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**Health Facility Programs
on Reproductive Health for
Young Adults**

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PREFACE

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

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

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

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

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ACRONYMS

AIDS	acquired immune deficiency syndrome
AMES	Mexicana de Educación Sexual Asociación
CORA	Centro de Orientación para Adolescentes
CSW	commercial sex worker
FHI	Family Health International
FPA	family planning association
HIV	human immunodeficiency virus
ICRW	International Center for Research on Women
IEC	information, education, and communication
ICPD	International Conference on Population and Development (Cairo)
ICRW	International Center for Research on Women
IPPF	International Planned Parenthood Federation
MSI	Marie Stopes International
MOH	Ministry of Health
NGO	nongovernmental organization
OC	oral contraceptive
PAHO	Pan-American Health Organization
PREA	Educational Program for Adolescent Mothers
RH	reproductive health
STD	sexually transmitted disease
UN	United Nations
UNFPA	United National Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

HEALTH FACILITY PROGRAMS FOR YOUNG ADULTS

I. INTRODUCTION

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

The biological events related to sexual maturation are now only part of this life phase. Considerable attention is also being given to psychosocial and behavioral aspects of young adulthood, especially in view of its risk-taking activity and the assumption of unhealthy social habits such as smoking, drug use, and violent behavior. Many of the concerns have intensified in recent decades, because of urbanization, increased exposure to media, and high rates of unemployment, including, in some areas, persistent homelessness and various forms of social upheaval.

Reproductive health is a major concern of the young adult period, in part because earlier sexual maturation and later marriage have increased the period of risk for early or nonmarital pregnancy and exposure to sexually transmitted diseases (STDs), including the likelihood of multiple partners. Changes in familial and societal patterns and values have also resulted in a relaxation of social constraints on nonmarital sexual activity. HIV infection is the most recent, and most serious, addition to the array of STDs common in this age group.

It is likely that the HIV pandemic, with its impact on young adults, has provoked otherwise reticent governments to address reproductive health more overtly and strongly. Some countries have developed information, education, and communication (IEC) and outreach programs for young people that are franker and more open than information communicated on family planning and pregnancy prevention. Increased attention to women's health, and women's contributions to development, have also encouraged governments to change policy and programs allowing younger women access to services to prevent too-early pregnancy. High maternal mortality and morbidity rates and school discontinuation because of pregnancy are two of the factors that dramatize the need for policy change related to addressing young women's health and development.

The delivery of clinical reproductive health services to young adults, other than to married women who are generally treated as adults whatever their age, is a new and emerging area. Agencies, especially nongovernmental organizations (NGOs), are trying out new ways to serve this population more effectively and in ways that meet their needs. However, there is great hesitancy because of the sensitivities involved in providing reproductive health care to unmarried young women in most countries. Furthermore, young people who survive childhood diseases to reach adolescence are

considered by service providers as a healthy age group; often overlooked are new risks and problems at this developmental stage. Inadequate training and orientation of providers to adolescents are associated with discomfort and lack of coverage. Thus, most efforts are small, isolated, and without significant resources.

Should, therefore, efforts be made to attract young people to clinical services in view of the challenges? Should special attention be focused on provider attitudes and clinical atmosphere to become more welcoming of young adult participation? With other sources of counseling and services available, should clinics still try to attract young people?

Given the needs and experiences reviewed in this paper, the answers to these questions are "yes, yes, yes." First, reproductive health services are often very much needed by young men and women and are not adequately available elsewhere. For example, a full array of contraceptive methods is not provided by outreach projects or from drugstores, and STD diagnosis and treatment are commonly available only at a clinic site. Second, clinical services are already established and available in many places and could serve young people well with proper staff training and other selected adjustments. Third, some young people already come to health facilities for other reasons — general health care or delivery or abortions — and could be served with needed reproductive health services at the same time and/or place.

Experience in developed — and a few developing — countries suggests higher participation of young, including unmarried, women and men in health facility programs. While it may take some time and effort, especially for attitudes about serving young people to change, the benefits of increasing access to clinical services will be worth the investment.

A. Content and Methodology

This paper on health facility services for young adults is part of a process to identify effective projects and set a practical research agenda. It describes existing health facility programs and provides some evidence about their achievements, presents programmatic lessons learned on strategic and operational elements based on a literature review of published materials and on reports and testimonials from project staff and professional opinion, sets forth key elements for delivering services at health facilities and suggests some critical research questions for the future. A summary of key elements, apparent values and benefits from their inclusion in young adult programs, and examples of their implementation is contained in Table 1.

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

This paper covers health facility programs providing reproductive health services to young adults. Included are hospital-based projects and clinics, including facilities offering a broad array of health services and those more specialized in family planning and/or reproductive health. For the purposes of this paper, experiences and recommendations will be largely limited to clinical settings in which health care is the major service and not one component among many of equal importance (as in youth centers). Youth centers as well as projects that bring activities to youth, including peer programs, are reviewed in a companion paper on outreach. Outreach projects typically stress counseling and motivation, and refer clients elsewhere for clinical services. Clinics housed within schools or universities are covered in the paper on school-based programs. IEC projects designed mainly to educate and inform, along with social marketing activities, are discussed in the fourth paper.

B. Summary of Project Models and Elements

Providing young adults with specialized reproductive health information, counseling, and services is a relatively recent practice, especially in developing countries. Reproductive health facility programs have traditionally served young women if they were married; usually, such service provision related to pregnancy and childbirth, since pregnancy prevention was not typically sought by the newly married woman who, in many cultures, wished to prove her fertility and begin childbearing promptly.

Family planning service programs, in their early phase, emphasized service to older, married women who had completed their childbearing or who wished to determine the spacing and timing of the children they would bear. Given this emphasis, clinics did not seem relevant or welcoming to young women, especially unmarried ones who were not expected to need reproductive health services. Men felt even less included in the family planning setting.

As narrowly focused family planning clinics expand to include broader reproductive health issues, as many are doing, they continue to be largely avoided by young men and women. Some of young people's reluctance to attend clinics relates to the facilities' past emphasis and environment, while some reflects the continuing sense of disapproval of adolescent sexual activity perceived by potential clinic-goers. Particularly important to young adults is a concern for privacy and confidentiality, which they fear will be compromised in clinical settings. Many young people are anxious and embarrassed; this is especially true in situations involving sexual abuse and/or violence.

In many countries, young people have access to reproductive health information, counseling, and products through other sources, such as peer projects and drugstores, so a preferred source of care can be chosen. Too often, however, needed information, advice, and services are not sought merely due to difficult access and personal discomfort in seeking them.

In spite of these obstacles, projects have been developed and implemented. And though limited, evidence of success exists and is summarized in this paper. A project model that emerged logically is one that provided specialized services to prenatal, postpartum, and post-abortion adolescents. These usually involve add-on features to work more specifically with adolescents, such as specialized training for key staff or educational sessions for young women already admitted as patients. Some efforts of this type have proven successful at increasing use of prenatal care,

decreasing the incidence of low-birth-weight babies, increasing the duration of breastfeeding, and increasing the use of contraception to prevent a subsequent pregnancy.

More challenging is the provision of reproductive health services to unmarried young people who need to be attracted to a health facility. Family planning associations have often pioneered such efforts, developing effective ways to recruit and serve young people. Recruitment typically involves outreach efforts into the schools, workplace and recreational areas, frequently by youth themselves. Tailored services tend to include specialized training, convenient hours, drop-in appointments, age-appropriate IEC materials, additional time for counseling, special educational sessions and reduced fees. Public health facilities, which sometimes forge a partnership with NGOs during a transitional or continuing phase, usually take on this task only after the groundwork has been laid. The Latin America and Caribbean region is in the forefront of young adult projects of this type in the developing world.

Given the experience of programs in developed countries, along with emerging efforts in developing countries, some lessons have been learned. In terms of impact, the record seems to be mixed. There is some evidence of greater contraceptive continuation and lower pregnancy rates in one study, though other programs have not yielded such results or have not conducted sufficient evaluation to determine such outcomes. More available is information regarding adolescent use of services, which can increase with specialized services and recruitment, and feedback from young people about their preferences and needs within clinical settings.

Although evaluative findings are generally not available about specific characteristics that are essential to or could enhance clinical reproductive health projects, the following table sets forth "key elements" identified by young people and professionals who work with adolescents as important to project acceptability and effective implementation.

