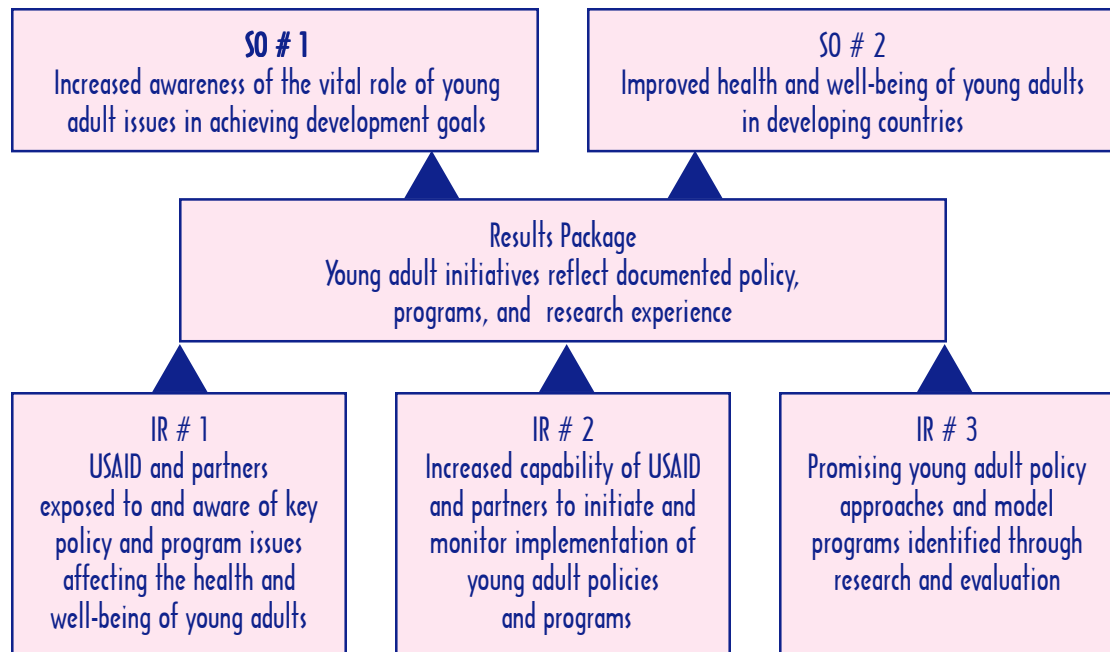




# APPENDICES

# APPENDIX A

## FOCUS STRATEGIC FRAMEWORK



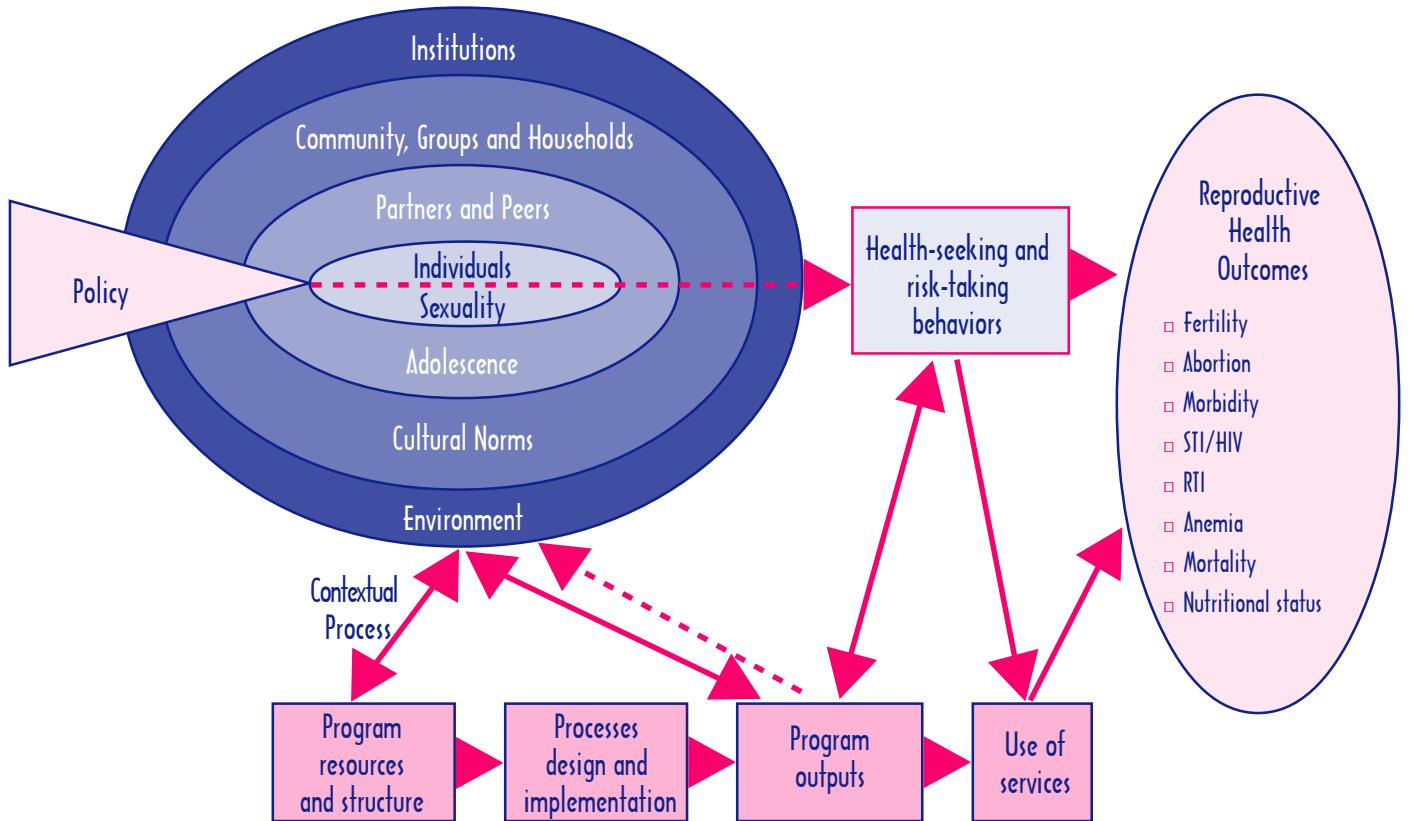
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FOCUS/USAID, 1995

# APPENDIX B

## FOCUS RESEARCH AND EVALUATION

### CONCEPTUAL FRAMEWORK



## APPENDIX C

# FOCUS ON YOUNG ADULTS: KEY QUESTIONS GUIDING FOCUS ON YOUNG ADULTS PROGRAM

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### Broad Key Questions

Why should policymakers and programmers focus on reproductive health (RH) programs for youth?

What are the reproductive health needs of youth?

What works to change the environment and the youth behaviors that put youth at risk for RH problems?

What works to initiate programs?

What works in program design and implementation?

### Key Questions

- What demographic trends relate to youth?
  - What are the dimensions of specific health issues (well-being, STI/HIV/AIDS, high-risk pregnancy, general nutritional needs, anemia) of youth?
  - What are the socioeconomic consequences of poor health and unintended pregnancy among youth?
  - What human rights and gender issues pertain to youth?
- 
- What do youth perceive their needs to be?
  - What do program evaluations and research identify as youth needs?
  - How do reproductive health needs relate to other youth needs (e.g., education, employment)?
- 
- What social, cultural, economic, and political conditions contribute to risk behaviors?
  - At what levels of social structure (e.g., individual, family, community, institution) can risk behaviors be influenced?
  - What research methods are needed to assess risk for RH problems?
  - How can research results inform policy and programs?
- 
- What has been the experience in initiating programs?
  - What policy actions (e.g., advocacy, demonstration projects) have stimulated YARH activities?
  - How can training influence program development?
  - What role can leaders play in stimulating YARH actions?
- 
- What are the strengths and shortcomings of different types of adolescent reproductive health programs in terms of the following?
    - *Program and service issues*
      - Coverage
      - Quality
      - Replicability
      - Scaling-up
      - Cost and Cost-effectiveness
      - Sustainability
    - *Social determinants*
      - Gender issues and differences
      - Violence
      - Poverty
    - *Youth Involvement*
      - How have programs enhanced their strengths and dealt with shortcomings?

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## Broad Key Questions

What works in program design and implementation?

## Key Questions

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### Community-based Programs

- What types of community-based initiatives (e.g., outreach, youth centers) lead to positive RH outcomes (defined as participation, knowledge, skills, attitudes, service use, and behavioral change)?
- How can existing community groups and social institutions be mobilized to act as catalysts for change in social and cultural norms (through individual action, collective action, or both)?
- How can peer and parental involvement have a positive impact on youth RH?

### Mass Media/IEC Programs/Social Marketing

- What strategies, channels, and content reach various youth populations (e.g., out-of-school youth, high-risk groups, married youth, young men)?
- What recommendations can be made for program content? For project sustainability? For linkages with existing products and services?
- How can the private sector be mobilized to promote positive RH messages for youth (e.g., through the recognition of the profitability of marketing youth issues)?

### Health Facilities

- What components of health facility services lead to positive outcomes among youth?
- What recommendations can be made for service content? For provider recruitment and training? For counseling training and methods? For the physical environment? For hours of operation and flexibility in appointments? For stand-alone or integrated clinics?
- How can adult services be adapted to increase their effectiveness in serving youth?

### School-based Programs

- What components are mostly likely to result in positive outcomes at various ages and grades?
- What recommendations can be made for sexuality education, skills training, and other curricula? For training of instructors? For classroom teaching methods? For Family Life Education out of school? For parental involvement?
- What recommendations can be made for referral to health and associated services? For location (school-based or school-linked)?

### Workplace Programs

- How does the workplace environment protect youth from or expose them to RH health risks?
- What recommendations can be made to get workplace management to support RH programs in the workplace? On content and types of programs appropriate to the workplace that lead to positive outcomes?
- How can workplace programs be linked to other RH education and health services?

### Organizational Networks and Coalitions

- What strategies work best in initiating and building networks among youth-friendly organizations?
- What recommendations can be made to foster program collaboration and resource sharing?

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Continue on page 104

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## Broad Key Questions

## Key Questions

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What works to increase program coverage and use?

- What factors and processes lead to program expansion?
  - ▣ What policy and program conditions are necessary, beneficial, or harmful?
  - ▣ What management factors (e.g., costs, quality control, monitoring, and evaluation) are needed?
  - ▣ What training/supervision issues are involved?
  - ▣ What are the factors and the processes for institutionalization?
  - ▣ What policy and program conditions are necessary, beneficial, or harmful?
  - ▣ How can commitment to sustain programs be reached?
  - ▣ What are the critical decision points?
- What types of programs have led to increased demand and use of services?

What works to evaluate youth RH programs?

- What methods and measurements are needed by policymakers, program managers, service providers, and youth to assess effectiveness? Measures of cost?
  - How can low-cost management information systems and other quantitative and qualitative data analysis be developed and promoted?
  - How can the effect on adolescents be evaluated in programs that cater to all age groups?
  - How can results be used in decision making to improve services, programs, and policies?
  - What methods and measurements capture changes in perceived social and cultural norms?
-

## APPENDIX D

# NOTES ON METHODOLOGY AND SOURCES OF DATA

### METHODS FOR FOCUS-SPONSORED RESEARCH ON RISK AND PROTECTIVE FACTORS IN 10 COUNTRIES (CHAPTER 1)



**Types of Studies.** The FOCUS study populations varied and included large, household-based samples of boys and girls; in-school populations exposed to sex education and reproductive health intervention programs; and a cross-national comparative study of DHS data assessing the effects of girls' in-school status on age at initial participation in sexual intercourse. Appendix E summarizes FOCUS-sponsored survey data, the country in which each survey was undertaken, the type of sample used, and the reproductive health outcomes examined for each data set in multivariate analyses. The individual-, peer-partner-, family-, institutional-, and community-level factors tested in country-specific analyses are listed also.

**Comparability of Analysis.** The similarities among the FOCUS-sponsored surveys and the fact that the analyses were guided by a single project permit comparison of fairly similar models, most of which provide information on several of the factors identified in each of the five broad categories, or levels of influence, identified above. Because of variations in sample size, however, and

methodological decisions made in collaboration with local research and program counterparts, none of the FOCUS surveys or analytic models are identical in terms of the independent variables included in the models. Nonetheless, all make use of similar multivariate statistical approaches for both of the primary outcome variables discussed here, whether or not a respondent had ever had sexual intercourse and whether or not he or she had used a condom at last sexual encounter.

**Analytic Methods Used.** Logistic regression, pooled logistic regression, and survival analyses were used unless otherwise noted. All three of these approaches are appropriate for dichotomous outcome variables, such as ever having experienced sexual intercourse, or whether or not an individual used a condom at last sex. The analytic models examining the factors associated with sexual initiation are available for all 10 countries, and they have larger samples available to them for statistical analyses than do the analytic models examining the factors affecting condom use at last sex (which are available for only 8 of the 10 countries).

**Sample Size Limitations.** Unfortunately, in the statistical models examining the factors affecting condom use, sample sizes do not permit multivariate analyses of the cases

involving young women in Paraguay, Peru, and Jamaica. Despite these limitations, this body of research suggests that certain factors are particularly robustly associated with whether or not adolescents have experienced sexual intercourse. Though the findings presented for the outcome variable of condom use are less definitive, it is hoped that they will motivate further investigation of the most common factors affecting contraceptive use among young people.

**Unclear Direction of Causation.** The data analyzed for this report were obtained from cross-sectional surveys, and thus it is often not possible to determine the direction of causation between the factors and outcomes considered, only that they are statistically associated. For example, though it can be concluded from the analyses that peer behaviors are significantly associated with selected adolescent reproductive health outcomes in many countries, it cannot be determined from the available data whether associating with sexually active peers occurs after inexperienced young people themselves become sexually active or, alternatively, whether associating with sexually active peers actually accelerates sexual debut among the sexually inexperienced. Panel or retrospective history data are needed to determine which of these explanations is the correct one (see chapter 6 for suggestions for further research).

