evidence is needed from developing countries. In theory such a system can help allay fears and legitimize care-seeking (Brabin, 2002).

#### **HIGHLIGHTED STUDY:** IN-SCHOOL EDUCATION, ENDO, NIGERIA (OKONOFUA ET AL., 2003)

Formal referral systems were set up between schools and health facilities. The involvement of health professionals in providing education within the school setting generated demand for services and strengthened their uptake. This study shows the great potential of linking schools and health services to increase demand.

### Community-based facilitated education sessions

Community-based education has the potential advantage of reaching out-of-school young people as well as those in school. The former are often more vulnerable but, because of low enrolment and high drop-out, they often form a significant group. Sessions can be more informal and relaxed, promoting more open and participatory discussion. The sensitivity of the subject usually makes it difficult both politically and practically to introduce the topic formally in schools. As with in-school education, participatory and life skills educational approaches show the greatest potential. However, they are less likely to follow curricula which have proved relatively successful in schools. Sessions within the community may struggle to maintain attendance over a period of time, with other commitments often getting in the way. The involvement of the target group in the design and implementation of the programme has been shown to help address this and to ensure that activities are closely targeted to adolescents' requirements. The use of community members to carry out education in a culturally sensitive way also shows potential, as does the combination of these sessions with wider community mobilization activities (e.g. see Pande et al., 2007 in relation to India). Although there is evidence of such interventions influencing knowledge of ASRH issues and some related behaviours, there is not strong evidence of it influencing the uptake of services. However, for those participating over a period of time there is evidence of improvements in awareness and even changes in risk-taking behaviours when interactive, participatory methods are used. Further research is needed into sustaining education sessions in the community and strengthening links to services.

**HIGHLIGHTED STUDY:** COMMUNITY EDUCATION, MAHARASHTRA, INDIA (PANDE ET AL. 2007)

The programme focused on married adolescents. The involvement of key decision-makers (husbands and mothers) as well as adolescents was vital to the effectiveness of the education sessions in influencing utilization of services. The other important factor was the setting up of a referral system which meant that participants in education sessions who were in need of care could easily access services.

**HIGHLIGHTED STUDY:** SOCIAL MOBILIZATION, MAHARASHTRA, INDIA (PANDE ET AL., 2007)

This programme also focused on married adolescents. Women's groups and other community-based organizations provided effective existing vehicles for raising awareness of ASRH issues. Similarly the involvement of key decision-makers (husbands, mothers, elders) was crucial to success. Without their support, married adolescents do not have the autonomy to seek care.

## Community-based youth centres

The use of existing youth structures such as youth centres not only has the benefit, much like schools do, of providing a ready-made target audience, but also has the added benefit of enabling out-of-school young people to be involved. There are many examples of youth centres being set up with an SRH purpose in mind, and these tend to combine services with recreational activities to attract young people, as well as providing vocational and educational components. There has been some success in promoting youth centres for information, recreation and services (e.g. Centre Dushishoze, Rwanda) but, in general, evidence for encouraging young people to access services is poor. Those that do use the services tend to be older than the target age and often female. In general, the high costs of maintaining centres, compared to the costs of supporting outreach/peer promotion components of interventions, does not seem to be justified (Erulkar & Mensch, 1997; FHI/YouthNet, 2002, 2006). There is some evidence of young people's preferences for health facilities or for the private sector (e.g. pharmacies) when seeking commodities and services, and more research into the effect of youth centres on the uptake of other services available in the community would be useful.

### NO HIGHLIGHTED STUDIES



WHO-217018

## Community-based IEC outreach from health facilities

Much effort has been put into providing youth-friendly services but, although they have had some impact, by themselves they do not appear to be effective at attracting youth. Nevertheless, intensive promotion via IEC materials and media combined with outreach educators who can provide referrals does show potential for increasing uptake, as does the use of these techniques as part of a branded social franchising model. The innovative use of private sector outlets such as pharmacies also needs further investigation since these are often the first choice for young people seeking contraceptives and other commodities.

**HIGHLIGHTED STUDY: PATH RX, THAILAND (BOND, FIRESTONE & FRANCIS, 2003)**

Adolescents are commonly more comfortable purchasing commodities through the private sector where anonymity is easily maintained. The combination of community IEC and the training of pharmacists and drug sellers to provide wider SRH advice and referral to health services has proved to be an effective way of reaching young people and increasing utilization of services. The combination of education to increase demand and the opportunity for referral and easy access to services is very effective.