Table 1: KEY ELEMENTS

Element	Value/Benefit	Example(s)
A. PRELIMINARY ACTIONS 1. PROGRAM DESIGN AND DEVELOPMENT		
a. Strategic Approach	<ul style="list-style-type: none"> • helps prevent failures due to planning or promising more than is possible or desirable • helps chart a politically acceptable and sequential approach to a sensitive topic 	<ul style="list-style-type: none"> • Projects can target pregnant young adults before planning primary prevention efforts • Projects state as objectives what is achievable in project timeline (e.g., # of contraceptive acceptors and not reduced pregnancy rate in two-year project)
b. Target Audience Identification	<ul style="list-style-type: none"> • cost-effectiveness • greater likelihood of reaching most desired population 	<ul style="list-style-type: none"> • analyze data to identify group most in need of clinical services
c. Needs Assessment	<ul style="list-style-type: none"> • relevance of intervention • cost-effectiveness (pinpointing most important program offerings) • involvement of target audience 	<ul style="list-style-type: none"> • survey target audience regarding such service variables as fees, clinic hours, types of counseling, types of services most needed, etc.
d. Youth Involvement	<ul style="list-style-type: none"> • relevance of intervention • "ownership" of project by target audience • built-in recruitment mechanism 	<ul style="list-style-type: none"> • establishment of Youth Advisory Committee • youth member on project planning team; involved in evaluation, implementation • youth member on Board of Directors • youth employed by project
e. Community Involvement	<ul style="list-style-type: none"> • increase understanding, support and "ownership" • prevent later backlash • engage community leadership • facilitate linkages for program coordination, referrals 	<ul style="list-style-type: none"> • presentations and briefings with community • establishing a community leadership council
f. Parental Involvement	<ul style="list-style-type: none"> • increase support, prevent opposition to their children's involvement • educate and develop skills for supporting young adult children 	<ul style="list-style-type: none"> • education / skills building workshops for parents • joint discussion sessions for young adults / parents
g. Evaluation, Design and Monitoring	<ul style="list-style-type: none"> • ability to know project's progress and success • ability to adjust operations and improve project outcomes • ability to attribute outcomes to interventions 	<ul style="list-style-type: none"> • seek assistance from universities, other national / international agencies • keep data on appropriate age groups (e.g., one- or two-year cohorts)
h. Continuation, expansion or replication considerations	<ul style="list-style-type: none"> • expansion of successful activities more likely to occur if planned • "expanders" can begin planning project adoption well before it occurs 	<ul style="list-style-type: none"> • involve agency staff early who would later adopt or expand project activities • facilitate involvement by government agencies

Table 1: KEY ELEMENTS (continued)

Element	Value/Benefit	Example(s)
2. INFRASTRUCTURE READINESS		
a. Delineation of responsibilities, guidelines, and standards	<ul style="list-style-type: none"> • clear procedures for staff to follow reduces dependence on subjective treatment options • transition to new treatments and concerns are facilitated • training and supervision of staff are facilitated 	<ul style="list-style-type: none"> • identify areas of greatest confusion or lack of clarity to begin a guideline development process • adapt existing set of standards of health care services (e.g., from Columbia program) for use in facilities where these are lacking
b. Staff selection / hiring, new assignments and training	<ul style="list-style-type: none"> • staff adequate in number and preparation for their responsibilities • staff assigned to young adults who understand and want to work with this age group 	<ul style="list-style-type: none"> • select staff according to skills <u>and</u> interests • assess staff needs, properly train staff before start of project
c. Collaborative Agreements	<ul style="list-style-type: none"> • agency can use available resources without obligating itself to full-time professionals 	<ul style="list-style-type: none"> • arrange with vocational training agency for referral
B. PROJECT IMPLEMENTATION 1. RECRUITMENT		
a. Use of tested messages / materials	<ul style="list-style-type: none"> • increase client base by effective recruitment • facilitate recruitment in wider community 	<ul style="list-style-type: none"> • use needs assessment to identify what target audience needs to know about services • field test printed and A/V materials before finalizing
b. Word of Mouth (person to person)	<ul style="list-style-type: none"> • satisfied clients are very convincing advocates of a service • utilizing an existing universe of experienced young adults can be cost-effective 	<ul style="list-style-type: none"> • provide educational/referral materials to clients to share with their peers • train a group of peer promoters to give presentations to schools and youth groups
2. FACILITY CHARACTERISTICS		
a. Convenient Location	<ul style="list-style-type: none"> • increase client base if easy to reach • reduce chances of failing to treat medical emergencies 	<ul style="list-style-type: none"> • if a choice is possible about where to situate clinical services, do so within easy reach of and via good transportation for target group
b. Separate hours / location	<ul style="list-style-type: none"> • young adults feel they are using a service designed for them and their needs • fears of adult disapproval or exposure reduced 	<ul style="list-style-type: none"> • separate hours (e.g., an evening clinic once / week) could be tested to observe any benefits and expanded if indicated

Table 1: KEY ELEMENTS (continued)

Element	Value/Benefit	Example(s)
c. "Youth-friendly" environment	<ul style="list-style-type: none"> clients are attracted to a place that feels comfortable client comfort can benefit counseling and service task 	<ul style="list-style-type: none"> de-medicalize environment by using posters and decor popular with young adults test a change of dress, comparing use of street clothes to uniforms
d. Comfortable for Young Men	<ul style="list-style-type: none"> increase participation of young men for own reproductive health care and for joint decision-making and responsibility 	<ul style="list-style-type: none"> includes decor and reading material of interest to young men insure some male staffing offer services specifically designed for young men
3. SCHEDULING / CLINIC HOURS		
a. Convenient Hours	<ul style="list-style-type: none"> higher use of facility if target group can come at convenient hours 	<ul style="list-style-type: none"> make sure some late afternoon, evening, and weekend hours are scheduled for young adult clients
b. Drop-ins welcome / accommodated	<ul style="list-style-type: none"> greater clinic use if young adults do not need to plan ahead service can build on adolescent tendency to be impulsive 	<ul style="list-style-type: none"> arrange scheduling to accommodate at least some drop-ins if warranted
c. Confidential recontacts	<ul style="list-style-type: none"> increase follow-up care and re-visits 	<ul style="list-style-type: none"> include question on in-take form concerning client's preferred means of recontacting
4. SERVICE PROVISION		
a. Private consultation and examination rooms	<ul style="list-style-type: none"> young adults will patronize facilities which assure confidentiality and privacy 	<ul style="list-style-type: none"> use separate rooms, with sound barriers, whenever possible, for consultations at least, use curtain or other divider for examinations
b. Counseling provided by trained professionals	<ul style="list-style-type: none"> understanding, empathetic counselors can better gain trust of clients effective counselors can assist young adults to make appropriate decisions, get proper services 	<ul style="list-style-type: none"> make sure counselors have taken a training course specific to adolescent reproductive health assess various uses of peer and adult counselors in clinic facility allow additional time for counseling young adult clients
c. Strong link between counseling and services	<ul style="list-style-type: none"> increase number of contraceptive acceptors ensure young adults receive protection before pregnancy or STD transmission 	<ul style="list-style-type: none"> allow for counseling and method selection to occur in same facility during same consultation
d. Providers trained to work with young adults	<ul style="list-style-type: none"> young people will be attracted to clinics where providers have accepting, positive attitudes 	<ul style="list-style-type: none"> ensure that <u>all</u> providers (including physicians) have a minimum of orientation and training for working with adolescent clients schedule extra time for provider to consult with clients

Table 1: KEY ELEMENTS (continued)

Element	Value/Benefit	Example(s)
e. Appropriate array of contraceptives available	<ul style="list-style-type: none"> • use of contraceptives likely to increase and be sustained if client can choose a preferred method • pregnancy and STD prevention can be enhanced if proper contraceptives are adopted 	<ul style="list-style-type: none"> • ensure a real choice of contraceptives for clients • make sure clients understand relative risks of pregnancy and STD transmission when choosing methods
f. Comprehensive reproductive health services: including STD/HIV protection, nutrition and prenatal/postnatal care	<ul style="list-style-type: none"> • if STD services are part of reproductive health offerings, adolescents can be assisted with both STD and pregnancy prevention as part of same visit and decision-making process • STD services may help recruit young men to become involved in FP decisions • young people may be reluctant to seek STD counseling in a separate clinic or face the need to make additional visits • good nutritional status and pre-natal care improves birth outcomes 	<ul style="list-style-type: none"> • FP clinics can phase in an STD/HIV prevention effort through training, procedures development and availability of educational materials • post-natal and post-abortion care should routinely offer pregnancy and STD prevention services • nutritional supplements can be provided to young people in need
g. Integrated, holistic approach (if possible)	<ul style="list-style-type: none"> • young people can have broad needs met in holistic way • services can treat common, underlying causes of multiple problems 	<ul style="list-style-type: none"> • staff can be added, as possible, to make staff more integrated, perhaps beginning with a psychologist or social worker • use of professionals from larger or related institutions can be deployed for limited periods of time
5. COSTS		
a. Affordable fees	<ul style="list-style-type: none"> • client base increases if costs are not a barrier 	<ul style="list-style-type: none"> • a sliding scale can be used for a fee schedule • token payments can be used instead of free services if clients feel the quality of free services is poor

II. TYPES OF HEALTH FACILITY PROGRAMS FOR YOUNG ADULTS

A. Background

Given that adolescence, or young adulthood, is a newly acknowledged life phase in many regions, the practice of serving this age group with specialized services has only recently begun, primarily in Western countries. Most developing countries do not have clinical services tailored for young adults in the public sector. The few activities that exist are most often implemented by NGOs, though some governments have begun testing activities, most typically with NGO involvement. This chapter will review the main program approaches that have developed to better accommodate young adults or to recruit this population to specially established services. Evidence of successes in attracting the target population and improving reproductive health outcomes will be presented.