**Educational Attainment versus School Attendance as an Indicator for Schooling Effects.** Educational attainment may not be

as good an indicator of sexual experience as school attendance or school enrollment when interviewing young people who have not yet completed their education and for whom we have incomplete information. Thus, in the FOCUS-sponsored studies, when assessing the effects of schooling using educational attainment or literacy as predictor variables, only in the case of South Africa was educational attainment significantly associated with sexual debut for young men, and in this instance, its effects ran in the opposite direction from those of school attendance and school enrollment. Similarly, though educational attainment and literacy variables were significantly associated with sexual initiation for young women in Ghana and Zimbabwe, in the case of Ghana, educational attainment was positively associated with sexual debut whereas school enrollment was negatively associated. A study in Kenya showed current enrollment in school to be associated more with lower levels of sexual activity than with the level of schooling attained (Ajayi et al 1991). A study in Botswana showed mixed results: boys were more likely to have had sexual experience if they had some level of secondary education, and current enrollment had no significant effect on sexual experience. For girls, current enrollment was associated with lower levels of sexual experience, and having a secondary education had no significant effect. Studies in Kenya and Liberia (Nichols et al.1987) showed that current enrollment in school had a greater negative influence on pregnancy than the level of schooling achieved (Ajayi et al 1991; Nichols et al.1987).

## LIMITS OF THE EVIDENCE BASE FOR MEASURING EFFORTS TO AFFECT THE ENVIRONMENT FOR YARH PROGRAMMING (CHAPTER 3)

**A**lthough many strategies purport to improve the environment for young adult reproductive health, virtually no rigorous evidence or studies document successful interventions. A number of factors explain the absence of this evidence. First, the evaluation of these strategies must take place at the macro level, either through institutional or community assessments, surveys of opinion makers, or reviews of policy documents, legislation, and regulations. Most assessments or evaluations of interventions focus on changes in knowledge, attitudes, and behaviors at the individual level of survey respondents, a technique ideally suited for assessing changes in goals 2 and 3, but less well suited for assessing changes in the overall environment in which an individual lives. In addition, even when such macro-level reviews or impact assessments are undertaken, they are rarely conducted using experimental or quasi-experimental design approaches, particularly in the case of policy formulation and implementation. Documentation of the effectiveness of YARH policy initiatives usually comes from more descriptive efforts to document the development of successful or promising policy initiatives and the changes that have occurred in the availability of information and services for young people (Rosen 2001d); Calves 2000; Oliveira et al. 2000; Stern and Reartes 2000, Gutierrez, Gogna, and Romero 2000; Luke 1998; Callender 2000).

## METHODS FOR REVIEW OF THE LITERATURE ON PROGRAM EFFECTIVENESS (CHAPTERS 3–5)


**T**o identify intervention studies and evaluations from developing countries for inclusion in the synthesis, three computerized databases were searched for studies related to young adult reproductive health over the period 1990-2001: POPLINE, MEDLINE, and ERIC. A search was also conducted of the database for USAID's Center for Development Information and Evaluation, which lists program evaluations and other documents from USAID-supported activities. Examples of keywords used in the database searches include youth, adolescents, schools, school-based, sex education, social marketing, mass media, AIDS, family planning, condom, pregnancy, program effectiveness, program evaluation, developing countries (specifically, countries in Africa, Asia, Latin America, and South America), community, and research studies. Only studies for which data were available for adolescents (age 10-19) or young adults (age 20-24) were included in the review. Programs that targeted broader age groups were considered only if evaluation results were presented separately for adolescents, young adults, or both.

In addition to the database searches, a comprehensive search for other, unpublished literature was undertaken. Individuals and organizations working in the field of international reproductive health were contacted and requested to provide copies of reports on and evaluation studies of their adolescent reproductive health programs.

The bulk of the findings presented in chapters 3 through 5 are the result of evaluation studies undertaken during the 1995-2000 period. However, because the number of rigorous evaluations of YARH interventions in developing countries remains modest, studies undertaken during the 1990-1995 period and a small number of pre-1990 studies were included in the synthesis of findings. It was, however, necessary to set a cutoff date for the inclusion of studies in the synthesis to allow sufficient time for the report to be published. The cutoff date chosen was May 1, 2001; that is, the synthesis includes all evaluations and studies available in published or unpublished form prior to this date. Unfortunately, the cutoff excludes from consideration evaluation findings from some ongoing studies whose findings had not been disseminated by this date.

Three of the rigorous studies found in the literature search concerned nonpregnancy-related outcomes; two focused on nutrition-related outcomes and one on breastfeeding behaviors. Because their small number precluded arriving at conclusions as to the effectiveness of interventions directed to such outcomes, these studies were not included in this document (nor in the 40 studies cited above).

## LIMITATIONS OF THE REVIEW OF PROGRAM EFFECTIVENESS (CHAPTERS 3–5)

 First, the review was limited to programs that have undergone formal evaluation or, at least, for which some program output data have been compiled and reported. These programs would appear to be only a modest proportion of the adolescent reproductive health initiatives that have been undertaken in developing country settings. We have no way of knowing whether the programs for which evaluation results and program output data have been reported are “representative” of all programs undertaken to date with respect to the level of success in achieving their objectives.

Second, among the programs that have been evaluated or for which program output data have been reported, the review is limited to those whose findings have been reported in peer-reviewed journals or disseminated to the adolescent reproductive health community in the form of program reports. In the case of peer-reviewed journals, a bias is likely to operate in favor of the more successful programs because, although “negative” findings are as scientifically important as “positive” findings, journals tend not to publish large numbers of studies reporting negative results. It is also possible, although less clear-cut, that reports of successful programs have been more widely disseminated by sponsoring and implementing agencies, and among the available program reports, a bias is likely to favor the more successful undertakings.

Third, the findings reviewed underrepresent the impact of programs directed to nonreproductive health outcomes that may have had unmeasured impacts on the reproductive health of adolescents. For example, as the use of drugs appears to be associated with a higher likelihood of risky sexual behaviors among adolescents (see chapter 1), effective drug prevention programs may well have a positive impact on sexual risk-taking behaviors. However, if these impacts were not measured and reported in connection with program evaluations, they could not be included in the review of evidence.

Fourth, although reports in Spanish and French were sought out, most of the studies reviewed were in English. This language limitation will result in an underrepresentation of impact findings from studies published in other languages.

Fifth, because data on program costs were virtually nonexistent in the literature that was reviewed, the review does not address the issue of cost-effectiveness. Cost-effectiveness is a crucial issue in deciding how to spend limited resources in YARH programs and whether to scale up a program. Nevertheless, establishing the effectiveness of alternative program approaches in achieving program goals is an important step in addressing cost-effectiveness.

Sixth, the review does not systematically address sustainability and replicability. These issues are considered in chapter 6. It should be noted, however, that informed discussion

of these issues is contingent on empirical evidence as to the effectiveness of alternative program approaches because it is unclear as to why programs that have not been shown to be effective should be sustained, expanded, or replicated.

Seventh, again, because information in the materials was insufficient, reviewers were unable to ascertain whether programs that failed to achieve an impact failed because the program approach used was flawed or because the program was not well carried out. Consequently, the findings are likely biased toward understating the effectiveness of the program approaches considered.

Eighth, studies were designated as providing “strong” evidence or as being “rigorous” according to their capability to address the question of attribution with respect to interventions. Other factors, of course, can determine the strength or rigor of a study—for example, the measurement tools and field procedures used. However, because of insufficient information, it was not possible to make informed judgments as to the merits of studies based on criteria other than their capability to address the question of attribution with respect to interventions.

Finally, in summarizing findings across studies, simple proportions were used—for example, the proportion of social marketing programs in which impact on condom use was observed. These summary statistics should not be mistaken for a formal meta-analysis, which would require that much more data be compared across settings than were available for the present review.

## APPENDIX E

### DETAILS ON FOCUS SURVEYS EXAMINING INFLUENCES ON REPRODUCTIVE HEALTH BEHAVIOR

Organization	Country	Date of Survey	Sample Size (N)	Age Range	Geographic Location	Outcome Variable
PSI/PROMESA Follow-up to Magnani, Robinson et al. (2000) study in Paraguay*	Paraguay	October 1999	1,575 males and females	15-19 years	Urban and peri-urban	Ever had sex <i>N</i> = 605 males; 649 females No. of recent partners (last 6 months) <i>N</i> = 504 males; 540 females Modern contraceptive method use at first sex (males only) <i>N</i> = 306 Modern method use at last sex (males only) <i>N</i> = 306
FOCUS Follow-up to Magnani, Gaffikin et al. (2000) Study in Peru*	Peru	September- November 1998	6,962 males and females (2,759 males; 4,203 females) In-school sample	13-18 years	Urban, peri-urban, and regional capitals	Ever had sex <i>N</i> = 2,532 males; 3,985 females No. of recent partners among those who ever had sex (last 3 months) (males only) <i>N</i> = 1,995 males Modern method use at first sex (among those who ever had sex) <i>N</i> = 600 males Modern method use at last sex (among those who ever had sex) <i>N</i> = 250 males
FOCUS Follow-up to Gaffikin et al. (2000) study*	Brazil	November 1999	3,520 males and females  In-school sample	11-19 years	Urban and peri-urban	Ever had sex <i>N</i> = 1,088 males; 1,237 females Modern method use at first sex (among those who ever had sex) <i>N</i> = 720 males; 533 females Modern method use at last sex (among those who ever had sex) <i>N</i> = 724 males; 532 females
Ford Foundation, JHU, CEMERA	Chile	November- December 1996	3,915 males and females In-school sample	12-20 years (0-age at interview; retrospective information)	Santiago (urban)	Ever had sex <i>N</i> = 1,903 males; 2,010 females
Hope Enterprises, Addiction Alert Organization	Jamaica	September- November 1999	1,956 males and females  In-school sample	10-15 years	Kingston (urban)	Ever had sex <i>N</i> = 751 males; 499 females Modern method use at first sex <i>N</i> = 410 males Modern method use at last sex <i>N</i> = 410 males

Organization	Country	Date of Survey	Sample Size (N)	Age Range	Geographic Location	Outcome Variable
FOCUS Follow-up to Kouwanou and Amegee (2001) study*	Togo	November 1998	2,083 males and females; 1,881 singles (only single sample used for models of "ever had sex"; only single sample "recently sexually active" used for other models)	10-24 years	Lomé, capital of Togo; population-based sample	Ever had sex N = 926 males; 925 females No. of recent partners among those who ever had sex (2+ partners in last 12 months versus no partner or one partner) N = 405 males; 425 females Modern method use at first sex (among those who ever had sex) N = 398 males; 413 females Modern method use at recent sex (among sexually active in last 3 months) N = 235 males; 329 females
JHU Baseline survey	Ghana	April-July 1998	5,632 males and females	12-24 years	National sample	Ever had sex N = 2,033 males; 1,442 females No. of lifetime partners (among those who ever had sex) N = 826 males; 847 females No. of recent sexual partners among those who ever had sex (had >1 partner in last 3 months) N = 770 males; 815 females Modern method use at first sex (among sexually active unmarried youth) N = 792 males; 555 females Modern method use at last sex (among sexually active unmarried youth) N = 627 males; 505 females
JSI/FOCUS Baseline survey	Zambia	September 1998	2,328 males and females	10-24 years	Urban and peri-urban sections of Lusaka	Ever had sex N = 968 males; 993 females No. of lifetime partners (among those who ever had sex) N = 553 males; 568 females No. of recent partners among those who ever had sex (had >1 partner in last 3 months) N = 611 males; 574 females Modern method use at last sex (among those who ever had sex) N = 509 males; 347 females
FOCUS Follow-up to Moyo et al. (2000)* study	Zimbabwe	September 1999	606 males and females	12-24 years	High-density, residential areas of Gweru	Ever had sex N = 344 males; 241 females
FOCUS, Horizons, Measure II, Population Council	South Africa	September–October 1999	3,096 males and females (1,402 males; 1,694 females)	14-22 years	Durban metro area and Mtunzini districts of Kwa Zulu-Natal province	Ever had sex N = 1,009 males; 1,104 females No. of recent partners (in last 12 months) N = 458 males; 400 females Modern method use at first sex N = 687 males; 733 females Modern method use at last sex N = 565 males; 641 females

NOTE.: \* See appendix I for citation and details. Sample sizes differ because of restrictions on some subsets of the overall sample and because of the volume of missing data.

## APPENDIX F

### DISTRIBUTION OF THE FOCUS STUDY SAMPLES BY SEXUAL EXPERIENCE, CONTRACEPTIVE USE AT FIRST SEX, AND CONTRACEPTIVE USE AT LAST SEX\*

Outcome	Paraguay		Peru		Brazil		Chile		Jamaica		Togo		Ghana		Zambia		Zimbabwe		South Africa	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Ever had sex																				
<i>N</i>	(713)	(867)	(2775)	(2025)	(1261)	(2238)			(1149)	(742)	(943)	(948)	(2618)	(1905)	(1122)	(1168)	(352)	(254)	(1399)	(1693)
Yes	56.7	31.7	27.4	5.9	76.2	29.1			53.9	11.9	43.9	45.4	43.3	54.9	59.8	54.7	38.1	13.8	51.1	44.9
No	43.3	68.3	72.6	94.1	23.8	70.9			46.1	88.1	56.1	54.6	66.7	45.1	40.2	45.3	61.9	86.2	48.9	55.1
Method use at first sex																				
<i>N</i>			(754)	(115)	(893)	(652)			(410)	(429)										
Used any method			43.5	44.4	47.6	62.8			31.0	29.4										
<i>N</i>	(209)	(113)							(619)	(89)			(828)	(592)					(715)	(757)
Used condom	51.9	41.6							29.9	53.9			17.6	26.5					20.6	21.6
Method use at last sex																				
<i>N</i>			(754)	(115)	(906)	(659)											(134)	(33)		
Used any method			54.8	56.8	82.3	83.6											84.3	75.8		
<i>N</i>					(906)	(651)														
Used modern contraceptives					74.8	69.3														
<i>N</i>	(260)	(114)	(399)	(63)	(906)	(659)			(619)	(89)	(235)	(329)	(769)	(559)	(653)	(628)			(630)	(718)
Used condom	64.7	42.0	80.9	53.9	72.1	51.1			34.6	44.9	50.0	40.6	42.9	37.0	38.7	27.7			55.2	43.9
<i>N</i>									(235)	(329)										
Used female methods											1.3	3.3								
<i>N</i>									(235)	(329)										
Traditional methods											20.3	20.3								

\* Note: For more information on these surveys, see appendices E, G, and H. Sample sizes in this table differ from those in other tables because of restrictions on some subsets of the overall sample and because of the volume of missing data.