**Peer education and counselling**

Providing peer education/counselling is a popular and flexible approach that has been used in many different contexts (e.g. schools, universities, youth clubs and the community). Educators themselves seem to benefit the most but there is evidence for some impact on the knowledge and behaviour of recipients. It has been found that educators must be selected carefully to ensure that target groups are reached, since educators tend to focus on people similar to themselves. Peer programmes vary considerably in objectives and operations. All provide education but peers may also act as counsellors or condom distributors, or they may provide referrals to formal health services. These are often not closely monitored, however, and although there is some evidence for their impact on condom use, evidence is weaker for uptake of services. There is some demonstration of the influence on stimulating demand for services though this has not always been planned for and it is important that peer education is combined with strengthening of provision of youth-friendly services (Population Council, 1999). Youth and community participation helps retain and motivate educators, sustain programmes and maintain responsiveness to local needs. Peer education may be implemented alone or as part of a larger programme but evidence suggests that it is most effective as a component of wider interventions, ideally including outreach services of some kind (e.g. Lusaka, Zambia (Mmari & Magnani, 2003), Botswana, Ghana, Tanzania and Uganda (African Youth Alliance, 2007)). There is some debate about sustaining peer education programmes outside the NGO setting and about the quality and accuracy of information that peer educators provide (Brabin, 2002)

**NO HIGHLIGHTED STUDIES****Life skills education**

The failure of narrow problem-specific education programmes has led to an increasing investment in broader life skills or youth development approaches. These aim to address the wider determinants of behaviour, placing SRH behaviour in the broader context of adolescents' lives. Such approaches should increase adolescents' autonomy, mobility, self-esteem and decision-making (WHO, 2005; Reynolds et al., 2006; Blum, 1999) which should positively influence both ASRH and life more broadly. In many settings, reproductive health and wider life skills interventions are beginning to be linked due to the combined needs of adolescents. However, these interventions are being designed on a fairly ad hoc basis. There is a need to develop technical

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capacity in this area in order to carry out evaluation over longer time-scales and share best practice. The degree to which programmes link with services and specifically aim to increase utilization varies. A range of demonstrated best practices exists upon which more ambitious linked programmes could be built and some work has been done on linking reproductive health in with livelihoods approaches that look at improving employment opportunities (Esim et al., 2001). In general life skills approaches show potential, and are certainly more effective than narrow didactic approaches. However, there has been little long-term evaluation and evidence available suggests that it is difficult to sustain changes after programmes are completed.

**HIGHLIGHTED STUDY: BETTER LIFE OPTIONS, INDIA (LEVITT-DAYAL & MOTIHAR, 2000)**

This study demonstrated that a focus on services within the ASRH component of a life skills approach can have an impact on service utilization. It focused on married and unmarried young people, but impact was noticeably achieved on the use of reproductive rather than sexual health services. This implies that while improvements in autonomy and decision-making associated with life skills can influence the use of available reproductive health services, the use of sexual health services by unmarried adolescents may be more dependent on wider cultural factors.

## Use of media

The use of media covers a wide spectrum of different approaches, from the distribution of IEC materials at health centres, schools, workplaces and other locations to comprehensive mass media campaigns using television and radio. In general, participatory education methods and a holistic approach to adolescent health are being advocated for. Although IEC materials may be a valuable educational component, alone they are unlikely to produce changes in behaviour. The use of mass media is unique in its ability to reach easily large numbers of people, and the mass media's wide coverage means it can influence social norms and practices and provide population-level sensitization to ASRH issues. Disentangling the impact of media efforts on knowledge and behaviour is difficult and, in general, evidence suggests that they are more effective in influencing the former than the latter. There is only weak evidence that media efforts successfully increase uptake of services, but more research is needed as this is often not adequately monitored. Media programmes seem to be most effective when combined with other complementary activities such as educational materials, entertainment and health services. Social marketing of ASRH commodities and services with focused marketing of branding also shows potential and requires further investigation. As mentioned earlier, this can form a component of the broader social franchising of services (e.g. PATH RX Thailand).

**HIGHLIGHTED STUDY: MEDIA, ZIMBABWE (KIM ET AL., 1998, 2001)**

This study showed that if a variety of media are used specifically to promote services they can have an impact on utilization. In this case, launch events, drama and leaflets were found most effective. In general, a multi-pronged approach maximizes exposure and has the most impact.