Reproductive health services for this age group present a particular challenge to public officials. There are continuing sensitivities around sexual and reproductive issues in some countries; these become especially acute in serving unmarried young people.

Discrimination by marital status continues to be the norm in many Asian and African countries, though there are indications of change. For example, in Kenya, young women who have borne a child, who have had an abortion, or who are commercial sex workers are considered high-risk and thus gain access to services. This is the practice in other countries, too, but typically these are not articulated policies that can be followed in a consistent way.

In Latin America, specialized services are developing in pilot projects, but it is very rare for young women to approach a clinic to postpone a first pregnancy. In Chile, for example, projects have been designed for, and frequented by, pregnant adolescents in order to improve birth outcomes and to delay subsequent pregnancies (Corona, Canessa et al., 1995).

Even where there are no legal restrictions to serving young, unmarried adults, as in Thailand, young people are reluctant to use public facilities for reproductive health care. This is generally true nearly everywhere in the developing world. They fear a lack of privacy and confidentiality, a judgmental and unsympathetic reception, and feel that the facilities are not geared to their needs and concerns. And to varying degrees, they are accurate in their perceptions. A "mystery client" study in Senegal confirmed the reality of provider attitudes and bad treatment that adolescents so fear: young people were made to feel embarrassed, were given lectures about the dangers of sex before marriage, and were not provided contraceptives when requested (Naré et al., 1996).

Another reason why some young women are hesitant in seeking services relates to the circumstances of their sexual experiences. Many pregnancies to young teens are unwanted and often result from sexual abuse, coercion, or violence. The resulting shame and embarrassment are strong deterrents to obtaining services, as are the service providers' usual lack of training to deal with these issues.

In spite of the sensitivities and traditional views on pregnancy and childbearing, there are several types of clinical programs that explicitly serve young adults with reproductive health care. The

most basic is the hospital, clinic, or health center whose policies remove or minimize restrictions against adolescent access and treatment though no specialized services are provided. However, given the reluctance of young unmarried people to patronize public facilities for reproductive health care, and the usual practice of seeking "cures" rather than prevention, young clients of these services most likely consist of pregnant or delivering teens and those who face an emergency situation. While not truly a model of service delivery, removing barriers to adolescent access is at least a basic action that can be taken without the establishment of new and/or reorganized services.

B. Specialized Services for Pregnant Young Women

Some clinics have developed specialized services within facilities serving all ages. Projects cover a range of service adjustments; they can be as modest as training a counselor to work with adolescents or as significant as inviting in an outside agency to provide educational sessions or reorienting a cluster of professional staff to attend adolescent patients. This model involves program add-ons to facilities where large numbers of young women are giving birth or seeking post-abortion treatments. These would typically offer special prenatal and postnatal care with concerted efforts to educate young mothers about breastfeeding and infant care and to encourage follow-up visits. Many such programs also attempt to help clients establish contraceptive practices to delay a repeat pregnancy.

It is no doubt true that adding some activity onto an existing clinic facility is less expensive than creating a new one. In terms of achieving various objectives, there is also some evidence that such programs work, though the available record on a few evaluated efforts is mixed and somewhat inconsistent.

1. Increasing Postpartum Contraceptive Prevalence

Hospital-based educational interventions targeted at postpartum young women were implemented and evaluated at two Mexico City sites. Although they involved different designs and agencies, both were primarily intended to assist these clients in accepting a contraceptive method and delaying the second birth. One of these, implemented by Asociación Mexicana Educación Sexual (AMES), provided family planning information and counseling at both prenatal and postpartum sessions to women under age 20 delivering at a public hospital as well as education and services through a special adolescent clinic in the hospital. The evaluation, using focus groups, a survey of program participants and controls, and a discussion with a "panel of specialists," found that although the experimental group had a somewhat higher contraceptive prevalence rate than the control group (86 percent vs. 73 percent), more than half (54 percent) of the intervention group did not remember receiving the talk given immediately after delivery (Corona et al., 1988).

As a result of these findings, efforts were made to reach women at various points prepartum and postpartum. A second evaluation of this project, two years later, showed some positive results for behavioral intent: more young adults who had attended an educational session planned to space their births than the nonattending clients (86 percent vs. 64 percent), though actual behavioral change on birth-spacing was not assessed. The greatest impact seemed to be on prenatal care, however, with participating adolescents receiving a greater number of prenatal checkups (Pathfinder International [PI], 1995).

In the other project, Educational Program for Adolescent Mothers (PREA), conducted by Centro de Orientación Adolescentes (CORA), participants attended postpartum and one or more subsequent sessions on family planning. An evaluation consisting of direct observation, focus groups, in-depth interviews, pre- and post-tests, and systems analysis showed that PREA participants who attended postpartum and one or more subsequent sessions had a longer duration of breastfeeding and a higher rate of contraceptive use than the control group. That these young women seemed to remember the postpartum session, and that it was an effective motivational and educational tool, contradicts the conclusion of the earlier AMES approach on the value of using the immediate postpartum period (Martin et al., 1992).

In an intervention that combined hospital-based counseling during prenatal sessions and postpartum home visits in Barbados, evaluation findings suggested that the interventions did not increase the overall percentage of young women who had ever used a contraceptive method, although there were positive effects on intention to use a contraceptive method at the next sexual episode. Interestingly, three home visits did not show any different impact from only one visit (Ministry of Health [MOH], Barbados, 1986).

In a Brazilian hospital-based program, responding to the high incidence of first deliveries to women under age 20, an outpatient clinic was instituted to decrease the number of unwanted pregnancies for postpartum and post-abortion adolescents. These services are offered at specific hours and include counseling, education and provision of contraception. Evaluation of the project showed that 50 percent of the young women patients who received services or educational talks returned to the outpatient clinic for follow-up. Furthermore, the ratio of abortion to births in one hospital declined from 18 to 13 percent (Shepard et al., 1989).

Another example of such services evolved from the high incidence of young obstetric patients at the Bogota Children's Hospital in Colombia. Family planning and reproductive health information, counseling, and services are provided at special hours to adolescent inpatients at the hospital and those young people referred from the ob-gyn or psychological outpatient units. An evaluation showed that 31 percent of the total adolescent population seen in one ob-gyn services became new family planning users at the special clinic (Shepard et al., 1989).

2. Improving Birth Outcomes

In the United States, a study was made of a comprehensive program for pregnant women under 18 at a medical university that used nurses, social workers, a nutritionist, obstetricians, and a psychiatrist, with management of the caseload done by nurse-midwives. Evaluators, using medical records of 738 program participants and a control group of 2,034, concluded that such an approach can result in a significantly lower incidence of low-birth-weight babies even among a population of socioeconomically high-risk adolescents. Although family planning was part of the intervention, evaluation limitations prevented any conclusions about repeat pregnancies (Piechnik and Corbeth, 1985).

Multidisciplinary teams have been engaged to improve birth outcomes and postpartum practices in hospitals and clinics in Chile among high-risk young women. Medical records show several positive results, including lowered infant mortality, higher rates of continued breastfeeding and reduced rates of second pregnancies (Maddaleno, 1994).

Given that many pregnant adolescents are undernourished, yet face increased nutritional needs during pregnancy, some programs have focused on providing supplements in their prenatal care, with positive outcomes. A birth survey in Nigeria found that pregnant adolescents who received antimalarial drugs and iron and folic acid supplements in the second half of pregnancy showed a reduced incidence of cephalopelvic disproportion (Harrison et al, 1985). In the US, a group of pregnant adolescents who received calorie, protein, vitamin, and mineral supplements gave birth to infants with a significantly higher mean weight than a group that received no supplements; larger effects were observed among girls under 16 (Rosso and Lederman, 1982).