## APPENDIX G

### FINDINGS FROM SURVEYS EXAMINING INFLUENCES ON SEXUAL DEBUT\*

Antecedent Variables	Paraguay	Peru	Brazil	Chile	Jamaica	Togo	Ghana	Zambia	Zimbabwe	South Africa
<b>Individual-Level</b>										
Characteristics:										
Puberty				+						
Age	+		NS	+	+	+	+	+	+	+
Race/Ethnicity			NS			NS	M: SV F: NS			SV
Region/Residence		SV							NS	
Marital/Union status							+	+		+
Educational attainment/ Literacy		N/A	N/A	N/A	N/A	NS	M: NS F: +	M: NS F: -	NS	M: + F: NS
School attendance	M: - F: NS	N/A	N/A	N/A	N/A	M: NS F: -	M: NS F: -	M: NS F: -		-
Work/Employment		NS	NS		NS					+
Religion/Religiosity				NS		NS				NS
Knowledge of contraceptives/ condoms								M: + F: NS		NS
Knowledge of risks of STI/HIV/ pregnancy								M: - F: NS		-
Liberal attitudes re: premarital sex						+				
Higher self-efficacy/locus of control (general)		M: + F: -			M: - F: NS					
Higher self-efficacy/locus of control re: sexual relations, contraceptive use							M: NS F: -		M: NS F: -	+
Engagement in nonsexual risk behaviors				+	M: + F: NS		NS	+	+	+
<b>Peer and Partner-Level</b>										
Peer network extensiveness			NS				M: + F: NS	NS		M: NS F: -
Peers/friends are sexually active/have experienced pregnancy/abortion		+	+		+	+	+	+		M: NS F: +
Peers/friends would ridicule if didn't have sex							M: + F: NS			
Peer/friend perceptions important			NS							
Engagement in nonsexual risk activities			NS					M: + F: NS		

Antecedent Variables	Paraguay	Peru	Brazil	Chile	Jamaica	Togo	Ghana	Zambia	Zimbabwe	South Africa
Communication with friends about SRH			+				M: + F: NS			
Communication with last/current partner re: sexuality/STI/AIDS/ pregnancy	—							+		
<b>Family-Level</b>										
Living with one parent (vs. both)		NS			NS	NS	NS	NS	NS	
Living with other (vs. both parents)	M: NS F: +	NS			M: + F: NS	NS	M: NS F: +	M: NS F: +	NS	
Parents' education			NS							M: — F: NS
Socioeconomic status	M: NS F: —	M: NS F: —		M: + F: NS +	NS	M: + F: —	M: — F: —			
Mother had adolescent pregnancy										
Sister had premarital pregnancy							M: + F: NS			
Connections with parents/ other adults		—	—		NS				NS	M: — F: NS
Communication with parents		NS	—							
Communication with parents about SRH	M: NS F: —		—				M: — F: NS			
<b>School-Level</b>										
Connections to teachers			—		M: NS F: — +					M: — F: NS
Perceived level of safety/ violence at school										
<b>Community-Level</b>										
Community economic status										NS
Connections with community			NS				NS	NS		M: NS F: —
Protective community environment										M: NS F: —
Perception of sexual activity/ pregnancies among adolescents as common							+			

**Key Legend:**

+ = Positive association  
— = Negative association

NS = Not significant at the .05 level  
Blank = Not measured

SV = Significant variation within categories at the .05 level  
N/A = Not applicable for population studied

M = Male  
F = Female  
SRH = Sexual and Reproductive Health

\* NOTE: For more information on these surveys, see appendices E–H. Sample sizes in this table will differ from those in other tables because of restrictions to different subsets of the overall sample and the volume of “missing data.”

## APPENDIX H

### FINDINGS FROM SURVEYS EXAMINING INFLUENCES ON CONDOM USE DURING LAST SEXUAL ENCOUNTER \*

Antecedent Variables	Paraguay (Males Only)	Peru (Males Only)	Brazil	Jamaica	Togo	Ghana	Zambia	South Africa
<b>Individual-Level</b>								
Characteristics:								
Age	NS	NS	NS	M: + F: NS	NS			
Race/Ethnicity		SV	NS		NS	M: NS F: SV SV		
Region/Residence								
Educational attainment/ Literacy		N/A	N/A	N/A	NS			
School attendance	NS	N/A	N/A	N/A	NS		M: NS F: +	
Work/Employment		NS	NS	NS				
Religion/Religiosity					M: SV F: NS			
Knowledge of contraceptives/ condoms; risk of HIV/ pregnancy	NS		NS				NS	M: + F: NS
Positive attitude toward condom use	+		+				+	
Perception of being at risk for STI/HIV; worried about getting HIV			NS				M: + F: NS	M: NS F: —
Liberal attitudes re: premarital sex; gender egalitarian index			NS		+	M: + F: NS		
Higher self-efficacy/locus of control (general)		+		NS				
Higher self-efficacy/locus of control re: sexual relations, contraceptive use	NS		NS			+		
Engagement in nonsexual risk behaviors				NS			M: + F: NS	
<b>Peer and Partner-Level</b>								
Peer network extensiveness		NS						
Perception that peers/friends are sexually active/use condoms/have experienced pregnancy/abortion	NS	—	NS	NS		M: — F: NS		
Peer/friend perceptions important			NS					
Engagement in low-risk activities with friends							—	

Antecedent Variables	Paraguay (Males Only)	Peru (Males Only)	Brazil	Jamaica (Males Only)	Togo	Ghana	Zambia	South Africa
Communication with friends about SRH	+		NS				M: + F: NS	
Use of condom during first sex								+
Age of recent partner (continuous)								-
Recent partner from same neighborhood								M: NS F: -
Communication with last/ current partner re: sexuality/ STI/AIDS/pregnancy	NS					+	+	+
<b>Family-Level</b>								
Living with other than both parents <sup>1</sup>	NS	-		NS	NS			
Parents' education			NS					
Socioeconomic status	NS	+		NS				
Sister had premarital pregnancy								
Connections with parents/other family members		NS	NS	NS				
Communication with parents	NS	NS	+			NS		
<b>School-Level</b>								
Connections to teachers			NS	NS				
Perceived level of safety/ violence at school				NS				
<b>Community-Level</b>								
Community economic status								M: + F: NS
Connections with community			NS				M: NS F: -	M: - F: +
Perceived level of safety/ violence in the community								M: NS F: -
Perceived norms: many in the community use condoms							NS	

Key Legend:

+ = Positive association  
- = Negative association

NS = Not significant at the .05 level  
Blank = Not measured

SV = Significant variation within categories at the .05 level  
N/A = Not applicable for population studied

M = Male F = Female  
SRH = Sexual and Reproductive Health

NOTES. "For more information on these surveys, see appendices E-G. Sample sizes in this table will differ from those in other tables due to restrictions to different sub-sets of the overall sample, and the volume of "missing data."

<sup>1</sup> For Peru—"mother only" vs. "both parents."

# APPENDIX I

## DETAILS ON THE 39 AVAILABLE EVALUATION STUDIES WITH STRONG RESEARCH DESIGNS<sup>1</sup>

FOCUS sponsored studies are shaded.

School Programs							
Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
1 Gaffikin et al. (2000) Evaluation of an Integrated Adolescent Sexuality Education/Health Service Provider Pilot Training Project in Salvador, Bahia, Brazil	Salvador, Bahia, Brazil N = 4,777	Age not reported  Males and females	Sexual reproductive health education program with the provision of adolescent-appropriate reproductive health services at linked public health facilities	Pretest/posttest matched control group design Six pairs of schools/clinics for intervention; six control schools located in same geographic area as intervention schools <b>Pretest:</b> intervention n = 2,424; control n = 2,353 <b>Posttest:</b> (30 months after pretest) intervention n = 619; control n = 706	Multivariate logistic regression	Received reproductive health-related information from school sources or health professionals: + SRH knowledge: 0 Ever had sex: 0 Condom use: 0 Use of clinics: 0	Significant barriers to adolescents' use of clinic services exist in most settings. These need to be addressed by changing norms surrounding the use of health facilities by youth and providing services in nonclinic settings, in addition to the linked efforts of this program. Clinic services are used primarily by older youth, many of whom are already pregnant.
2 Abolfotouh (1995) The Impact of a Lecture on AIDS on Knowledge, Attitudes and Beliefs of Male School-Age Adolescents in the Asir region of Southwestern Saudi Arabia	Asir region of southwestern Saudi Arabia Cross-sectional N = 838	14-19 years  Males only	One lecture on AIDS education given by a school doctor on World AIDS Day 1992	Quasi-experimental; posttest only Five secondary schools for males were randomly selected to receive intervention. Six months later, three of these schools and three controls were randomly chosen for posttest. <b>Posttest:</b> (6 months after one-time intervention) intervention n = 335; control n = 503	Chi-square tests	Overall knowledge about AIDS: 0  Fear of getting HIV/AIDS: +	One session is not long enough; need to integrate AIDS education with school comprehensive health curriculum;. Certified health instructors are the best-qualified individuals to provide AIDS education. The need exists for training, curriculum guides, and materials for both students and educators.
3 Antunes et al. (1997) Evaluating an AIDS Sexual Risk Reduction Program for Young Adults in Public Night Schools in Sao Paulo, Brazil	Sao Paulo, Brazil N = 394	18-25 years Work full time and attend high school in evening Males and females	Four 3-hour sessions <b>Content:</b> HIV/AIDS risk behavior, sexual norms, knowledge, attitudes, condom use; teacher training, small peer outreach component, and public events to generate community support; based on AIDS Risk Reduction Model of Behavior Change	Experimental, longitudinal study with one pre- and two posttests; wait-list control design approach Four schools randomly chosen to receive intervention (two) or to be control (two) <b>Pretest:</b> n = 394 <b>Posttest 1</b> (6 months after pretest): n = 304 (77% of baseline) <b>Posttest 2</b> (1 year after pretest): n = 198 (50% of baseline)	Analysis of covariance to compare baseline and follow-up	Communication with partner: Males: 0 Females: + Number of students who changed risky behavior between baseline and posttests: Males: 0 Females: + Commitment to safer sex: Males: 0 Females: 0	Programs need to consider the socioeconomic context of HIV risk behaviors. The qualitative component reveals that HIV is but one of many concerns, including unwanted pregnancy, unemployment, housing, violence, and drug use. Programs need to challenge traditional male sex roles and norms. High loss to follow-up occurred as the result of subject stress from working full time and going to school.

School Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
4 Ablasca et al. (1995) Results of a Model AIDS Prevention Program for High School Students in the Philippines	Manila, Philippines N = 845	Mean age = 14 years Males and females	In-school curriculum based on Cognitive Learning Theory; curriculum included lectures, games, role playing, and group discussions; 2-day teacher workshop also implemented 12 sessions; 40 minutes each over a 6-week period <b>Content:</b> Sexuality, AIDS, STIs, immune system, self-esteem, decision-making skills, and refusal skills for unwanted sex	Quasi-experimental; longitudinal, cluster-randomized, controlled trial, pretest, and two posttests Four high schools were randomly selected to be either intervention (two) or control (two) sites. Within each school, one classroom from each grade was either the intervention or control. <b>Pretest:</b> n = 845 <b>Posttest 1</b> (2 weeks after completion of 6-week intervention) n = 420; control n = 384 <b>Posttest 2</b> (8 weeks after completion of 6-week intervention) n = 420; control n = 384	Two-tailed student <i>t</i> tests; estimate of interclass correlation by one-way analysis of variance	Knowledge of AIDS biology, transmission, and prevention: + HIV-related attitudes: + Overall intended preventive behavior: 0 Agreement that sex should be delayed: +	Involvement of teachers in curriculum development facilitated acceptance and ease of implementation. However, the curriculum was too extensive for the classroom period and more time was given to basic sex and drug education than AIDS prevention. The authors recommend expanding and improving this intervention with intensive student participation. Teachers need more training, and the curriculum should include more information on AIDS and building of skills to refuse sex and resist peer pressure. Behavior change not measured
5 Caceres et al. (1994) Evaluating a School-Based Intervention for STD/AIDS Prevention in Peru	Lima, Peru N = 1,213	11-21 years; median age = 15.5 years Primarily Catholic Males and females	Formal education curriculum guided by a theoretical framework using behavioral theories, models of AIDS risk reduction and theories of empowerment; curriculum included discussions, verbal exercises, and role playing; teachers were trained in a 15-hour workshop over a 3-day period Seven weekly, 2-hour sessions <b>Content:</b> Increasing STI/AIDS knowledge, improving attitudes, and developing skills to use condoms Three-month intervention	Quasi-experimental; longitudinal survey of intervention and control youth; pre-and posttests Adolescents in 14 schools were randomized into intervention and control groups. <b>Pretest:</b> intervention n = 604; control n = 609 <b>Posttest</b> (immediately following intervention-4 months after pretest) intervention n = 406; control n = 402 (67% of baseline) Paired student <i>t</i> tests; multiple linear regression	Paired student <i>t</i> tests; multiple linear regression	Knowledge of sex: + Knowledge of AIDS: Males: 0 Females: + Positive sexuality attitudes: + Machismo (gender role attitudes): Males: + Females: 0 Attitudes toward contraceptives: + Attitudes toward condoms: + Discrimination against people with HIV: + Behavioral intentions: + Self-efficacy: Males: 0 Females: +	This intervention was designed to be a short, intensive educational effort aimed at older adolescents unable to participate in longer term sex education programs. Further research on gender/machismo issues would strengthen curriculum;. Authors also suggest looking at how this approach could be adapted to other settings. Programs must consider structural supports (e.g., parent programs, condom distribution, individual counseling) to encourage behavioral change. Behavioral change not measured

School Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
6 CEDPA, JHU/PCS (1993) Evaluation of Population/Family Life Education Programme in Secondary Schools in Nigeria	Sokoto, Kano, and Borno states in the northern zones; Anabra, Rivers, and Oyo states in the southern zones of Nigeria N = 3,194	Mean age of junior secondary schools = 14.25 Mean age of senior secondary schools = 17.2 60% males and 39% females	Formal curriculum implemented in secondary school classrooms; subgroup exposed to intensive "Population/Family Life Education" campaign and more frequent monitoring visits Training given to 462 teachers in curriculum and participatory methods	Quasi-experimental; baseline and follow-up surveys, panel design Intervention took place in six states; in each one, three schools received the intervention and three were controls. One classroom from each school was randomly chosen to participate in the study. <b>Baseline:</b> n = 3,194 <b>Follow-up:</b> (1 year after baseline in northern zones; 11 months after baseline in southern zones) n = 2,209 (70% of baseline)	Student t tests	Knowledge of benefit of family planning, AIDS, reproductive anatomy, and signs of malnutrition: Senior/south: + Others: 0 Knowledge of STIs: 0 Attitudes about monogamy: + Attitude toward family planning: Senior/north: + Others: 0 Attitudes about marriage: 0 Attitudes toward family size: Males only (junior/north): + Others: 0 Discussion of Pop/FLE topics: Senior and junior/south: + Others: 0	Some variability was observed between zones (north versus south) and by level of education (junior secondary school or senior secondary school). Curriculum begins to fill the gap in adolescent knowledge. To observe effect will take longer than 1 school year. Program also needs more of an "action" orientation. Did not examine reproductive health behaviors.
7 Coplan et al. (in press) Sexual Behavior and Health Care-Seeking Behavior for Sexually Transmitted Diseases among Nigerian Youth (Based on summary report)	Benin City, Edo, Nigeria N not reported	Not reported	Formal and peer education about sexually transmitted infections <b>Content:</b> STI symptoms; complications from nontreatment; how to inform partners; prevention, especially correct use of condoms Selected doctors, pharmacists, and "patent medicine" vendors were trained to provide confidential and high-quality services to youth; peer educators referred students to these providers	Quasi-experimental, pre- and posttest with intervention and control groups Four intervention sites, eight control sites Prefest and posttest 1 year apart Numbers in groups not available from summary report	Chi-square tests	Knowledge of STIs: + Self-reported STI symptoms: + Use of private physicians or pharmacist for STI treatment: + Use of condoms: +	Health-seeking behavior among adolescents can be improved through better health education and counseling. Sexuality education in the schools is a cost-effective way to provide information. Training of health care providers in youth-friendly services is critical.

School Programs cont...

Study Information		Sample Description		Study			Results
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
8 Eggleston et al. (2000) Evaluation of a "Sexuality Education Program for Young Adolescents in Jamaica" Jackson et al. (1998) The Jamaica Adolescent Study: Final Report	10 "new secondary" and "all age" schools across Jamaica N = 945	11-14 years 7th grade students at baseline Low to lower middle socio-economic status Males and females	Specially developed family-life education curriculum One session per week for 1 year <b>Content:</b> Reproductive anatomy and physiology; benefits of sexual abstinence; negative consequences of sexual activity and pregnancy; transmission, symptoms, and treatment of STIs; family planning; peer pressure Comparison group: regular sex education program	Quasi-experimental; longitudinal study with baseline and two follow-up surveys Five intervention schools; five control schools (urban and rural) <b>Baseline:</b> intervention n = 426; control n = 519 <b>Follow-up 1:</b> (9 months after baseline) intervention n = 392; control n = 476 (boys were more likely to be lost at follow-up) <b>Follow-up 2:</b> (21 months after baseline) intervention n = 339; control n = 379	Chi-square tests of association; t tests, and multivariate logistic regression (using GEE methods)	Knowledge of pregnancy prevention and condom use: + (not sustained at follow-up 2) Knowledge of when pregnancy occurs: - Attitudes about sexual activity: + (not sustained at follow-up 2) Attitudes on parenthood: + (not sustained at follow-up 2) Sexual initiation: 0 Use of contraceptive: 0	The study was rigorous, methodologically sound. Educational programs for youth can have short-term effects, but the need exists to consider what else is necessary to obtain a longer term effect (more than 1 year). Participatory teaching methods and smaller class size are recommended to strengthen impact of intervention.
9 Fawole et al. (1999) A School-Based AIDS Education Programme for Secondary School Students in Nigeria: A Review of Effectiveness	Ibadan, Nigeria N = 433	Mean age of intervention group = 17.6 years Mean age of control group = 17.8 years Males and females	Six weekly sessions held in schools, each lasting from 2 to 6 hours; included lecture, film, role play, debate, stories/songs, and essays	Experimental; longitudinal design; pre- and posttest evaluation Four schools (two intervention sites; two control) Multistage sampling technique used to select intervention and control sites with students chosen randomly for each site (two arms with 20-25 students in each) <b>Pretest:</b> intervention n = 233; control n = 217 <b>Posttest:</b> (6 months after completion of intervention) intervention n = 223, control n = 210 (96.2% of baseline)	Chi-square tests of association and analysis of variance	Knowledge about AIDS: + Attitudes toward people with AIDS: + Proportion of students sexually active: + Number of sexual partners: + (among sexually active participants) Use of condom at last sex: 0 Consistent use of a condom: 0 Knowledge about AIDS: +	Behavior change, specifically condom use, needs more attention in these programs. The program requires more time and motivation on the part of students; sustainability issues and expansion of the program must be addressed. These programs need to have a person with AIDS speak out to combat negative attitudes.
10 Harvey et al. (2000) Evaluation of a Drama-in-Education Programme to Increase AIDS Awareness in South African High Schools: A Randomized Community Intervention Trial	KwaZulu-Natal province, South Africa N = 1,080	13-29 years Males and females	Three-phase drama-in-education intervention: (1) teachers, nurses, and actors presented a play in each school; (2) teachers and students used participatory methods in drama workshops; (3) students made a presentation on "school open day" to celebrate culmination of program. Control group had a booklet only.	Experimental; pre-and posttest evaluation, panel design Seven pairs of schools randomized to receive intervention or booklets about HIV/AIDS <b>Pretest:</b> n = 1,080 <b>Posttest:</b> (about 8 months after pretest, 6 months after completion of intervention) n = 699 (64.7% of baseline)	Linear regression	Attitudes toward HIV/AIDS: + Condom use: + (among sexually active participants) Sexual activity: 0 Number of sexual partners: 0 Ever had STI: 0	The program needs measures such as changes in HIV incidence over time to assess the impact of these types of programs. No evidence of increase in number of partners or other changes in sexual behavior patterns was found. Concerns were raised about sustainability of intervention and high attrition rate, but 6-month follow-up period shows it had more than a short-term effect.

School Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
11 Klepp et al. (1997) AIDS Education in Tanzania: Promoting Risk Reduction among Primary School Children  Klepp et al. (1994) AIDS Education for Primary School Children in Tanzania: An Evaluation Study	Arusha and Kilimanjaro regions of Tanzania N = 1,063	Primary school children 6th grade-1992 7th grade-1993 Mean age = 13.5 Males and females	"Ngao" (shield) education program implemented over 2 to 3 months in primary schools; curriculum adapted to rural and urban settings; intervention guided by a theoretical framework using theory of reasoned action and social learning theory 20 hours of class time; teachers received 1 week of training	Experimental; longitudinal survey; randomized, controlled community trial with pre-and posttests 18 schools (6 intervention; 12 controls) were included in study; in the intervention groups in each region, at least one school was urban, semi-urban, or rural <b>Pretest:</b> n = 1,063 <b>Posttest:</b> (12 months after pre-test) n = 814 (77% of baseline)	Analysis of covariance and adjusted means to determine direction of intervention effect	Exposure to AIDS information and communication: + Knowledge about AIDS: + Attitudes toward people with AIDS: + Attitudes toward having sexual intercourse: 0 Subjective norms and behavioral intentions toward having sexual intercourse: + Initiation of sexual intercourse during previous year: 0	School program led to community awareness about AIDS. High rates of attrition on follow-up resulting from school drop-out rates show need for efforts to reach out-of-school youth. The need exists to study long-term effects of programs like this one. What happens when the intervention group leaves school?
12 Kuhn et al. (1994) Participation of the School Community in AIDS Education: An Evaluation of a High School Programme in South Africa	Cape Town, South Africa N = 567	12-30 years; mean age = 18 Low SES Males and females Mean age = 14.5 Males and females	Pilot AIDS education program; participatory methods used to design and implement program; included role playing, videos, games, and art activities Intense, high-profile focus on AIDS in school over a 2-week period	Quasi-experimental; pre- and posttest, two cross-sectional samples One school only (two classes from each grade received intervention; comparison group came from nearby school in same community) <b>Pretest:</b> (took place after program planning) intervention n = 231; control n = 336 <b>Posttest:</b> (no information on follow-up period) intervention n = 206; control n = 276	Pearson chi-square tests	Knowledge about AIDS: + Attitudes toward people with AIDS: + Beliefs about personal susceptibility or vulnerability to AIDS: 0 Intentions to use condoms and other plans in response to AIDS: 0 Communication with parents, peers, teachers, sexual partners, and nurses about AIDS: +	Intervention had positive impact on knowledge and attitudes, but authors express concern about lingering misconceptions about AIDS after intervention. The need exists for ongoing interventions to see lasting impact and behavior change. Achieving that change requires more teacher and parent involvement, which is difficult in the context. Teachers do not seem open to increased workload, and they need better training.

School Programs cont...

Study Information		Sample Description		Study			Results
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
13 Mbizvo et al. (1997) Effects of a Randomized Health Education Intervention on Aspects of Reproductive Health Knowledge and Reported Behaviour among Adolescents in Zimbabwe  Rusakaniko et al. (1997) Trends in Reproductive Health Knowledge following a Health Education Intervention among Adolescents in Zimbabwe	Selected schools in Zimbabwe (exact location not reported) Randomized cluster design for sampling N = 1,689	Mean age = 14.5 Males and females	Health education program consisting of IEC materials (leaflets, pamphlets, posters) and lectures <b>Content of IEC materials:</b> Male reproductive function, sexuality, HIV/AIDS, female reproductive function, anatomy, STIs, human sexuality and responsible behavior, unwanted pregnancy, contraception, and career posters <b>Content of lectures:</b> Reproductive biology; STI/HIV/AIDS issues; unwanted pregnancy and contraception; human sexuality and responsible behavior	Experimental; baseline and two follow-up surveys with randomized experimental and control groups in rural and urban areas Five intervention schools, three control schools <b>Baseline:</b> intervention n = 1,159; control n = 530 <b>Follow-up 1:</b> (5 months after baseline) intervention n = 1,103; control n = 502 <b>Follow-up 2:</b> (9 months after baseline) intervention n = 1,071; control n = 518	Comparison between groups — Chi-square tests and Wilcoxon — on two-sample tests, 9-month trend analysis	Knowledge of menstruation: + (5 months) 0 (9 months) Knowledge of wet dreams: + (5 months) 0 (9 months) Knowledge of pregnancy: + (5 and 9 months) Knowledge of family planning: + (5 and 9 months) Ever had sex: 0 (5 and 9 months)	Health education in schools has an impact on knowledge: positive trends of knowledge on reproductive health, STIs/HIV/AIDS have been observed.
14 Munodawafa et al. (1995) Effectiveness of Health Instruction Provided by Student Nurses in Rural Secondary Schools of Zimbabwe: A Feasibility Study	Five rural schools in Zimbabwe (exact location not reported) N = 285	Forms 2 and 3 (equivalent to 9th and 10th grades) Males and females	Student nurses assigned to provide health instruction to in-school adolescents as a requirement for graduation at nursing school; nurses received in-service training for 2.5 hours, two times a week for 6 weeks Students attended 14 40-minute classes over a 7-week period. <b>Content:</b> STI/HIV/AIDS prevention; drug, alcohol, and tobacco use	Quasi-experimental; linked pre- and posttest; nonequivalent control group design Five rural schools participated (three intervention schools; two control schools) <b>Pretest:</b> intervention n = 141; control n = 144 <b>Posttest:</b> (immediately following 7-week intervention) intervention n = 141; control n = 144	Analysis of covariance, chi-square tests	Knowledge of STIs, HIV/AIDS, drugs, and alcohol (14 out of 24 items): +	This study demonstrated the feasibility of using nurses to provide instruction about STI/HIV/AIDS and risk behaviors, thus relieving overburdened teachers. Making this activity a requirement for graduation from nursing school demonstrated political will on the part of the MOH and the government. Despite this high-level commitment, however, the study revealed a need to overcome resistance on the part of teachers and school officials, especially their objections to instruction about condom use.

School Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
15 Murray et al. (2000) An Evaluation of an Integrated Adolescent Development Program for Urban Teenagers in Santiago, Chile	Santiago, Chile Cross-sectional sample N = 4,238	Males and females 7th-12th grades	School and health facility education program; curriculum implemented over 2-year time period <b>Content:</b> Healthy relationships; sexuality; STIs; gender; risk behaviors such as drug use and smoking Local adolescent research and services group (CEMERA) provided additional information and referrals to clinic	Quasi-experimental; four rounds of data collection from March 1994 to November 1996 Two intervention sites; three control sites <b>Baseline:</b> intervention n = 2,512; control n = 1,736 <b>Follow-up 1:</b> n = 2,247 (8 months after baseline) (data collected only at intervention sites for monitoring purposes) <b>Follow-up 2:</b> intervention n = 2,242; control n = 1,920 (20 months after baseline) <b>Follow-up 3:</b> intervention n = 1,940; control n = 2,195 (32 months after baseline) Life table techniques	Life table techniques	Knowledge of human reproduction and STIs (index): + Knowledge about STIs: + Knowledge of contraception: 0 Attitudes (teen pregnancy, sexual relationships between youth): 0 Sexual activity: 0 Contraceptive use: Males: 0 Females: + Method use at last sex: 0	Program produced changes in knowledge and behaviors. Having the clinic/services at the school may have resulted in higher contraceptive use among sexually active students. The curriculum was rigorously evaluated and supported by parents, teachers, and students.
16 Pick de Weiss and Palos (1989) Development and Longitudinal Evaluation of Comparative Sex Education Courses	Cuajimalpa and Padierna, Mexico N = 491	Average age range: 13.4-14.9 Males and females	Two treatment groups: (1) traditional sex education curriculum (2) new "Planeando tu vida" (Planning your life) curriculum Two-day training included for educators 12 sessions-2 per week for 6 weeks <b>Content:</b> Relationships; decision making; interpersonal communication with partners and parents; assertiveness with the traditional sex education curriculum	Quasi-experimental; baseline and two follow-up surveys, panel design Intervention subjects compared with two control groups, one receiving traditional sex education and the other receiving no sex education <b>Baseline:</b> intervention n = 159; control N = 133 and 199 <b>Follow-up 1:</b> (4 months after course completion) intervention n = 130; control N= 148 and 192 <b>Follow-up 2:</b> (8 months after course completion) intervention n = 123; control N= 105 and 188	Student t tests Results based on only 8 months of follow-up data	General knowledge: + Communication with parents: 0 Perception of condom use and access: + Self-efficacy ("personality characteristics"): + Sexual initiation: 0 Contraceptive use at first sex: 0	Study was limited by age differences among the three groups, small sample size, and the young age of the three groups. (Most youth had not had their sexual debut.) The findings on contraceptive use are thus limited.

School Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
17 Seidman et al. (1995) Fertility Awareness Education in the Schools: A Pilot Program in Santiago, Chile	Santiago, Chile N = 532	Mean age of intervention group = 16.1; mean age of control group = 15.6 Males and females	Values-based fertility awareness/sexuality education curriculum called "Teen Star" in private and public secondary schools and a postsecondary school; parental approval required for participation 18 classes (of unspecified length), separated by gender for first 8 classes Teachers of biological and social sciences received workshop training	Quasi-experimental; baseline and follow-up surveys; panel design <b>Pretest:</b> intervention <i>n</i> = 289; control <i>n</i> = 243 <b>Posttest:</b> (8 months after pretest –immediately following intervention) intervention <i>n</i> = 289; control <i>n</i> = 243	Student <i>t</i> tests	Attitudes about abstinence: 0 Attitudes about sex: 0 Peer influences: 0 Likelihood of having sex within next year: 0 Fertility awareness: + Initiation of sexual activity: +	Authors note that intervention was not implemented consistently in all schools. In some schools, the topic was taught as a separate course; in others it was integrated. No control was in place for demographic differences in intervention and control groups.
18 Shuey et al. (1999) Increased Sexual Abstinence among In-School Adolescents as a Result of School Health Education in Soroti District, Uganda	Soroti District, Uganda N = 400	Average age = 13-14 Males and females	Education program aimed at increasing access to information and resources for healthy sexual decision making, improved communication between adolescents about sexuality, and improved quality of school system to implement education program <b>Activities:</b> One-day sensitivity training for local leaders and headmasters; KAP survey and focus groups on sexuality issues to inform program design; increased supervision of school health program; meetings of parents, teachers, and community leaders to discuss health education issues; training for "senior women" and science teachers; training at local teachers' college in school health and AIDS curriculum; answering questions in student box	Quasi-experimental; pretest and posttest design with P7 students at pre- and posttests 38 primary schools chosen randomly from 3 counties within the district; 10 students randomly selected from each school <b>Pretest:</b> intervention <i>n</i> = 287; control <i>n</i> = 113 <b>Posttest:</b> (2 years after pretest) intervention <i>n</i> = 280; control <i>n</i> = 120	Chi-square tests, cross-tabulations	Knowledge of AIDS: 0 Communication between peers and teachers about sex: + Perception that peers are sexually active: 0 Agreement that abstinence is good: + Sexual activity: + Number of partners: 0	Rather than just disseminate information, education programs should encourage communication and interaction among participants during implementation of the project. Good supervision of efforts is critical; the quality of implementation is probably more important than details of the curriculum.

School Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
19 Stanton et al. (1998) Increased Protected Sex and Abstinence among Namibian Youth following a HIV Risk-Reduction Intervention: A Randomized, Longitudinal Study	Omusati and Caprivi, Namibia N = 515	15-18 years; mean age = 17 Males and females	Adaptation of U.S.-based "FOCUS on Kids" program, based on social cognitive theory program called "My Future is My Choice" 14 after-school sessions with groups of 15 to 20 students 2 hours a week for 7 weeks <b>Content:</b> Emphasis on abstinence and safer sex practices Facilitator training lasted 40 hours	Experimental; randomized intervention trial; baseline, and three post-intervention surveys; longitudinal survey of intervention and control youth 10 schools were selected; youth within each school were randomly assigned to an intervention or control group; control group received intervention after the final follow-up survey <b>Baseline:</b> intervention n = 262; control n = 253 <b>Follow-up 1:</b> (2 months after baseline) n = 452 <b>Follow-up 2:</b> (6 months after baseline) intervention n = 209; control n = 170 <b>Follow-up 3:</b> (12 months after baseline) intervention n = 201; control n = 158	Chi-square tests	Perception that they could find condoms: Males: + (2 and 6 months) Females: + (12 months) Perception that they could ask for condoms at clinic: 0 Belief that they could put condom on: Males: 0 Females: + (2, 6, and 12 months) Intention of using condoms: Males: 0 Females: + (2 months) Alcohol use: + (2, 6, and 12 months) Delay of sexual initiation: Males: 0 Females: + (12 months) Condom use (those who became sexually active during intervention): Males: + (2 months) 0 (6 months) 0 (12 mo.) Females: 0 Number of sex partners: 0 Perception that they could refuse sex without a condom: 0	This type of intervention is effective but costly. The need exists to find ways to modify successful U.S.-based programs for low-resource settings: Relevant cultural adaptations can make U.S.-based programs successful in developing country settings, reducing the actual program development costs. Gender differences in intervention response must be addressed when revising the program. The program must concurrently increase condom availability. Further monitoring and evaluation indicators are needed to track program success and challenges. Biological markers are especially needed to corroborate self-reported behavior.
Fitzgerald et al. (1999) Use of Western-Based HIV Risk-Reduction Interventions Targeting Adolescents in an African Setting (same design)							

School Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
20 Thongkrjai et al. (1994) AIDS Prevention among Adolescents: An Intervention Study in Northeast Thailand	Northeast Thailand N = 2,909	Males and females	Two interventions: (1) established a learning environment that provided information on STIs, HIV, and safer sexual behavior (through videotapes, slideshows, leaflets, and posters); (2) training for peer counselors in IEC activities for each class and in how to make referrals to clinics	Quasi-experimental; longitudinal design; baseline and follow-up surveys Two intervention schools; one control school; one high school; and one vocational/commercial school in each group <b>Baseline:</b> n = 2,909 <b>Follow-up:</b> (6 months after baseline) n = 2,356	Chi-square tests	Knowledge: 0 Awareness of high-risk sexual behavior: 0 Awareness of the benefits of condom use: 0 High-risk sexual behavior: 0 (unreliable data)	Authors note that data regarding high-risk sexual behavior were unreliable.
21 Wilson et al.. (1991) An Experimental Comparison of Two AIDS Prevention Interventions among Young Zimbabweans	Zimbabwe (exact location not reported) N = 84	Mean age = 23.1 Student teachers Males and females	Intervention group: One skills-based education session in school lasting 90 minutes <b>Activities:</b> Condom demonstration; role playing; large and small group psychodrama; video Control group: Information-based session for 1 hour	Experimental; longitudinal design; pre-and posttests <b>Pretest:</b> intervention n = 42; control n = 42 <b>Posttest:</b> ( 4 months after intervention) intervention n = 42; control n = 42 (not reported, but implied in report)	Analysis of variance	Knowledge about condoms: + Knowledge about correct use of condoms: + Self-efficacy: + Perceptions of barriers to action: + Number of sexual partners: + Number of unprotected sexual acts in previous months: +	The need exists for skills-based programs with well-trained leaders, and there are not enough of these individuals in most areas of Africa. The need also exists to train AIDS educators and to develop training packages and manuals as well as a system of supervision and support for educators.

## Mass Media Programs

Study Information		Sample Description		Study			Results
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
22 Magnani et al. (2000) Evaluation of "Arte y Parte": An Adolescent Reproductive Health Communications Project Implemented in Asuncion, San Lorenzo and Fernando de la Mora, Paraguay	Asuncion, San Lorenzo, and Fernando de la Mora, Paraguay Random sample Baseline: N = 947 Follow-up: N = 1,575	15-19 years Males and females In school and out of school	Project used adolescent-specific mass media product development and placement and the use of peer educators Project was designed to 1) increase the media's understanding and coverage of YARH issues; 2) increase knowledge of reproductive health to promote responsible sexual behavior among adolescents; and 3) improve communication and negotiation skills related to reproductive health issues among young adults	Pretest/posttest with reflexive controls using two cross-sectional samples <b>Baseline</b> (n = 947) and follow-up surveys (n = 1575) were conducted with youth residing in the three cities to measure project reach and changes in impact indicators; impact was measured on the basis of changes-in-outcome indicators between surveys and the magnitude of dose-response relationships between indicators of project exposure 30 months between baseline and follow-up surveys	Weighted proportions calculated for project exposure; Chi-square tests, and F-tests; t tests; multiple logistic regression analysis	Knowledge of selected reproductive health issues (e.g., that condoms prevent STIs): + Attitudes of selected reproductive health issues (e.g., that both partners are responsible for protection when having sex and that girls who protect themselves are responsible): + Ever had sex: 0 Condom use at first sex: +	Although mass-media strategies are successful in reaching youth, they may not be the best methods for transmitting in-depth information. More continuous and intense interventions may be necessary to promote significant behavioral change.
23 Kim et al. (2001) Promoting Sexual Responsibility among Young People in Zimbabwe	Five pilot sites in Zimbabwe: Mutare (urban), Maphisa, Tongogara, Nzvimbo, and Nemanwa (all towns at the center of rural districts) Cross-sectional sample	10-24 years, with more than half 15-19 years Males and females	Youth multimedia campaign to educate about YARH issues; also trained providers in "youth-friendly services" to improve the quality of counseling and clinic practices; intervention also encouraged parental involvement Multimedia campaign lasted for 6 months; training course consisted of 2-week training-of-trainers workshop, 1-week training course for health workers, and 2-week course for peer educators <b>Communications:</b> Posters, leaflets, peer educators, radio, drama, campaign launch events, telephone hot line, support (media design workshop), training programs for drama, seminars to solicit media and local leaders	Quasi-experimental; baseline and follow-up; two cross-sectional samples Five intervention sites; two comparison sites (not true controls because of inadvertent national exposure through radio) <b>Baseline:</b> n = 1,426 (3 months before launch) <b>Follow-up:</b> (1 year after baseline—3 months after completion of intervention) n = 1,400 Not a true comparison group because it was exposed to elements of the media programs and advertisements for the hot line	Chi-square tests	Knowledge of family planning: 0 Knowledge of reproductive health: + Approval of unmarried couples using family planning: 0 Sexual decision making: 0 Discussion with anyone about reproductive health topics: + Use of reproductive health services: + Refusal of sex: + Use of contraception (among sexually experienced): + Activity with only one partner (among sexually experienced): + Use begun of condoms (among sexually experienced): +	The study affirmed the importance of involving youth in every aspect of program design and implementation as well as the need to involve the community. It also showed that youth need to increase their knowledge about contraceptives, not just family planning and reproductive health in general.

Mass Media Programs cont..

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
24 Meekers et al. (1997) Changing Adolescents' Beliefs about Protective Sexual Behavior: The Botswana Isa Banana Program	Lobatse, Botswana Cross-sectional sample N = 1,002 baseline N = 2,396 follow-up	13-18 years Males and females	Youth-friendly outlets for reproductive health information and products that referred adolescents to Isa Banana clinics; multimedia campaign; social marketing of condoms; peer sales outreach to community; and education sessions in schools  <b>Communications:</b> Radio, print media, and information targeted to parents, teachers, and community leaders	Quasi-experimental; pre-and posttests One intervention site; one control site <b>Pretest:</b> n = 1,002 <b>Posttest:</b> (8 months after implementation of project—16 months after baseline) n = 2,396	Logistic regression analyses	Belief that condoms reduce AIDS risk: Males: 0 Females: + Belief that AIDS is not curable: Males: 0 Females: + Belief that sex leads to marriage: Males: 0 Females: + Belief that having sex increases one's status: Males: — Females: 0 Belief that sex is an AIDS risk: 0 Belief that abstinence is protective: Males: 0 Females: + Attitude toward female condom: 0 Self-efficacy in getting partner to wear a condom: Males: + Females: 0	There were some undesirable trends such as shyness when buying condoms, which were found in young men in the control group. Programs should avoid stigmatizing condoms to counter these trends. A need also exists to target men and women separately. No information was available on behavioral impacts.
25 Meekers (1998) The Effectiveness of Targeted Social Marketing to Promote Adolescent Health: The Case of Soweto, South Africa Van Rossem and Meekers (1999a)	Soweto, South Africa Control: Umlazi, South Africa Cross-sectional; multistage, stratified sample N = 430	17-20 years Females only reported in analysis	Participatory media development; mass media campaign; peer education; and targeted condom distribution 70 adolescents trained in participatory media development process, peer education, and condom distribution 300 condom distribution outlets opened to support intervention Intervention: 6/94–4/97	Quasi-experimental; pre-and posttests, two cross-sectional samples One intervention site; one control site <b>Pretest:</b> intervention n = 118; control n = 108 <b>Posttest:</b> (1 year after pretest) intervention n = 101; control n = 103	Logistic regression analyses	Awareness about risks of becoming pregnant: + Awareness of STI and HIV risks: — Perceived susceptibility to sexual risk: 0 Believe condom use is best way to protect against HIV/AIDS: + Perception of barriers to pregnancy prevention: + Discussion of STI/HIV prevention: 0 Discussion of HIV/AIDS: 0 Current use of condoms to prevent pregnancy: — Current use of contraceptives for family planning: 0 Ever used condoms: + Condom use at last sex: 0 Sexual behavior patterns: 0	Intervention was more effective at changing knowledge and attitudes about pregnancy than HIV/AIDS. The author concludes that the focus on pregnancy was at the expense of participants learning more about HIV, which raises questions about involving youth in project design. The program must be sure that the media campaign addresses all reproductive health issues of concern, not just pregnancy. The author recommends steps to "expand and intensify" activities targeted to adolescents.