## Finance interventions – vouchers

The provision of vouchers for subsidized or free SRHS shows great potential but there is a lack of rigorously evaluated studies and a need for more research. Voucher schemes can utilize the private sector and give adolescents a choice of services so that they can pick the ones that they feel most comfortable with. The schemes show great potential for targeting adolescents even within a politically conservative context, and of realizing unmet demand for care (e.g. Managua, Nicaragua). Such schemes require careful monitoring, however, and may be labour-intensive to run.

### **HIGHLIGHTED STUDY:** USE OF VOUCHERS IN NICARAGUA (MEUWISSEN ET AL., 2006A & 2006B)

The very high uptake of vouchers distributed to provide free SRHS demonstrates the great potential of this approach in increasing service utilization.

### **HIGHLIGHTED STUDY:** KENYA, FRIENDS OF YOUTH (ERULKAR ET AL., 2004)

In Kenya, uptake of vouchers was also high. Their combination with education and community sensitization activities is thought to have helped to ease additional non-financial barriers to utilization.

## 5.2 Effectiveness of interventions aimed at generating community support for use of sexual and reproductive health services by young people

### Education sessions in the community

Education sessions that involve the wider community rather than just adolescents have the same problem of sustaining interest and attendance. However, they have the advantage of being able to encourage intergenerational dialogue and wider discussion even on taboo subjects, and they can help to break down stigma and discriminatory attitudes. Sessions may be ongoing but are commonly concentrated in the first phase of programmes in order to gain support for the implementation of other intervention components, including the provision of services. In some cases it is necessary to make key actors in the community, such as parents and community leaders, an important focus of activities. For example, many parents and community leaders recognize that there is a need for ASRH education, but they usually do not agree to extensive or intensive education on sex or sexuality. They think adolescents will be promiscuous if they learn about sexuality and contraceptives and do not understand the risk of not providing information. Although the evidence is generally weak, there is some evidence of the protective effects of positive attitudes of parents and adolescents and it has been observed that, in some contexts, it is impossible to address ASRH needs without support from key leaders and constituents. There are some innovative examples in which community members themselves, including influential figures such as religious leaders, are used to provide information and counselling (e.g. imams and “Senegas” in Uganda). Such approaches need further investigation.

### Community IEC activities at festivals, celebrations and sports events, and use of media

Cultural and social events bring large numbers of people together and it may be useful to link ASRH activities to them. There is no evidence of their impact on increasing uptake of services, and evidence for influencing knowledge and awareness is mixed. There is, nevertheless, potential for them to contribute to nurturing community support for addressing ASRH. These events must be part of a wider intervention and must be sustained rather than one-off in order to have a lasting impact.

As mentioned above, mass media techniques can achieve very wide coverage and, if sustained, there is the potential to influence social norms, especially if messages are reinforced through other means. There is very little evidence linking media efforts directly to the creation of greater support specifically for service use, but the one study available shows the potential of this approach and more research is needed. Media programmes are more effective when combined with other, complementary activities such as educational materials, entertainment and health services. However, evaluation rarely allows the impact of different components to be measured. It is also crucial that counselling and services are actually made available as part of ARSH communication efforts, since existing services may not be sufficient or acceptable to young people.

### Community participation and mobilization

Community participation encompasses a continuum of approaches from inclusive collective action and mobilization to simple community awareness-raising (see above). Community and adolescent involvement in the design, implementation and evaluation of interventions can help ensure that they meet the needs of the population, and also brings a sense of ownership that helps sustain the interventions in the longer term. There is some evidence that dealing with adolescents in isolation is not helpful and that programmes need to involve the adults around them (teachers, parents etc). A study by Mathur et al. (2001) concluded that involvement does not need to be all-encompassing but that it should focus on strategic people at strategic points. Broader community mobilization may be useful in helping to generate a supportive environment for SRHS and may have additional broader positive effects on community connectedness and social capital. There has more recently been an increase in attempts to measure success in creating a supportive environment for youth services. There is evidence that broader community mobilization activities can help gather even wider support for youth SRH programmes and can ease some of the barriers to adolescents accessing services (WHO, 2005). However, most are multi-component interventions with the separate components not evaluated. Community mobilization approaches have the potential to reach young people in numerous ways – as individuals, members of families, community members, and so on – and to increase their demand for services along with wider community support for them to utilize them (Maclean, 2006). Nevertheless, they may not reach the adolescents who are most at need. There are contexts in which some young people are marginalized, not embedded in a community (e.g. sex workers and migrants), and for whom more targeted interventions may be needed. Additionally, in societies where stigma and conservatism towards adolescent sexual and reproductive health exist to a degree that makes community mobilization around the issues unrealistic, more focused approaches may be more successful (e.g. demand side financing).