C. Specialized Reproductive Health Services for Young People

Moving beyond the care of inpatient young pregnant women, some clinics are beginning to offer specialized services for pregnancy prevention (including early, first pregnancies) and STD prevention among young people, as well as providing guidance on and treatment of other reproductive health concerns. These offerings usually include staff trained to work with young adults, reduced fees, drop-in scheduling, and extended hours to meet after-school (or after-work) time frames. Services can be made even more focused by occupying separate space or utilizing separate entrances. To attract young clients, outreach is conducted in places where they spend time — school, work, or recreational locales.

Clinics that address broader youth needs have often been pioneered by NGOs, which have more freedom to experiment, tend to operate smaller projects, and, in some cases, have a youth constituency and activities already in place. Family planning associations (FPAs) — often, but not always, IPPF affiliates — have initiated young adult projects in many countries, testing various other components to attract and retain their clients. One common activity at such clinics is the use of young people to recruit, educate, counsel, and refer their peers, variously (and not always consistently) called peer promoters, educators, and counselors. FPAs usually include significant educational activities, both on site and by outreach to the schools and to other places where youth congregate. They tend to disproportionately reach the schools, however, leaving out-of-school youth underserved.

In both Colombia and Peru, the IPPF affiliates have established special programs for young people, with separate staff and hours devoted to them or clinics just for them. A great benefit of locating such services within existing FPAs is the availability of clinical and educational staff and infrastructure. And while cost can be an obstacle, the FPA in Colombia has moved significantly toward self-sufficiency by charging fees for services and by applying some of the earned income from other services to the youth program (IPPF/WHR, 1995).

Some NGOs, including Asociación Salud con Prevención in Bogota, Colombia, have implemented partnerships with local health departments by deploying personnel to provide health care on fixed days at specified times. In addition to the immediate benefits to young people derived from a friendly and convenient setting, the partnership facilitates training opportunities for the health center as well as the transition from an NGO to a public health operation (Rizo, 1997).

U.S. studies have tried to assess the impact of instituting specialized services on contraceptive use and delayed pregnancy, with mixed conclusions. In one study, selected family planning

clinics implemented a special adolescent protocol that stressed psychological and social concerns and included the following elements: one-to-one counseling, delay of pelvic exam, special staff training, trained teen counselors, encouragement of male partner involvement, encouragement of parental involvement, additional time for visits, more frequent follow-up visits, and other refinements. A study was conducted with 1,261 patients under 18 at six non-metropolitan family planning clinics, using a patient satisfaction survey, a questionnaire on method use completed by clinic staff, and clinic records. This intervention resulted in greater contraceptive continuation and lower pregnancy rates (within one year) among clients in the experimental group compared to controls (Winter and Breckenmaker, 1991).

A more ambitious U.S. study tried to look at the effect of expanded teenage-directed family planning services on its surrounding area, with very disappointing results. Among the added strategies were expanded afternoon and evening hours, walk-in hours, decreased waiting time, and outreach efforts directed at teens and their parents. An evaluation surveyed random samples of teenagers in the clinics' catchment area and in the entire city prior to project implementation and 2.5 years later. The project was found to have no measurable impact on reproductive behavior, attitudes, or knowledge among its target population (Hughes et al., 1995).

Although it is assumed that tailoring services for adolescents requires significant new resources, some project staff and analysts conclude that *most* adjustments necessary to better attract and meet the needs of this population can be achieved with little or no financial costs, given selection of staff with positive attitudes and staggering of schedules to accommodate adolescent-appropriate hours. This was reported to be the case at a public health facility in Chicago serving low-income teens, the Teen Clinic, which documented a 82 percent increase in teen family planning registrants following the implementation of special services. These included free services, special clinic hours extended to 6 P.M., a multidisciplinary staff, rap group discussions, outreach and recruitment into local schools, development of key relationships with influential peers, and establishment of referral arrangements (Herz et al., 1988).

In Chile, the new Adolescent Health Program planned at the regional level is implementing specialized centers with comprehensive care. Though some additional funds are provided by the Ministry of Health, the program is primarily based on a reallocation of the resources previously used for traditional programs, including infrastructure, equipment, and personnel, but with more specific objectives and strategies. These include youth participation, emphasis on prevention, and an integrated approach involving family, school, work, peers, and national affairs sectors (Maddaleno & Gattini, 1995).

III. PROGRAMMATIC LESSONS LEARNED

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

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

There is considerable consensus on what constitutes good projects for young people in spite of a dearth of data on their cost-benefit breakdown, on whether they are effective in attracting and improving the health of their clients compared to more traditional interventions, and on which of the identified components are essential and which are more optional. (While these are important areas for research efforts overall, it must be underscored that some of these questions will vary considerably from place to place and should be assessed directly with the intended target audience.)

This review presents lessons learned in twelve basic areas regarding young adult reproductive health programs based in health facilities. These lessons involve the following concerns:

A. Youth Involvement

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

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

While professionals working with youth usually know key behavioral aspects of their constituency, they may not know what elements of a new program will attract or sustain a particular target group, especially since young people vary so much according to different demographic variables and subcultures (Senderowitz, 1995b). Thus, once the target audience has been identified, it is important to do a needs assessment of that specific group (Theman, 1996).

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

Trends support this growing strategic emphasis on youth involvement. A study of 103 adolescent reproductive health projects carried out by the International Center on Adolescent Fertility of the Center for Population Options reported that more than one-half of the projects involve youth in some significant way, indicating an increasing trend from an earlier study (Barker et al., 1991). An ICRW survey of 52 programs concluded that youth participation is the most commonly reported strategy among adolescent reproductive health projects, with 30 percent using this approach (Peplinsky, 1994).

Program managers and evaluators, though lacking quantitative evidence, feel that youth involvement is a major program feature that contributes to a project's success. This has been claimed for an integrated health and development project in Chile (Barker and Fontes, 1996) and a comprehensive adolescent fertility project in Jamaica (Vadies and Clark, 1988), among other projects.

B. Community Involvement

As with youth involvement, community involvement has not been measured as a factor leading to programmatic success, but there is wide agreement that it does play a role (Barker and Fontes, 1996; Koontz and Conly, 1994; Theman, 1996; Vadies and Clark, 1988). Many international donors and implementing agencies, such as Pathfinder International, WHO, UNFPA, UNICEF, and IPPF, have stressed involving community leaders as a key program design feature helping to ensure their support and acceptance (IPPF, 1994; PI, 1993; UNHCR, 1995; UNICEF, 1996; WHO, in press).

Depending on a program's objectives and sensitivities, specific groups are identified for special efforts; these include, for example, policy makers, health professionals, and religious leaders. At the same time, attempting to accommodate widely diverse interests can cripple a project's forward motion. An ICRW study on adolescents and AIDS concluded that communities might be more willing to challenge traditional beliefs that result in holding back necessary information

and services from young women if they were made aware of the positive benefits of such activities (Weiss et al., 1996). Using data to demonstrate that interventions can (or did) make a difference helps to gain this political support (PI, 1993).

In a Chilean program for adolescents, a community health promotion group was used to emphasize the role of the community and to activate the community social network to provide services to youth (Maddaleno, 1994).

C. Parental Involvement

Parents are an important subset of the community, and their acceptance and support are highly valuable to programs. They have an additional role as well: if parents are involved and well informed, they can play a direct role in communicating with their children. And young people have indicated a desire that their parents be better informed and, where possible, that they participate in special activities of youth programs (Ferrando et al., 1995; Kurz et al., 1995; MSI, 1995; Naré et al., 1996).

Although this program design area, too, lacks conclusive evaluative data, there is general, but not unequivocal, agreement that parents' support should be gained (IPPF, 1994; IPPF/WHO, 1995; Paxman, 1993) though it is necessary to assess the best way to involve parents (WHO, in press). While most agree that parental opposition can be a barrier to success, as occurred with a hospital-based program in Bolivia (Ferrando et al., 1995), there is also some limit to the roles that parents can constructively play in their children's reproductive health education and service programs due to issues of confidentiality.

In a U.S. project designed to promote greater involvement of the teen's family, the expected results of increased contraceptive use and decreased conceptions were not achieved. Researchers concluded that to expect that parental knowledge of a clinic visit would lead to their children's improved contraceptive use is "extravagant and unsupported" (Herceg-Baron et al., 1986). An experienced youth program analyst sums up the balancing act by advocating that parents should be sold on the idea, but ultimately, they should trust others to carry out the project (Paxman, 1993).

D. Protocols, Guidelines, and Standards

Given that reproductive health projects for young adults are new, operational policies governing how providers should serve this group are evolving and not always clearly spelled out. This makes service decisions subjective, placing the responsibility on providers who do not always have a positive view regarding reproductive health services for unmarried young people (Senderowitz, 1995c). In Kenya, for example, providers do not have a clear mandate about services to this group and tend to interpret the ambiguous government policy narrowly (UNFPA, in press). In Antigua, nurses serving adolescents admit to giving lectures and condemning the sexual behavior of their clients (Senderowitz, 1995c).