Mass Media Programs cont..

Study Information		Sample Description			Study		Results
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
26 Van Rossem and Meekers (1999a) An Evaluation of the Effectiveness of Targeted Social Marketing to Promote Adolescent and Young Adult Reproductive Health in Cameroon	Edea, Cameroon Control: Bafia, Cameroon Cross-sectional; multistage, stratified sample N = 1,606-baseline N = 1,633-follow-up	12-22 years Males and females	Peer education, youth clubs in schools, mass-media campaign, behavior change communications, social marketing of condoms <b>Communications:</b> Brochures, posters, and radio-targeting of youth with messages about reproductive health and condom use	Quasi-experimental; pre-and posttests, two cross-sectional samples One intervention site; one control site <b>Pretest:</b> intervention n = 805; control n = 801 <b>Posttest:</b> (15 months after baseline—1-2 months after completion of 13-month intervention) intervention n = 811; control n = 822	Logistic regression analyses	Knowledge of preventive behavior: + Perception of risk of STI/AIDS: Males: + Females: 0 Perception of risk of unwanted pregnancy: 0 Awareness of being responsible for the use of protection during sex: Males: 0 Females: + Discussion of issues related to sexuality and contraceptive use: + Visitation of a health center for contraceptive information: 0 Initiation of sexual activity before age 15: Males: 0 Females: + Ever had sex: Males: 0 Females: + Ever tried condoms: Males: 0 Females: + Condom use at last sex: 0 2+ sexual partners in past 30 days: Males: + Females: 0 2+ regular sexual partners in last 12 months: 0 Awareness of risk for HIV and pregnancy: 0	Cost and availability of condoms are not important barriers to protective behavior. No evidence exists of increase in condom use for STI prevention. This strategy is a good one for reaching adolescents, but it needs 2 years of ongoing activity, and this intervention lasted only 13 months. The need exists to further examine constraints to condom use

Mass Media Programs cont...

Study Information		Sample Description			Study		Results
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
27 Van Rossem and Meekers (1999a) An Evaluation of the Effectiveness of Targeted Social Marketing to Promote Adolescent and Young Adult Reproductive Health in Cameroon	Conakry and Kankan, Guinea Cross-sectional; multistage, stratified sample N = 2,016-baseline N = 2,005-follow-up	12-19 years Males and females	Peer education; media campaign; intense, targeted marketing effort in context of broader social marketing activity; small youth-friendly service component (certain clinics held special hours for youth); recreational activities <b>Communications:</b> Brochures and posters to increase knowledge and use of condoms and modern contraceptives; encouragement of delayed sexual initiation and abstinence; theater, dance, and discussion groups added to the social marketing program	Quasi-experimental; pre-and posttests; two cross-sectional samples One intervention site; one control site <b>Pretest:</b> intervention n = 1,512; control n = 504 <b>Posttest:</b> (13 months after baseline—about 8-month intervention period) intervention n = 1,500; control n = 505	Logistic regression analyses	Awareness of risk for HIV and pregnancy Perceptions abouts benefits of prevention: 0 Self-efficacy: 0 Knowledge of contraceptive methods: 0 Patterns of sexual behavior (including sexual initiation): 0 Number of partners: 0 Condom use among sexually active: Males: + Females: 0 Condom use at last sex: Males: + Females: 0	This kind of program can increase knowledge, but behavioral change requires a longer term intervention. Low-budget peer education programs have a limited reach. The program needs an educational component to be more effective. Peer educators should be complemented with a large-scale, mass media effort.

## Community Programs

Study Information		Sample Description		Study			Results
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
28 Magnani et al. (2000) Evaluation of 'Juventud EsSalud': An Adolescent Reproductive and Sexual Health Peer Education Program Implemented in Six Departments in Peru	Six departments in Peru: Lima, Lambayeque, Ica, San Martin, Arequipa, and Tacna In-school sample N = 6,962	Males and females from grades 7-11, which peer leaders chosen Criteria for peer leaders: 14-15 years; 1st-5 <sup>th</sup> grade in secondary school	School and community peer promotion pilot project: third-year secondary school students selected as peer leaders and trained by health professionals over a 2-month period; each peer leader responsible for making at least 25 youth contacts in a 6-month period <b>Content of Peer Leader Workshops:</b> Sexual development; body consciousness; self-esteem; assertiveness in sexual relations, anatomy, and physiology; identification of values; STIs/HIV; parenthood; relationships; adolescent pregnancy; understanding sexuality as the integration of many aspects of the individual	Pretest/posttest panel group design Baseline KAP surveys administered prior to project implementation and again after 18 months of project implementation Students attending project schools who were exposed compared with (1) students not exposed to project and with (2) students from comparable secondary schools.	Pearson chi-square tests; multivariate logistic regression	Knowledge of correct day of ovulation: + Knowledge that a woman can get pregnant the first time she has sex: + Belief that it would be easy to convince partner to use condom: 0 Ever had sex: + (measured among boys only) Contraceptive use at last sex: + (among boys only)	Well-designed and implemented peer promotion programs that feature sufficient training and supervision can successfully influence young adult knowledge, attitudes, and behaviors. As peer leaders tend to reach youth similar to themselves, consideration needs to be given to recruiting peer leaders who are in higher risk subgroups to expand program coverage, especially in in-school environments.
29 Levitt-Dayal and Motihar (2000) Adolescent Girls in India Choose a Better Future: An Impact Assessment	Peri-urban slums of New Delhi; rural Madhya Pradesh; and urban slums of Gujarat, India Random sample from three project sites N = 1,693	15-26 years Unmarried and married females	Better Life Options (BLO) program that seeks to empower young women to make better choices for the future <b>Activities:</b> Income-generating activities; formal and nonformal education; Family Life Education; vocational skills training; health education and services; public awareness creation and advocacy; work with parents, community leaders, and decision makers to raise awareness about the need for girls' empowerment <b>Content:</b> Decision making; mobility; self-esteem/confidence/empowerment; childbearing and spacing; contraceptive use and health-seeking behavior	Quasi-experimental; posttest only One intervention group among alumni who had attended program from 1996 to 1999; one control group of young women living in comparable areas untouched by program <b>Posttest:</b> intervention n = 858; control n = 835	Multivariate analysis; calculation of risk ratios Data controlled for girls' education, parents' education, and parents' occupation	Awareness of HIV: + Age at marriage: + Completion of secondary education: + Employment and income: + Ability to make independent decisions: + Ability to speak in front of elders or a group of people: + Ability to use public transportation/visit a market: + Use of contraceptive: + Use of pre- and post-natal care: + Use of hospital for childbirth: + Use oral rehydration salts for children's diarrhea: + Number of children: + Child mortality: + Children vaccinated: +	Vocational skills as a point of entry to program and parental involvement are key to the program's success. The need exists to initiate a boys' program, strengthen the youth-friendly services component, and promote formal schooling for girls.

Community Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
30 Speizer et al. (2000) Survey Findings from the West African Youth Initiative Project: Final Evaluation of Peer Education Intervention	Eight Nigerian communities: Bauchi, Birnin Kebbi, Calabar, Ibadan, Kaduna, Lagos, Osogbo, and Owerri; two Ghanaian communities: Kumasi and Atebubu N = 3,399	12-24 years Males and females In and out of school	Worked with youth-serving organizations to develop activities for youth; all sites developed peer education programs; some sites worked in schools (secondary or postsecondary); others worked with out-of-school youth 18-month intervention period	Quasi-experimental; longitudinal design; baseline and follow-up surveys Random sample of 100 youth from 10 intervention and 10 comparable control areas <b>Baseline:</b> intervention n = 911; control n = 803 <b>Follow-up:</b> (at least 18 months after baseline in each community—18-month intervention period) intervention n = 908; control n = 893	Multivariate logistic regression	Knowledge (of AIDS, STIs, ways to prevent pregnancy, and understanding of the reproductive process): Males (in-school): + Females: 0 Self-efficacy: Males (in-school): + Females: 0 Willingness to purchase contraceptives: + Use of protective methods against STIs: + (in-school only) Sexual activity in last 3 months: Males: — Females: 0 Condom use: 0	The need exists to determine what works for out-of-school youth.
31 Speizer et al.. (2001) Evaluation of the "Entre Nous Jeunes" Peer Education Program for Adolescents in Cameroon (Draft report)	Nkongsamba, Mbalmayo, Cameroon Multistage sampling N = 818	10-25 years Males and females	Peer education program to increase contraceptive prevalence and reduce prevalence of STIs and unwanted pregnancies <b>Activities:</b> Training peer educators to provide information to peers in communities and refer them through discussion groups; one-on-one meetings; development of health associations; also developed and distributed promotional materials such as calendars, comic strips, and posters 18-month intervention period	Quasi-experimental; baseline and follow-up Among eligible household members, one was randomly chosen for interview One intervention group; one control group <b>Baseline:</b> intervention n = 402; control n = 400 <b>Follow-up:</b> (17 months after baseline—3 months after completion of intervention) intervention n = 405; control n = 413	Multivariate logistic regression models	Spontaneous knowledge of contraceptives: + Spontaneous knowledge of female STI symptoms: + Spontaneous knowledge of male STI symptoms: Males: + Females: 0 Use of modern method: + Use of condom at last sex: +	In the absence of the program, use of modern contraceptives and condoms would have been significantly lower. It is necessary to determine whether or not this intervention can be replicated on a larger scale. Operations research is necessary to assess whether the observed impact is the result of the peer component or the fact that there were more resources for reproductive health education invested in the community.

## Community Programs

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
32 Kouwonou, Kodjovi, and Kodjopatapa Amegee (2001) Evaluation de la Connaissance de l'Attitude et de la Pratique Sexuelles des Jeunes de Lomé: Enquête Évaluation de Centre des Jeunes de l'ATBEF à Lomé, EVACJEUNE2	Lomé, Togo N = 2,083	10–24 years Males and females	Establishment of a youth center in March 1998 to offer YARH clinical services, recreational services, counseling, IEC, and vocational and literacy classes	Panel with reflexive controls (Adolescents living in vicinity of youth center were compared with adolescents living elsewhere in Lomé.) <b>Baseline:</b> n = 2,083 adolescents; 1,027 parents <b>Follow-up 1:</b> (18 months after baseline) n = 1,679 (817 direct follow-up from baseline) <b>Follow-up 2:</b> (1 year after follow-up 1) n = 2,083 adolescents covered in baseline survey and sample from follow-up 1)—conducted in spring 2001	Multivariate logistic regression	Sexual knowledge <sup>3</sup> : 0 Knowledge of condoms: + Contraceptive or condom use at last sex: 0	The youth center was the preferred but not the actual source of condoms. Improvements occurred in the awareness of the youth center among all groups, but was greatest among those who lived close to the center. Visits to the youth center had no discernible impact on attitudes or practices.
33 Moyo et al. (2000) Reproductive Health Antecedents, Attitudes, and Practices among Youth in Gweru, Zimbabwe	Five high-density residential areas in Gweru, Zimbabwe: Mutapa, Ascot, Mambo, and Mkoba, and Senga	12–24 years Males and females Unmarried	Meetings to increase awareness of adolescent reproductive health issues among parents, teachers, community leaders; implementation of youth-friendly services protocol in clinics, which included the creation of “youth corners” in clinics, nurse training in youth-friendly services, peer education, and renovation of the Ndhlovu Youth Center to support reproductive health services	Baseline and follow-up cross-sectional surveys to assess program effectiveness, which were based on cluster sampling of census enumeration areas in Gweru and which used program monitoring data, peer education contact questionnaires, client exit interviews, and provider surveys Youth in follow-up were asked whether they had ever visited a youth center, a reproductive health clinic, a youth corner, or a peer educator. Those youth that had visited (the exposed group) were compared with youth that had not visited (the unexposed group). <b>Baseline:</b> n = 250 <b>Follow-up:</b> (18 months after baseline) n = 606 <b>Peer-educator contact questionnaires:</b> n = 292 <b>Client exit interviews:</b> n = 233 <b>Provider surveys:</b> n = 14	Bivariate analysis; analysis of service use trends; multivariate logistic regression	Awareness of YARH issues <sup>4</sup> : + (among parents and community leaders) Knowledge of contraceptive methods: 0 Communication between parents and youth about sex: + Attitudes toward condom use: Males: — Females: + Smoking and using drugs: + Consuming alcohol: —	The age differential between sex partners is a risk factor to be addressed, particularly for young girls and older men. Programs need to better target different needs of youth, especially those engaging in high-risk activity. Reproductive health services should be linked with family support organizations. More emphasis should be placed on condom skills in counseling and IEC activities. The programs should target young women for instruction in negotiation skills to avoid unwanted sex and encourage condom use.