## HIGHLIGHTED STUDIES

### ZIMBABWE (KIM ET AL., 1998, 2001)

Multimedia approach shown to be an effective way of building community support for service provision and use.

### ZAMBIA (NELSON AND MAGNANI, 2000)

Participatory activities with the community are key to gaining acceptance of adolescent SRHS provision, and this acceptance correlated with adolescent utilization.

### INDIA, MAHARASHTRA (PANDE ET AL., 2007)

The targeting of key decision-makers is important. For instance, mothers-in-law play an important role in decisions regarding care-seeking for married adolescents, so their approval is therefore essential.

### JAMAICA (TIFFANY ET AL., 2003)

In the Jamaican context a multi-pronged approach using the media and key stakeholders (e.g. pastors) as advocates has shown that it is possible to change traditional attitudes towards premarital sex and to increase support of service use.

### MOZAMBIQUE, GERACAO BIZ (SENDEROWITZ ET AL., 1997)

Involving community members as advocates themselves can be very powerful. The training of parents as community activists had an influence on wider support for adolescent SRHS in Mozambique.

### AYA IN BOTSWANA, GHANA, TANZANIA AND UGANDA (AYA, 2007)

A multi-level approach using mass media, education and events can have an impact on social norms. Involving influential leaders, and particularly religious leaders, as advocates is especially influential.

### NEPAL (MATHUR ET AL. 2001)

Participation of the community at key stages in programme development, implementation and evaluation is important for gathering support and ensuring sustainability. This applies to improving attitudes towards services and has had a demonstrable impact on their use.

### BURKINA FASO (YARO ET AL., 2003, 2007)

Participatory approaches help create an enabling environment, that enable young people to take responsibility for their sexual and reproductive health. This includes the capacity to seek care when it is needed.

### 5.3 Multisectoral approaches

Adolescents are influenced by other individuals, their families, school, community and societal factors. Thus, multi-component strategies that tackle at least some of these areas may be necessary to sustain changes in behaviour. An important link has also been made between adolescents' sexual and reproductive health and their wider developmental needs has been established. Overall, it seems that a comprehensive approach is most promising. Ultimately young people need relevant information, life skills and access to care when needed. These can be provided in various ways and the best methods probably vary by gender, developmental stage and social setting (Speizer et al., 2003). For example, it is clear that the needs and issues that influence the use of services by unmarried and married young people are very different. Premarital sex remains taboo in many areas of the world, and the sensitization and involvement of the wider community is particularly key if an acceptance of their need for contraceptives and services is to be established.

More large-scale, innovative, integrated, multifaceted research interventions in adolescent sexual and reproductive health are needed. Within these approaches there is the opportunity to incorporate a specific focus on increasing the demand for services into the various intervention components. Experiences from the African Youth Alliance indicate that this is possible, and show that the impact of different components on service use can be evaluated.

### 5.4 What seems to work best in different contexts

Because of the small numbers of rigorous evaluations conducted, variations in the period of observation and behaviours studied, and lack of study replication in multiple settings, it is difficult to be certain that particular programme models are more effective for particular contexts than others. The interventions reviewed in this study are also mostly fairly complex, multi-component programmes, which makes it difficult to attribute impact to specific components. The Frontiers initiative studies in Bangladesh, Kenya, Mexico and Senegal are exceptions, controlling for the inclusion of a school-based component in addition

to community-based and clinic-based components. However, a consistent pattern of results was not found, this highlights the importance of local contexts and exact implementation of different approaches in determining impact. Nevertheless, available information does not allow more detailed conclusions to be drawn regarding why the school intervention was effective in some countries and not in others (Diop et al., 2004; Bhuiya et al., 2004; Vernon et al., 2004; Askew et al., 2003).



Giuseppe Franchini/World Bank



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ISBN 978 92 4 159848 4



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