While no study has assessed the differing impacts of diverse protocols, clearer, more detailed operational policies may result in a more consistent and evenhanded provision of services. And to the extent that such protocols are actively supportive of young people's access, there is a

greater potential for recruiting and maintaining a young clientele. Many experts and analysts strongly back this approach (Brabin, 1995; McCauley and Salter, 1995; Paxman, 1993; UNICEF, 1996).

Training and orientation, along with appropriate supervision, may be required to assure compliance with guidelines or when introducing a new component that the staff must implement. For example, a family planning service program in South Africa did not effectively incorporate AIDS prevention into its service provision. A study of this situation concluded that if AIDS prevention is to become part of the service offerings, it must be an explicit part of the clinic policy and current staff must be trained to carry it out (Abdool, et al., 1992).

In at least one project, the delivery of integrated health care services to adolescents in six cities in Colombia, the development of clinical standards and procedures were credited with significantly strengthening the effort. In fact, this component ultimately went far beyond the project's activities by providing a set of materials and strategies to other programs for adoption (Corona, Romero et al., 1995). To assist in the assumption of guidelines by governments, the Adolescent Health Programme at WHO is developing a set of such policies for use at the national level (Paxman, 1996).

E. Selection, Training, and Deployment of Staff

Given that poor treatment and negative attitudes serve as deterrents to adolescent access to clinical services (see next section), it is clear that staff selection and training (or retraining) are key project components. Most program managers and evaluators consider that a staff trained specifically to serve young people is essential to such projects (Abdool et al., 1992; IPPF, 1988; McCauley and Salter, 1995; PI, 1993; Ferrando et al., 1995; UNICEF, 1996; WHO, 1995; WHO/UNFPA/UNICEF, 1995). Part of this training must include helping providers to accept the reality of teenage sexual activity (Gorgen et al., 1993). Furthermore, in focus groups and interviews, young people clearly state their desire to be served by trained, competent, and sensitive providers (Kurz et al, 1995; MSI, 1995).

The literature is peppered with examples of poor staff attitude as a barrier to adolescent access. A key action to improve this situation involves selecting staff with positive views toward and interests in serving adolescents. In Kenya and Nicaragua, a cross-cultural study reports that service providers in public facilities are abusive and give disciplinary talks to young people seeking reproductive health services (MSI, 1995).

Similar situations have been observed elsewhere; in both Antigua and Thailand, providers give lectures on morality to young people and try to divert their attention from sex to hobbies and sports (Senderowitz, 1995a; Senderowitz, 1995c). In a clinic established for high-risk adolescents at Kenyatta Hospital, staff were reluctant to provide contraceptives to young women. Although an orientation for hospital staff intended to "sell" the idea was planned, and needed, it never happened (Paxman, 1993). In Zimbabwe, although three-fourths of clinic providers surveyed thought young people should be informed about contraception, 72 percent did not favor providing methods to those under 16 (Kim and Marangwanda, 1996).

One of the most interesting studies on how adolescents are treated is the recent "mystery client" effort in Senegal. Adolescents participating in the research, unknown as such to providers,

reported that they were not well treated, that they received negative communications from staff, including lectures on the dangers of sex before marriage, and that none who requested a contraceptive method actually received it (Naré et al., 1996).

While projects can point to lack of training as an explanation for program goal shortfall, as with Kenyatta, there is no evaluative information regarding what is required for training to be successful. There are great variations among projects in terms of who is trained, how trainees are selected, course content, course length, training dynamics and approach (for example, is the training interactive or experiential?), and so on. Training courses for nurses, for example, can vary from one and one-half hours in Kenya to over 200 hours (including 150 in-service) in Colombia, as noted by UNFPA evaluation teams (UNFPA, in press). A recent survey of adolescent reproductive health materials recommends the development of a strong, comprehensive training guide (Theman, 1996). One such curriculum, for counseling youth, is currently being developed in Zimbabwe, based on a multifaceted survey of current practices in serving young people (Kim and Marangwanda, 1996).

There is scattered information on staff deployment, especially on the issue of counseling (see Section 8, below) and specifically on preferences for peer or adult counselors. This issue seems to vary considerably, and unpredictably, among groups of young people. It is interesting to note, however, that at least one study of young adults (in Kenya and Nicaragua) reports that this group rated the importance of knowledge, reliability, and communication skills over the age of the counselor (MSI, 1995). Another issue that varies and should be assessed with the actual target group is the gender of the staff; in some cases it can be important to young women (or men) that the staff be female (or male) (UNHCR, 1995).

F. Recruitment

It is a common conclusion among administrators and researchers that young people, especially unmarried ones, do not come to public health services for reproductive health care (Kim and Marangwanda, 1996; Kurz et al., 1995; MSI, 1995; Naré et al., 1996; Paxman, 1993; Townsend et al., 1987). Lack of privacy and bad treatment are frequently cited as reasons, according to studies in Kenya (MSI, 1995), Burkina Faso (Gorgen et al., 1993) and confirmed elsewhere; often, young adults would attend only as a last resort (Kurz et al., 1995). In Bolivia, a study found that young people did not want to admit they were engaging in a taboo behavior (Ferrando et al., 1995). Other reasons often relate to this point, such as feeling that services are intended for married people and not for them, as in a Philippine study (WHO, 1995).

Furthermore, young people are not aware of service locations or what types of services are offered (Bryce et al., 1994; Ferrando et al., 1995; UNICEF, 1996; WHO, 1995). For example, in an Indonesian study, four in 10 adolescents didn't know what reproductive health services were available in their area (WHO, 1995).

Projects in various regions have reported difficulty in attracting target numbers of young people to their services. For example, in Brazil, a hospital-based project was able to achieve only a 10–15 percent referral rate from the community for its postpartum program and virtually failed at attracting nonpregnant young women still in school for family planning services (Paxman, 1993). In a contraception recruitment effort by a Nigerian hospital-based project, there was considerable default even among those presenting for abortion complications and contraception: 43 percent

had dropped out in 30 months, including 13 percent who failed to show up for their first appointment for contraceptives (Ezimokhai et al., 1981).

A major challenge within the recruitment issue is the task of helping young adults to receive family planning services before their sexual debut. A U.S. study found that only 17 percent of sexually active teens made their first family planning visit before first intercourse and another 10 percent within the same month; for the rest, the average delay was 23 months following first sexual experience (Mosher and Horn, 1988). Clinics are obviously limited in how well they can counsel adolescents to be abstinent if they fail to attract them before they engage in sexual intercourse.

There is strong consensus that more efforts need to be carried out to effectively reach young adults, especially those who are not pregnant, are unmarried, or are out of school, with better information about services (Ferrando et al., 1995; Pearson et al., 1995; Senderowitz, 1995a). Given that most recruitment efforts that are made are done through the schools, out-of-school youth are particularly unreached with service information (Corona, Romero et al., 1995). Importantly, young adults must understand that they are welcome at reproductive health service facilities (McCauley and Salter, 1995).

Although evaluation is sparse on the effects of recruitment, and virtually absent on assessing different approaches or efforts aimed at diverse target groups, a U.S. study sheds some light on the relationship between special outreach activities and level of teenagers' needs, which are being — or not being — met. Researchers found that clinics in high-met-need areas (that is, where about 75 percent of teenagers at risk of unintentional pregnancy are served) more often have special outreach and follow-up activities involving teenagers, and are twice as likely to have made specific efforts at recruiting young people than are clinics in low-met-need areas (where only 28 percent of at-risk teenagers are served) (Chamie et al., 1982).

IEC activities are traditionally used by clinics to publicize services and attract clients. Sometimes these fall short of their objectives, as with a clinic-based project in Bolivia. Researchers concluded that the informational activities were not connected sufficiently to the adolescent hospital and health care services, and that more community materials must be developed (Ferrando et al., 1995). Yet, given the sensitivity of the issue, it may be difficult to communicate openly with the target audience through IEC efforts. In fact, an IPPF report on adolescent service provision in the East and Southeast Asia and Ocean region recommends that mass publicity be minimized and personal communication to adolescents maximized (IPPF, 1988).

One way to accomplish the IPPF approach (or to add to an IEC effort) is to increase word-of-mouth communication and referral. In the Brazilian hospital study mentioned above, referrals from the community increased from nine to 24 percent *after* community outreach was stopped, mainly as a result of word-of-mouth recommendations from former clients (Paxman, 1993). A similar conclusion on the value of referrals from clinic patients was reached in a U.S. study (Herz et al., 1988). Some projects institutionalize this practice by training promoters, usually young people and often former clients, to recruit new clients; a program in Chile uses this approach to reach out-of-school youth and street children (Barker and Fontes, 1996).