Community Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
34 Nelson et al. (2000) The Effects of Youth Friendly Service Projects on Service Utilization among Youth in Lusaka, Zambia	Lusaka, Zambia 10 urban and peri-urban public facilities	10-24 years Males and females	Implementation of youth-friendly services protocol in selected Lusaka clinics; implemented by the Lusaka District Health Management Team in collaboration with CARE, JSI/SEATS, UNICEF, and Family Life Movement of Zambia Three pilot projects examined; each included youth-friendly services/interpersonal skills training for service providers and peer educators/counselors; projects differed in how they conducted community outreach and selected peer educators	Ex-post-control group time series Eight intervention clinics; two control clinics Quantitative and qualitative data were collected to determine the youth friendliness of each clinic and community attitudes toward adolescent reproductive health services. Indicators of youth friendliness and community attitudes were related to levels and trends in adolescent service use.	Trends in service use analyzed in intervention and control groups as well as individual clinics Spearman's rank order correlation test calculated to determine associations	Use of services: + (marginal effect for family planning services at one intervention clinic group; for outpatient department services at another intervention clinic group) However, increased service use by youth was more closely related to community attitudes toward providing reproductive health services to youth (rather than the youth-friendly services modifications).	Attention needs to be directed not only to factors inside health clinics but also to the contextual factors that influence the health-seeking behaviors of youth.
35 Institute for Reproductive Health (February 2001) Reaching Adolescents at Family Planning Clinics: Applying the Reproductive Health Awareness Model	Ecuador, CEMOPLAF clinics Four intervention, four control	Adolescent clients	Education, counseling, and clinical services provided by trained clinic personnel in adolescent service delivery and adolescent health issues	Pretest and posttest design in four intervention and four control clinics, with a 7-year follow-up period May 1998–April 1999 No information on sample sizes from summary report	Trends; bivariate analysis	Number of new clients: 0 Number of returning clients: +	Improvements in continuity of care were observed. The need exists to consider strategies to increase overall usage.

## Workplace Programs

Study Information		Sample Description		Study			Results
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
36 FOCUS/CARE International-Cambodia (2000) Impact of an Adolescent Reproductive Health Education Intervention Undertaken in Garment Factories in Phnom Penh, Cambodia	Phnom Penh, Cambodia N = 1,072	Mean age = 20 92% female Factory workers	Reproductive health education provided to young garment factory workers using a participatory learning and action (PLA) approach	Quasi-experimental, matched-control group panel design Intervention group consisted of workers in "project factories"; control group consisted of workers in nonproject factories <b>Baseline:</b> intervention n = 500; control n = 500 <b>Follow-up:</b> (about 18 months after baseline) intervention n = 670 (254 participants + 416 nonparticipants); control n = 402 (from nonproject factories)	Chi-square tests	Knowledge of STI/HIV/AIDS: 0 Knowledge of contraceptive methods: + Knowledge of the risks of pregnancy: + Discussion of condoms with friends: + Worry about getting AIDS: 0 Knowledge of modes of HIV/AIDS prevention: 0 Knowledge of condom sources: 0	The findings confirm that health education interventions in workplace settings can increase levels of reproductive health and contraceptive knowledge. The PLA approach appears to be a feasible means of implementing health education initiatives (although the present study was unable to compare the PLA approach with alternative approaches). Whether gains in knowledge translated into reductions in sexual risk behaviors could not be verified in the study.
37 Bhawe et al. (1995) Impact of an Intervention on HIV, Sexually Transmitted Diseases, and Condom Use among Sex Workers in Bombay, India	Red light district of Bombay, India Sex worker N = 514; Brothel owner N = 37	More than 80% age 15-25 Females only	Sex workers attended sessions where they watched motivational and educational videos about HIV, participated in small group discussions about HIV, and were exposed to visual materials about HIV; brothel owners also attended sessions on the importance of sex workers' health and HIV information <b>Intervention duration:</b> April-September 1992 (6 months)	Quasi-experimental; baseline and follow-up panel design <b>Baseline:</b> intervention n = 334; control n = 190 <b>Follow-up:</b> (about 1 year after baseline) intervention n = 334; control n = 190	Chi-square tests; Fishers exact test; McNemar test; exact Poisson distribution	Knowledge of HIV/AIDS: + Likelihood of insisting on condom use: + Prevalence and seroincidence of HIV and other STIs: 0	It was difficult to assess impact of condom distribution relative to education session, although condom availability is still clearly a problem. Existing counseling and testing protocols are inadequate because the control group showed very discouraging levels of knowledge both before and after the testing and the counseling offered as part of the study. Programs need to deal with the isolation of sex workers—access to these women is strictly controlled by brothel owners and pimps. Most are not in a position to change their behavior.

Workplace Programs cont...

Study Information		Sample Description		Study		Results	
Author(s)/Publication Date/Title	Location/ Sample (N)	Age/Gender	Program Description	Design	Analytic Methods	Results: Change in Outcome <sup>2</sup>	Conclusions/Implications
38 Cash et al. (1995) Experimental Educational Interventions for AIDS Prevention among Northern Thai Single Migratory Factory Workers	Northern Thailand N = 252	15-24 years Unmarried female factory workers Educated to Grade 6 Migrated to Chiang Mai	Three interventions: (1) HIV/AIDS prevention materials; (2) HIV/AIDS prevention materials and nonformal education facilitated by health promoters; (3) HIV/AIDS prevention materials and nonformal education facilitated by trained peer educators	Quasi-experimental; pre-and posttest design, panel design Three intervention groups; one control group <b>Pretest:</b> n = 252 <b>Posttest:</b> n = 206 (about 45 subjects from each intervention group and control group) No information on time between surveys	Analysis of covariance, controlling for initial between-group differences	<b>Materials only:</b> Knowledge: + Attitudes/Beliefs: + Intention of performing protective behaviors: + <b>Health Promoter:</b> Knowledge: + Attitudes/Beliefs: + Intention of performing protective behaviors: + <b>Peer promoter:</b> (strongest results) Knowledge: + Attitudes/Beliefs: + Intention of performing protective behaviors: +	Programs that involve greater participation of young women are more likely to have an impact. Qualitative methods elicited more complete understanding of attitudes and behavior than written surveys in terms of informing program design. Condoms should be promoted among young women, who take the most responsibility for contraceptive behavior. Program may not have reached highest risk groups, who left immediately after work to go out and did not participate.
39 Celentano et al. (1998) Decreasing Incidence of HIV and Sexually Transmitted Diseases in Young Thai Men: Evidence for Success of the HIV/AIDS Control and Prevention Program	Northern Thailand 1991 Cohort- N = 2,417 1993 Cohort- N = 1,669	19-23 years Males, conscripts into Thai army	100% condom promotion program to increase condom use among visitors to brothels; components included: (1) communications strategy; (2) condom distribution in brothels; and (3) promotion of condom use at brothels, especially by men previously treated for STIs	Prospective cohort study: 1st cohort was made up of 1991 conscripts; the 2nd was composed of 1993 conscripts Each participant was interviewed and received a serologic test every 6 months from induction to discharge (total of 2 years' observation) 1991 Cohort <b>Baseline:</b> n = 2,417 <b>Follow-up 1:</b> n = 2,054 <b>Follow-up 2:</b> n = 1,788 <b>Follow-up 3:</b> n = 1,668 <b>Follow-up 4:</b> n = 1,788 1993 Cohort <b>Baseline:</b> n = 1,669 <b>Follow-up 1:</b> n = 1,502 <b>Follow-up 2:</b> n = 1,385 <b>Follow-up 3:</b> n = 1,285 <b>Follow-up 4:</b> n = 1,285	Incidence rates and 95% CI calculated using person-time methods; Poisson regression models; logistic regression analysis of repeated measures	STI incidence (including gonorrhea, syphilis, nongonococcal urethritis, and chancroid): + HIV incidence: + Risk behaviors: + (in '93 cohort) Brothel visits: + Consistent condom use: + (in '93 cohort)	This study confirms the effectiveness of the 100% condom program, which led to a decline in genital ulcer disease and other non-ulcerative STDs and to a reduction in HIV incidence. However, attributing this success to the program is difficult to substantiate because of the numerous interventions that occurred at the same time and because of the maintenance of behavior promoted by the program.

NOTES.

<sup>1</sup> Findings are forthcoming from two additional FOCUS-sponsored studies: "Transitions to Adulthood in the Context of AIDS in South Africa" and "Effects of a School-Based Peer Promotion Program on Adolescent Risk-Taking Behaviors among Inner City Youth in Kingston, Jamaica."

<sup>2</sup> Effect on outcome for intervention group compared to control: No significant difference = 0; significant desirable difference = +; significant undesirable difference = -.

<sup>3</sup> Preliminary results from the second round of data collection.

<sup>4</sup> Changes were not tested for statistical significance.



## APPENDIX J

# SUPPORTIVE<sup>1</sup> RESEARCH ON EFFECTIVENESS OF YARH PROGRAMS

School-Based Programs			
Author(s)/Publication Date/Title	Location	Results	Conclusions/Implications
Herold et al. (1994) Unintended Pregnancy and Sex Education in Chile: A Behavioral Model	Santiago, Chile	Women who had sex education before first intercourse and used contraception at that intercourse were one-third as likely to have a later unintended pregnancy as those who had sex education and did not use contraception at first intercourse.	Sex education can reduce unintended pregnancies among adolescents and young adults who engage in premarital sex, but this reduction depends on teaching use of effective contraception before first sexual experience.
Kane et al. (1993) Sexual Activity, Family Life Education, and Contraceptive Practice among Young Adults in Banjul, the Gambia	The Gambia	Attending a family life education lecture was positively related to knowledge of family planning among sexually active women. Among all sexually active women and men, those who attended at least one family life education lecture were more likely to have used contraceptives at first intercourse than those who had never attended one.	Attendance at family life education lectures in school had a significant positive relationship to both knowledge and use of contraceptives among youth surveyed. However, family life education lectures are not offered at all schools, and only about half of those offered in schools cover the topics of pregnancy prevention and STIs. Further, those with no formal education appear to have fewer opportunities to attend family life education lectures (author comments).
Pick de Weiss et al. (1990) Effect of Sex Education on the Sexual and Contraceptive Practices of Female Teenagers in Mexico City	Mexico City	Attendance at a sex education course did not affect age at first sexual activity, contraceptive use, or perception of accessibility to contraception. Receipt of information on pregnancy prevention and contraceptive sources was found to be related to contraceptive use.	The findings suggest that content areas with respect to pregnancy prevention and contraceptive sources are important for supporting contraceptive use. However, information with respect to pregnancy prevention had no effect on sexual behavior.
Tewari and Sanatha (2000) Reproductive Health Education: Experiences of Parivar Seva Sanstha (PSS) in Communicating With Youth	Delhi, India	Women's and men's pretest scores ranged from 0% to 58%. After the reproductive health course, scores ranged from 78% to 100% for women and from 27% to 90% for men.	The pre-intervention knowledge of the boys' group was better than the girls' group. However, the post-intervention knowledge and retention of the girls' group was found to be much better than the boys'.
Mass Media-Based Programs			
Diouf et al. (August 2000) Scenarios from the Sahel: Report on Time Series Survey	Senegal	Recall of project films was high (more than 80%). Overall, gains were made in indicators of knowledge, attitudes, practices, and self-efficacy.	The evidence of improvement across a wide range of indicators strongly supports the contention that the results observed are, at least partially, attributable to the Scenarios project (author comments).
Kiragu et al. (1998) Adolescent Reproductive Health Needs in Kenya: A Communications Response	Kenya	Evaluation results show that the radio programs were effective in reaching both youth and adults and were cost effective. The data also suggest that the programs were effective in motivating young people to go to the centers and to talk to their friends and adults about reproductive health issues.	Although many of the accomplishments of the last few years cannot be attributed entirely to the radio programs, it is believed that the project contributed positively to the debate on young adult reproductive health and helped significantly in shaping constructive responses at both the national and local levels (author comments).

### Mass Media-Based Program cont...

Author(s)/Publication Date/Title	Location	Results	Conclusions/Implications
Lewicky et al. (May 1998) Delivery of Improved Services for Health Project, Uganda	Uganda: rural and urban	The campaign reached a large portion of the intended audience. The campaign also contributed to an increase in knowledge and in the development of attitudes that promote responsible and safe sexual behavior, and it helped persuade youth to adopt some precautionary measures to guard against infection. The greater the exposure to campaign materials and events, the more favorable and responsible attitudes were (author comments).	These results suggest that youth in Uganda are attentive to messages about HIV/AIDS and can respond in sexually responsible ways.
Middlestadt et al. (1995) Evaluating the Impact of a National AIDS Prevention Radio Campaign in St. Vincent and the Grenadines	St. Vincent and the Grenadines	Exposed respondents were significantly more likely to agree that parents should talk to children about sexual responsibility, to believe their friends used condoms, and to have a partner that supported condom use (increase of normative beliefs). No significant differences were found in condom use between the two groups.	Mass media campaigns (when well designed and empirically based) can be an effective tool in producing changes in attitudes and beliefs that may ultimately lead to changes in behavior to prevent the spread of AIDS (author comments).
Rimon II et al. (1994) Promoting Sexual Responsibility in the Philippines Through Music: An Enter-Educate Approach	Metropolitan Manila, Philippines	The songs reached the vast majority of the targeted audience and persuaded its members to take some action. As a result of the campaign, young people talked to friends and parents, sought more information, and called the Dial-A-Friend Hotline (author comments). The media can inform a large number of people at low cost.	This project confirms that social messages promoted through popular music and mass media have a dramatic impact on people (author comments).
Samuels et al. (2000) An Evaluation of Soul City 4	South Africa	Research shows a strong statistical association between Soul City and a shift in people's position along the spectrum of the behavior change model (author comments). Evidence shows that the project increased accurate HIV/AIDS knowledge, created a shift in people's attitudes and social norms, as well as influenced changes in intermediate and direct practices (author comments).	Soul City was successful in creating a supportive environment in which behavioral change can take place (author comments).