G. "Youth-friendly" Environment

Many aspects of the clinic environment have been cited by young people as needing adjustments to make them feel more accepted and at ease. In general, the concept of "youth-friendly" suggests a setting that is welcoming to this age group, pleasing and comfortable to young people and even relaxing and enjoyable where possible (PI, 1993; Pearson et al., 1995; UNICEF, 1996; Wardle and Wright, 1993). Young people in the Caribbean described an "ideal center" for receiving reproductive health care as one that would offer many services, be open in the afternoon and evening, have empathetic, knowledgeable, and trustworthy counselors, and would "not look like a clinic" (Kurz et al., 1995). Another ICRW study summarized a user-friendly service for adolescents as being private, confidential, affordable, accessible, and staffed with sensitive service providers (Weiss et al., 1996).

Young people are particularly concerned with characteristics related to providers. In a U.S. study of adolescent perceptions regarding their decisions to seek health care in general, 14 of 15 top-ranked items pertained to providers, and six of these concerned interpersonal factors such as honesty, respect, and confidentiality. Interestingly, four of the top characteristics pertained to infection control, which undoubtedly results from adolescent concern over HIV transmission. This study revealed a need, in some circumstances, for better public education regarding the near-zero risk of HIV transmission through health care services if such fear presents a further barrier to their use (Ginsburg et al., 1995).

A clinic for young people in Chile, CEMERA, has adopted many innovative features, with an emphasis on making adolescents feel comfortable. This includes, for example, staff who wear casual clothes instead of "medical white" and a noninstitutional-appearing site developed in a cluster of renovated homes. Although evaluations showed this model to be effective (Corona, Canessa et al., 1995), it was originally designed for, and continued mainly to serve, pregnant adolescents. Furthermore, research has not been conducted that would identify which components contributed to what outcomes.

Neither is there specific information on various clinic characteristics from other studies. Nevertheless, analysts and experienced youth professionals tend to agree on several of the important "youth-friendly" elements, as follows:

1. Competent, trusted staff

Issues related to provider characteristics, skills, and approach were addressed in Section 5, "Selection, Training, and Deployment of Staff," above. An important additional component to staff competence is adequate and supportive supervision so that guidelines are followed and performance is monitored and adjusted as necessary.

2. Privacy and confidentiality

There is strong agreement regarding the importance of privacy and confidentiality for the young reproductive health client (Barker, 1994; Brabin, 1995; Ferrando et al., 1995; Koontz and Conly, 1994; MSI, 1995; North, 1989; Pearson et al., 1995; UNHCR, 1995; Waszak, 1993; WHO/UNPPA/UNICEF, 1995). Although little specific research on these characteristics is unavailable, both youth in interviews and program analysts have indicated that lack of privacy

and confidentiality are reasons for young adult nonuse of clinics, especially public facilities (Kurz et al., 1995; MSI, 1995; Senderowitz, 1995a; Stedman, 1993).

In a survey on serving young clients in Zimbabwe, although counseling usually occurred in a separate room, nearly one-fourth of the conversations could be overheard, outsiders could see what was happening in one-third of the sessions, and more than one-third experienced interruptions, usually by another staff member (Kim and Marangwanda, 1996).

Another aspect of confidentiality involves record-keeping. Where standard clinical records are kept at all, too often they are exposed on shelves in the open, available for unauthorized persons to view (Rizo, 1997).

In a U.S. study of high school students, 25 percent reported that they would not seek health care in some situations if their parents might find out (Cheng et al., 1993). In Bolivia, focus groups with adolescents revealed that many of the female participants would be too uncomfortable and ashamed to seek STD treatment at a health center if they were infected (Ferrando et al., 1995). Indeed, a clinic study in South Africa concluded that if AIDS counseling were to be added to family planning service provision, the facility would need to be altered to ensure greater privacy (Abdool et al., 1992).

3. Convenience of location

The convenience of a clinic's location is another factor of importance to young adults (IPPF, 1994; Koontz and Conly, 1994; Theman, 1996). Proximity is the key, with affordable transportation as part of the equation. Reliable transportation, necessary for routine clinic use, becomes even more vital for reproductive health emergencies (Leslie and Gupta, 1989).

In a U.S. study, lack of adequate transportation was identified as a barrier to adolescent use of clinical facilities (McHarny-Brown and Kaufman, 1991). A strong example of the role of location, and associated transportation, was demonstrated in Antigua. A modest clinic that was conveniently located for its adolescent clients closed down when a larger, more youth-specific facility was opened at another location. The clients of the former clinic simply stopped using services because they were unable to get to the new, specialized clinic (Senderowitz, 1995c).

4. Convenience of clinic hours

The issue of *when* clinics are accessible to young adults interrelates two factors of clinic hours: when they are open and whether there are special hours for serving young adults. An additional component is the opportunity to arrive as a "drop-in," that is, without an appointment.

Focus groups and interviews with young people, as well as conclusions reached by experts in the field, stress the need for clinic hours that are convenient for young adults, typically late afternoon, evening, and weekends (IPPF, 1994; Koontz and Conly, 1994; Kurz et al., 1995; McCauley and Salter, 1995; Senderowitz, 1995a; Stedman, 1993; Theman, 1996; Wardle and Wright, 1993). In a Senegalese study, it was stressed that service hours should be expanded so that young workers, a group often overlooked, could attend after work (Naré et al., 1996). A specially designed youth clinic in Antigua was observed to be hurt by its practice of closing at about 4 or 5 P.M., thus precluding access for most young people (Senderowitz, 1995c).

The provision of special hours for young adults within a broader clinic setting is generally thought to be effective and is usually recommended when developing a program (Barker and Fontes, 1996; Ferrando et al., 1995; Naré et al., 1996; Waszak, 1993). At the same time, this "separateness" can reduce confidentiality if reproductive health services are not integrated with many others (Corona, Canessa et al., 1995; Naré et al., 1996). The creation of separate hours, in fact, is somewhat synonymous with distinct services for young adults, with the various pros and cons of that approach, as previously discussed.

There appear to be differing conclusions concerning the importance to young adults of separate hours and any possible impact on behavior. In a U.S. study, special teen hours were not ranked high among reasons teens gave for choosing a clinic, though this feature was associated with clinic use before or soon after sexual debut (Zabin and Clark, 1983). In another U.S. study, however, a teens-only clinic was cited as a major reason for that choice (Herz et al., 1988).

Perhaps the special hours/clinics are more important for young people who feel overwhelmed by the idea of seeking reproductive health services. For example, a special evening clinic in Jamaica was found to attract many first-time clients (Vadies and Clark, 1988). And in a report on at-risk youth, it was noted that such young people may need separate services to overcome their reluctance to use the traditional health care system (Barker and Fontes, 1996).

There is only a modicum of information related to the practice of allowing young adults to receive services without a prior appointment. This approach, which responds to the adolescent pattern of not planning ahead, is thought to be an important clinic feature by IPPF and others (IPPF, 1988; Senderowitz, 1995a). Some confirmation is provided by two developed-country studies. In the United Kingdom, 78 percent of a young adult sample preferred a drop-in service (Wardle and Wright, 1993). And in the United States, a study of high- and low-met-need areas showed that high-met-need counties were more likely to allow drop-ins (Chamie et al., 1982).

5. Comfortable and useful for young men

Given how few young women who are not pregnant seek reproductive health services at health facilities, it is not surprising that young men are even less in attendance. This failure to attract young men has been significantly influenced by the traditional emphasis of family planning programs on women — and typically on older, married women who have completed, or at least begun, their childbearing. Thus, men do not feel welcome at family planning clinics and perceive, often correctly, that such services are not for them.

In the United States, services have been available for men at family planning agencies, yet they do not readily attract clients to use them. In a study reported by Dryfoos (1988), of 35 family planning agencies surveyed, all had services for men, yet 21 of the 31 reporting utilization data indicated that 100 percent of the clients were female, with the remainder reporting low numbers of male use of medical services. Barriers to such use appear to be lack of funding, lack of male staff, lack of staff training and experience, and low expectations that such services could be successful.

Yet at least one U.S. example has overcome many of the typical constraints. The Male's Place, run by a local health department, conducts special weekly sessions offering free family planning,

medical counseling, physical examinations and screening, and educational services to males 15–24. It mandates an educational class for discussion of life choices, reproductive health, STDs, and conception, and teaches how to do testes self-examinations. Transportation is provided. Community education, including outreach by male educators, is a high priority; recruitment for the Male's Place and provision of some mobile services and educational sessions take place in various settings frequented by young men. Good working relationships, for referral and activity sites, have been established with community groups. Very importantly, this project is part of an extensive, and successful, teen prevention program in this location, building on its support and track record (Dryfoos, 1988).

H. Counseling

In a review for the Adolescent Health Programme at WHO, the potential for successfully counseling the adolescent client was recognized (Wastell, 1995). While counseling has become a highly recommended component of most clinic programs, effective results depend greatly on the quality and extent of training that counselors receive (UNICEF, 1996; WHO/UNFPA/UNICEF, 1995). There is agreement that training should be geared to specifically serving the adolescent client; the lack of such training was identified as a weakness at a Kenyatta University project (Paxman, 1993).

As previously noted, young adults in the Caribbean identified characteristics of counselors at an "ideal center" as empathetic, knowledgeable, and trustworthy (Kurz et al., 1995). While sometimes overlooked, the personal traits of counselors appear to be very important to young clients, including an interest in working with adolescents and an ability to develop respectful relationships (WHO/UNFPA/UNICEF, 1995).

Even where basic interpersonal communication skills are assessed as good, as was the case in the Zimbabwe study, there are shortcomings in various counseling techniques. In that study, both observation and interviews revealed client shyness, anxiety, and embarrassment, especially among the youngest clients. Although clients stated they felt free to ask questions, very few actively participated in sessions. Importantly for adolescents, the broader issues of physical and emotional development, drugs, family conflict, and relationships were brought up considerably less often than the standard family planning topics (Kim and Marangwanda, 1996).

There has been little assessment of how effectively counselors assist young adults to achieve various objectives. The analysis for WHO admits that there is a great challenge in the reproductive health field in view of the poor results accomplished by discussing risky behavior. The study concludes that there will be minimal effects unless the client is assisted "to internalize the information and to own the resultant protective behaviours" (Wastell, 1995). Counseling must also connect effectively to services (WHO/UNFPA/UNICEF, 1995).

There appear to be some unanswered questions regarding counseling approaches, especially whether to use nondirective or directive counseling. A U.S. study found that if the client desires authoritative guidance and the provider uses persuasion in contraceptive counseling, the young client's adherence to the contraceptive regimen is stronger (Nathanson and Becker, 1985). Other recommendations (not apparently based on research) suggest helping the clients to make decisions for themselves and helping the client believe that he or she has control over life events,

though WHO admits that what works in developing countries is not yet clear (McCauley and Salter, 1995; WHO, in press; WHO/UNFPA/UNICEF, 1995).

There is also a mixed picture concerning the relative merits (or effectiveness) of peer versus adult counselors. Young people often (though not always) express a preference for talking with their peers, but it does depend on the circumstances of the client, what topics are discussed, whether they know the peer counselor and whether they believe the counselor is competent enough to handle their concerns. Two major problems with peer counselors is their lack of sufficient training and high turnover rate (Ministry of Health [MOH], St. Lucia, 1986; UNFPA, in press).

In health facility settings, counselors are usually adult professionals. In one U.S. study, however, the use of trained peer counselors (aged 17–18) was compared with young nurses (aged 26–29) who were experienced with adolescents to test possible different effects on adolescent compliance with oral contraceptives. Results indicated that, generally, adolescents counseled by peers had a lower noncompliance level than the group counseled by nurses. Some differences related to client characteristics were noted: whereas adolescents who had more frequent sexual activity, who had had two or more sexual partners, and who worried that they might become pregnant had significantly lower levels of noncompliance when counseled by a peer rather than a nurse, those adolescents who had had no sexual partners in the three months prior to the study had significantly lower levels of noncompliance with nurse counseling. The study suggests that peer counseling can enhance compliance among more sexually experienced young people and thus such trained peers could be a positive addition to the health care team (Jay et al., 1984). On the other hand, a study of adolescent programs and perceptions conducted in Nicaragua and Kenya concluded that adolescents preferred adults as counselors when they judged them to be more knowledgeable and skilled, which is often the case (MSI, 1995).

An area of increasing attention will need to concern counselors for young adult reproductive health care: sexual abuse and violence. Not only do pregnancy and STDs result from forced and abusive sex, but so does emotional trauma. Furthermore, the issue of counseling for abuse prevention is challenging, but indicated, in areas of high sexual abuse incidence or probability (IPPF/WHO, 1995). Most clinical programs established to prevent pregnancy and STD/HIV infection assume that the sexual activity involved is consensual; this assumption may be false and the client approach may be thus inappropriate (Stewart et al., 1994).

I. Appropriate Contraception and Informed Choice

Contraceptive appropriateness for adolescents is a changing arena — globally and in-country, dependent on emerging technology, research developments, laws and policies, and access to commodities within countries. While clear conclusions on contraception appropriate for young and/or nulliparous women remain somewhat elusive, significant research, both biomedical and behavioral, has shed light on the pros and cons of various methods.

Hormonal methods have been demonstrated as safe for young people. Oral contraceptives (OCs), though they present the challenges of storage (which for adolescents could present a confidentiality issue) and daily compliance, may be the best choice for pregnancy prevention (*Contraceptive Technology Update [CTU]*, 1988; Hatcher and Trussell, 1985). A study in the United States of two different OC preparations found no significant differences in compliance or

satisfaction levels (Woods et al., 1992). Injectables and implants, though typically associated with increased side effects, are very effective and do not require daily responsibility (Hatcher and Trussell, 1985; McCauley and Salter, 1995). Another major advantage to these methods is that no action is required at the time of intercourse, which can cause embarrassment and/or refusal of the partner to cooperate, usually more significant concerns for young people than for adults.

The IUD is generally not recommended for women with no children (Cacciatore and Apter, 1993; Hatcher and Trussell, 1985; McCauley and Salter, 1995). In addition to increased pain during menstruation, more common with young women, the risk of pelvic inflammatory disease and subsequent infertility is higher. Importantly, neither IUDs nor hormonal methods provide any protection against STDs.

Barrier methods are good choices for adolescents, but they also have pros and cons. Condoms, in particular, have been widely encouraged because they reduce the risks of contracting STDs, including HIV (Ajayi, 1996; Brabin, 1995; IPPF, 1995; McCauley and Salter, 1995). They are also intercourse-related, which is a benefit given the often intermittent nature of adolescent sexual activity, but a challenge given the need to plan ahead and to effectuate their use during sex. Their use may also require negotiation by the young woman, who may not feel empowered to assure this outcome. Other barrier methods, such as the diaphragm, cervical cap, and female condom, are effective if used correctly and consistently and offer some protection against STDs (McCauley and Salter, 1995).

Given the urgent need to protect against HIV in many countries, some professionals feel that condoms must be the method of choice and that family planning practitioners must be reoriented to this approach (Abdool et al., 1992). This may prove difficult in view of the family planning bias toward effectiveness issues and in situations where abortion is not available as a back-up for less effective condom use. Some advocates, therefore, have begun recommending the use of both OCs and condoms, referred to as the "dual method" or "Double Dutch" because of its use by increasing numbers of young people in the Netherlands (Stedman, 1993; Waszak, 1993). However, there is some evidence that consistent use of barrier methods declines when the dual approach is used; giving the woman a choice of disease prevention methods to use with OCs shows promising results on consistency of use (Finger, 1996).

So-called emergency contraception, especially the use of certain OC preparations within 72 hours of unprotected intercourse, is becoming better known, although the technology has existed for decades. It provides a second chance for protection after risky sexual behavior by adolescents, and for cases of coercion and rape, and can be easily and more widely used than is currently the case (IPPF, 1994; McCauley and Salter, 1995). To date, most users of this method have been young women; according to several studies, emergency contraceptive clients tend to be under age 25, never pregnant, sexually active for less than two years, and have used some form of contraception in the past. (ACOG, 1996). This method appears to have significant usefulness for a young population not yet established on a method and perhaps with sporadic sexual activity.

Because of differing availability and circumstances, young people will have to make decisions about contraceptives. It is important that counseling be provided to help them make informed choices, including the option of abstinence, which is 100 percent safe and effective (Waszak,

1993). Given that young adults, at least in the United States, have the highest pregnancy rates for each method compared to older women (Harlap et al., 1991), counseling and provision of adequate, clear information can also help people to use contraception more effectively .

Adolescents present a special challenge because of their insecurity about sexual behavior and fears about what to expect. In addition to better information available to adolescents at younger ages, before they need to seek services, other ideas to gain their confidence are being tested. One of these is "Smart Start," an approach tried successfully in the United States that allows young women, whose fear of being examined often keeps them from seeking services, to delay the pelvic exam for up to six months after they begin using OCs (CTU, 1990).

A full review of clinically oriented information designed for providers is contained in the *Pocket Guide for Family Planning Service Providers*, by Blumenthal and McIntosh (1995). This straightforward, easy-to-use handbook includes information on specific methods, management of side effects, and counseling basics. It contains a special section on adolescents.