### Community-Based Programs

Barkat et al. (1999) The RSDP/Pathfinder Bangladesh Newlywed Strategy: Results of an Assessment	Dhaka, Bangladesh	Evaluation results are encouraging. Positive results were seen in pill and condom use; delayed first pregnancy; tetanus toxoid immunizations; number of births attended by a trained health care provider; child-feeding practices; and use of government health facilities. None of these results can necessarily be attributed to the project, however.	The program functions as a source of information for newlyweds. Several improvements were identified to work toward in the future, including increasing capacity building for family planning field workers, increasing male participation, building alliances with related programs, and furthering evaluation efforts.
Barnett (2000) Programs for Adolescents: Reproductive Health Merit Badge for Scouts	Uganda, Zambia, and Egypt	The program increased girls' knowledge about health; gave participants a safe place to gather and an outlet for creativity; and gave young women a chance to interact with older women who are caring, nurturing role models.	The evaluation found that the program was successful in improving young girls' use of health-care services and their self-esteem (author comments).
Barnett and Katz (2000) Adolescent Reproductive Health: Navigating between Needs and Services	Cameroon	The percentage of male students reporting more than one partner in the last 3 months decreased from 53% to 36%; females reporting condom use with a high-risk partner increased from 63% to 77%.	To bring information to traditionally hard-to-reach groups, it is important to have peer educators specially trained to work with youth outside of the school setting.

## Community-Based Program cont...

Author(s)/Publication Date/Title	Location	Results	Conclusions/Implications
Flanagan, Williams, and Mahler (1996) Peer Education in Projects Supported by AIDSCAP: A Study of 21 Projects in Africa, Asia, and Latin America	10 countries in Africa, Asia, Latin America, and the Caribbean	Although peer educators were well regarded as knowledgeable and approachable sources of information, their usefulness in promoting behavioral change may have reached a plateau. Topics covered in training were identical across countries, although training duration varied greatly (from 3 hours to 3 weeks). Many expressed a need for counseling skills and training in how to care for people with AIDS. Peer educators had little contact with health professionals.	Project planners need to consider how and if their project should evolve to address the country-specific needs of the target audience. Subsequent training for peer educators will be necessary, along with their increased involvement with surrounding health-care professionals to create a cadre of professional support.
Johnston (2000) An Impact Evaluation of the Pathfinder Programme of Reproductive Health Services Support to Kenyan Universities: Peer Counseling and Clinic Services	Nairobi, Kenya	Trends over time reveal a decrease in unintended pregnancy, abortions, STIs, and pregnancy-related dropouts; an increase in use of modern and emergency contraceptive methods.	The evidence is very clear that these improvement trends were initiated and perpetuated by a Pathfinder reproductive health support program (author comments).
Randolph (1996) Evaluation of the Jamaica Red Cross Society's "Together We Can" HIV/AIDS Peer Education Project	Jamaica	Statistically significant results were reported for three of seven indicators of knowledge as follows: (1) proportion of peer educators that reported abstinence as a means for protecting against HIV/AIDS; (2) proportion that stated a doctor was a person to go to for help with an STI; (3) proportion of peer educators with a more positive attitude toward those with HIV.	Even in its short-term form, the workshops had a significant effect on many of the peer educators' HIV/AIDS-related knowledge and attitudes. The evaluation, however, did not produce convincing evidence that modification of behaviors occurred.
Visrutharatna et al. (1995) "Superstar" and "Model Brothel": Developing and Evaluating a Condom Promotion Program for Sex Establishments in Chiang Mai, Thailand	Chiang Mai, Northern Thailand	Pre- and Post-intervention: Women reporting consistent condom use increased from 42% to 93% in 1991. In 1992, the percentage reporting consistent use was 76%. Post-intervention only: The percentages of women reporting consistent condom use were 92% in 1991 and 80% in 1992.	A program directly involving sex workers as peer educators and enlisting the support of brothel owners and operators can result in improved condom use over time (author comments).
Wolf et al. (2000) Peer Promotion Programs and Social Networks in Ghana: Methods for Monitoring and Evaluating AIDS Prevention and Reproductive Health Programs among Adolescents and Young Adults	Ghana	Peer educators reach people that are similar to themselves. Those who have the perception that peers are protecting themselves from AIDS are more likely to do the same.	Data support the use of network analysis (as opposed to traditional individual approaches). Further analysis on the range and efficacy of peer education will help program managers to determine the number of peer educators necessary for community-level intervention (author comments).

## Facility-Based Programs

Barnett et al. (1996) Case Study of the Women's Center of Jamaica Foundation Program for Adolescent Mothers	Jamaica	Among program participants, 55% returned to school after their pregnancies compared with 15% of nonparticipants. The two groups exhibited only a marginal difference in contraceptive use (85% vs. 80%). Among program graduates, 14.6% had been pregnant a subsequent time compared with 38.7% of their nonparticipant counterparts.	This intervention during adolescence appeared to have an important effect on the women's later lives. At the women's center, the women gained the skills that enabled them to raise and nurture their children, complete their education, and seek employment (author comments).
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### Facility-Based Programs cont..

Author(s)/Publication Date/Title	Location	Results	Conclusions/Implications
Erulkar and Mensch (1997) Youth Centers in Kenya: Evaluation of the Family Planning Association of Kenya Programme	Nairobi and Mombasa, Kenya	Attendance at the youth centers was extremely low, most notably for counseling and RH services. Most of the youths that did visit came for recreation. Of those reached, the majority were older boys. Few youths and parents in catchment areas of the centers were aware of the centers' existence. The cost of maintaining the centers is extremely high.	The main strength of the program was found to be the network of peer promoters and coordinators, who reached a large number of youth through educational activities. These activities are also more cost-effective.
Glover et al. (1998) Youth Centres in Ghana: Assessment of the Planned Parenthood Association of Ghana Programme	Ghana	Significant proportions of those coming for clinical services (as opposed to using the library or other resources) were outside the target age and were mostly female. Only about half of youth center clients were aware of counseling and clinical services available (not available at all centers). Clients were deficient in RH knowledge.	The centers need to reach out to their existing clientele to inform them of the available services and to integrate reproductive health education into all activities at the centers.
Phiri and Erulkar (1997) A Situation Analysis of the Zimbabwe National Family Planning Council's Youth Centres	Zimbabwe	Staff were knowledgeable but lacked specific training to address adolescent needs; the number visiting the centers to seek RH information and services was poor. The multipurpose approach attracted more youths but not specifically for RH/FP. Many of the youths served were older than the target age; the approach was not cost-effective or sustainable.	The youth centers are reaching inadequate numbers of young people, far fewer females than males, virtually no youths under 15 years old, and many people too old to be considered youth. The cost of the program is much greater than the return and cannot be sustained over the long term. Measures are required to either increase use or investigate alternative means of reaching adolescents in a cost-effective way (author comments).

### Work-Based Programs

No supportive evidence of workplace-based programs was cited in the text.

<sup>1</sup>Supportive research is defined here as it is in the text, that is, as research conducted without a control group. This table refers only to this kind of research. Other studies mentioned in the text do not meet the criteria to be listed as supportive research but can be found in the reference list.

# APPENDIX K

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## APPENDIX L

# FOCUS ON YOUNG ADULTS PUBLICATIONS

### TOOLS SERIES: “HOW TO” GUIDES TO IMPROVE RESEARCH, PROGRAMS, TRAINING AND POLICY

Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents (*James-Traore, February 2001*)

A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs (*Adamchak, Bond, MacLaren, Magnani, Nelson, Seltzer, June 2000*)

Getting to Scale in Young Adult Reproductive Health Programs (*Smith, Colvin, April 2000*)

Assessing and Planning for Youth-Friendly Reproductive Health Services (*Nelson, MacLaren, Magnani, January 2000*)

Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents (*Shah, Zambenzi, Simasiku, June 1999*)

Annotated Bibliography of Training Curricula for Young Adult Reproductive Health Programs (*Zimmerman, October 1998*)

### RESEARCH, POLICY, AND PROGRAM SERIES: CURRENT KNOWLEDGE ABOUT YOUNG ADULT REPRODUCTIVE HEALTH

Dialogue on HIV/AIDS and Youth (*Rosen, August 2001*)

Dialogue on Young Adult Reproductive Health Research and Evaluation: Implications for Policies and Programs (*Rosen, May 2001*)

Dialogue on Social Marketing and Other Commercial Approaches to Improving Adolescent Reproductive Health (*Rosen, May 2001*)

Formulating and Implementing National Youth Policy: Lessons from Bolivia and the Dominican Republic (*Rosen, 2001*)

Making Reproductive Health Services Youth Friendly (*Senderowitz, February 1999*)

Involving Youth in Reproductive Health Projects (*Senderowitz, September 1998*)

Promoting Reproductive Health for Young Adults through Social Marketing and Mass Media: A Review of Trends and Practices (*Israel, Nagano, July 1997*)

Reproductive Health Programs for Young Adults: School-based Programs (*Birdthistle, Vince-Whitman, June 1997*)

Health Facility Programs on Reproductive Health for Young Adults (*Senderowitz, May 1997*)

Reproductive Health Outreach Programs for Young Adults (*Senderowitz, May 1997*)

## **IN FOCUS: BRIEFS ON SELECTED ISSUES IN YOUNG ADULT REPRODUCTIVE HEALTH**

Youth Livelihoods and HIV/AIDS (*Rosen, January 2001*)

Advocating for Adolescent Reproductive Health: Addressing Cultural Sensitivities (*Rosen, November 2000*)

Reaching the Youngest Adolescents with Reproductive Health Programs (*Sedlock, January 2000*)

Reaching Adolescents Through Hotlines and Radio Call-in Programs (*Moch, Stevens, December 1999*)

Reaching Newlywed and Married Adolescents (*Alauddin, MacLaren, July 1999*)

Reaching Socially Marginalized Youth (*Stevens, March 1999*)

Reaching Indigenous Youth with Reproductive Health Information and Services (*Farrell, Rosen, Terborgh, February 1999*)

Reaching Young Men with Reproductive Health Programs (*Green, Boyd, Moore, December 1998*)

Involving Parents in Reproductive Health Education for Youth (*Purdy, Ramsey, September 1998*)

Sexual Abuse and Young Adult Reproductive Health (*Shanler, Heise, Stewart, Weiss, September 1998*)

Reproductive Health Programs for Young Adults: School-Based Programs (*Birdthistle, Vince-Whitman, August 1998*)

Reproductive Health Programs for Young Adults: Outreach Programs (*Senderowitz, August 1998*)

Reproductive Health Programs for Young Adults: Social Marketing & Mass Media (*Israel, Nagano, August 1998*)

Reproductive Health Programs for Young Adults: Health Facility Programs (*Senderowitz, August 1998*)

Emergency Contraceptive Pills: An Important Option for Young Adults (*Klofkeorn, July 1998*)

Young People and Anemia (*Senderowitz, July 1998*)

Young People and STDs/HIV/AIDS Part I: Dimensions of the Problem (*Senderowitz, December 1997*)

Young People and STDs/HIV/AIDS Part II: Programs to Address the Problem (*Senderowitz, December 1997*)

Using Peer Promoters in Reproductive Health Programs for Young Adults (*Senderowitz, December 1997*)

Do Youth-Friendly Services Make a Difference? (*Senderowitz, December 1997*)

Making Reproductive Health Services Friendly for Young People (*Senderowitz, December 1997*)

Involving Young People in Reproductive Health Programs (*Senderowitz, December 1997*)

## PROJECT HIGHLIGHTS: SUCCESSES AND CHALLENGES OF PROJECTS AROUND THE WORLD

- CEMERA, Chile: Integrating Sexuality Education and Health Services for Students (*Luengo, Toledo, 2001*)
- Arte y Parte*/PROMESA, Paraguay: Combining Mass Media-, School-, and Community-Based Approaches (*Aguilar, Brookings, 2001*)
- Trendsetters*, Zambia: Teens Produce Newspaper to Encourage Healthy Behaviors (*Phiri, 2000*)
- Uganda Women's Effort to Save Orphans (UWESO), Uganda: Families, Communities Band Together to Ensure Sustainable Future for Young People (*Ntambirweki, 2000*)
- Youth Activists Organization (YAO), Zambia: Education Empowers Zambian Youth (*Hachonda, 2000*)
- BRAC, Bangladesh: Community Mobilization to Support Adolescent Development (*Khan, Ahmed, 1999*)
- Women's Centre, Jamaica: Prevent Second Adolescent Pregnancies by Supporting Young Mothers (*McNeil, 1999*)
- PATH, Kenya: Using Scouting as a Vehicle for Reaching Out-of-School Youth (*Kabuthia, Radeny, 1999*)
- REDESS-JOVENES, Peru: Building a Coalition to Support Youth (*Raguz, 1999*)
- Tsa Banana, Botswana: Social Marketing of Reproductive Health Services to Youth (*Harris, 1999*)
- TARSHI, India: Talking About Reproductive and Sexual Health Issues with Youth: A Telephone Helpline (*Chandiramani, 1999*)

- Kenyatta University, Kenya: Peer Counseling to Develop Tomorrow's Leaders (*Kamanja, 1999*)
- CEMOPLAF, Ecuador: Fertility Awareness and Sexuality Education for High School Students (*Cachan, Sevilla, de Vargas, 1999*)
- Lifenet, Thailand: Promoting Social Action Networks for Youth Health (*Fongkaew, Bond, 1999*)
- INPPARES, Peru: An Integrated Reproductive Health & Business Training Program for Youth (*Segil, Sebastiani, 1999*)
- Soul City, South Africa: Harnessing the power of media for health and development (*Molefe, 1999*)
- Homies Unidos, El Salvador: Peer Education with Gang Members: Protecting Life and Health (*Rose-Avila, 1999*)
- Adolescent Girls Project/SEEDS, Egypt: Income Generation to Expand Girls' Social Possibilities (*Bruce, Assaad, 1999*)

## WORKSHOPS: STATE OF THE ART TRAINING REPORTS

- Young Adult Reproductive Health State of the Art (SOTA) Training Course Report: Nigeria (*2001*)
- Young Adult Reproductive Health State of the Art (SOTA) Training Course Report: Southeast Asia Region (*2000*)
- Young Adult Reproductive Health State of the Art (SOTA) Training Course Report: East and Southern Africa Region (*1999*)