J. STD/HIV Prevention, Diagnosis, and Counseling

The idea of addressing broad reproductive health needs in the same facility — especially STD counseling and treatment — is a logical expansion beyond the traditional family planning concept. Although many of the behavioral and guidance issues are similar, there has been some hesitancy by family planning centers to screen for and treat STDs, including the development of protocols for overall reproductive health care. This challenge was pointed out previously in connection with a South African family planning clinic that was resistant to take on the added role of AIDS education and prevention with teenagers, especially where it compromised the effort to advocate the most effective contraception (Abdool et al., 1992).

Use of condoms to protect against HIV/AIDS and STDs was raised by health care providers in only one-third of the sessions, according to a Zimbabwe study (Kim and Marangwanda, 1996). Addressing STDs remains a problem at more broad-based clinics, too; a study in Jamaica revealed that only 23 percent of STD patients were offered condoms during their visit (Bryce et al., 1994).

Yet the need to control STD infection is vitally important — for both the direct consequences of the disease and also as part of the need to reduce HIV infection. In developing countries, one in 10 young people contracts an STD each year, and one-third of all STDs occur among 13–20 year olds (Islam, 1996). In a landmark study in rural Tanzania, researchers found that an STD intervention program not only reduced the STDs being treated, but demonstrated a 42 percent reduction in HIV incidence over two years of follow-up, with the greatest proportionate reductions occurring in young women 15–24 and men 25–34 (Grosskurth et al., 1995).

Given the advantages of providing diagnosis and treatment during the initial visit, and without laboratory support, the syndromic approach is increasingly advocated (Islam, 1996). This method, which uses groups of clinical findings and patient symptoms for diagnosis, provides treatment for all diseases that could cause a given syndrome. If combined with patient risk assessment, this technique, which must incorporate local data on STD prevalence, antibiotic resistance, and drug availability, may be the most effective way to diagnose and treat STD infection in resource-poor settings (Dadian, 1996). Partner management must also be considered

as part of STD treatment with adolescents. Importantly, service offerings should include risk-reduction education (FHI, 1993).

A major challenge for diagnosing and treating STDs among young adults is recruiting them to the formal sector. In Uganda, for example, treatment for STDs is frequently sought informally, through drugstores, traditional healers, family, or friends. Young people, in particular, avoid the formal sector and depend heavily on friends; if they turn to the health care system, it is typically after long delays and upon learning the dangers of untreated STDs (Kabatesi, 1996).

Reluctance of young adults to seek formal health care results from embarrassment, cultural taboos regarding discussion of sexual matters, high costs, crowded facilities and overburdened staff, and moralistic attitudes of the staff who are ill-trained to deal with adolescents (Kabatesi, 1996; Mazin, 1996). A few projects are attempting to address these obstacles. One of these pioneers in youth-oriented STD care is the Naguru Youth Health and Information Center in Kampala, Uganda, a comprehensive adolescent health service that has involved youth as leaders and participants in this effort (Kabatesi, 1996). FPAs in the Latin America and Caribbean region plan to incorporate HIV/STD prevention in adolescent reproductive health programs in the future (IPPF/WHR, 1995).

K. Integrated Approach

As discussed earlier, many efforts have been made to combine services for adolescents in the same facility. Some of these focus on integrated health care, to better serve adolescent health needs, especially as problems may be interrelated or stem from the same causes. Other models, which include recreational and vocational activities, are designed to attract young people to a center and meet broad interests of the age group, often serving out-of-school youth; these efforts will be covered in a separate paper on outreach models.

Combining preventive care, especially contraceptives, with prenatal and postnatal and post-abortion care is an increasingly used model for broader reproductive health, as discussed earlier, resulting in both positive contraceptive and maternal care benefits. Studies are still somewhat inconclusive on how effective different models of pre- and postpartum contraceptive counseling can be, partly because of limited follow-up, as in Barbados (MOH, Barbados, 1986) or lack of good statistics, as in Bolivia (Ferrando et al., 1995), a very common problem. But Mexican projects showed promising outcomes on attitude and behavioral change (Martin et al., 1992; PI, 1995). In a U.S. study, regions having a combination of reproductive health services, including prenatal care and abortion, were more likely to fully meet the needs of adolescents in those counties (Chamie et al., 1982).

There is scant evidence on adolescent breastfeeding, with very little known about interventions with young adults (Labbok, 1996). In the United States, teenagers are breastfeeding their babies at significantly lower rates than women in their 20s and above. While demographic characteristics of this U.S. adolescent mother group (such as lack of education and being unmarried) explain some of the difference, adolescent characteristics such as egocentricity, concern about body image, embarrassment, lack of appreciation of long-term benefits, and the need to be independent also appear to contribute (Peterson & DaVanzo, 1992; Zellman, 1988). The extent to which similar elements characterize young adult groups in developing countries is not known. However, given the advantages of breastfeeding and evidence of program potential

in at least two facility-based programs (in Chile and Mexico, as previously noted), project components encouraging adolescent breastfeeding should be designed and tested.

Attention to the nutritional needs of adolescents can also be accomplished within the health care setting. Given the prevalence of anemia among adolescents in developing countries — 27 percent, compared to six percent in developed countries (Kurz & Johnson-Welch, 1994) — and the higher risk of low birth weight and preterm delivery among iron-deficient anemic adolescents (Scholl & Hediger, 1994; Scholl et al., 1992), iron supplementation is an important program offering. Health facilities, however, too rarely provide iron supplements; they need to better understand the positive health benefits of doing so. More research is needed, however, to determine optimal doses and most effective means of administration as well as ways to improve compliance, which is notably poor among adolescents (Beard, 1994). Furthermore, as indicated by a nutritional study by ICRW in Guatemala, although iron status can be improved rapidly with supplementation, it will deteriorate without continuous interventions (Kurz & Johnson-Welch, 1994).

Given that there is limited time to carry out nutritional supplements effectively during pregnancy (Kurz, 1996) and that continued interventions are necessary for good nutritional status, health facility programs that serve young adults — before and beyond prenatal care — should screen and treat for anemia. This action should perhaps target boys as well as girls, given that they both have high iron requirements due to their rapid growth during adolescence. In fact, in ICRW's nutritional study, the prevalence of anemia was similar among boys and girls in three of the four studies that included both, and boys were more anemic than girls in one country, Ecuador (Kurz & Johnson-Welch, 1994).

In a U.S. clinical trial, the effects of iron supplementation on cognitive function were assessed in adolescent girls with nonanemic iron deficiency. Results showed that iron-supplemented girls performed better on a test of verbal learning and memory than the control group (Bruner et al., 1996).

The model of providing very broad, integrated services is being advocated by various groups and experts, including the Adolescent Health Programme at WHO, which underscores that a behavioral orientation, not purely a medical one, is needed to address adolescent concerns (Barker and Fontes, 1996; Paxman, 1996). WHO argues that to be effective, programs must have multiple interventions to meet youth needs. Although specific evaluative findings are not provided to make the case for effectiveness, the claim relates to "problem behavior theory": that is, because there are common denominators of diverse counterproductive behaviors, antecedents, and not just symptoms, must be addressed (WHO/UNPPA/UNICEF, 1995). On the other hand, many adolescents who are generally healthy need good preventive services to remain that way.

The provision of multidisciplinary, integrated services is promoted and viewed positively in Latin America and the Caribbean, with an emphasis on addressing developmental, social, and emotional concerns along with medical needs (Kurz et al., 1995; Pan American Health Organization [PAHO], N.d.). The holistic approach of an adolescent clinic in Jamaica was credited as part of that clinic's success in attracting and serving young people with reproductive health care (Vadies and Clark, 1988).

L. Costs

Costs for reproductive health services, if they are to be covered by the young adults themselves, must be affordable; if costs are too high, they constitute a barrier to clinic use (Ferrando et al., 1995; IPPF, 1988; IPPF, 1994; Koontz and Conly, 1994; McHarny-Brown and Kaufman, 1991; Naré et al., 1996; Theman, 1996). A U.S. study reported that young people cited free services as a major reason for clinic choice (Herz et al., 1988).

Although affordability is important, its translation into a specific fee varies according to the country and the group targeted for services (UNICEF, 1996). For example, as researchers learned from young people in a cross-cultural study (Kenya and Nicaragua), most adolescents could not afford very much, but would rather pay something because they tend to view free services as being of poor quality (MSI, 1995).

II. KEY ELEMENTS

A. Preliminary Actions¹

1. Program Design and Development

a. Strategic approach

From the earliest stage of program planning, designers should attempt to develop activities that are politically feasible and will have the most impact (Theman, 1996). For clinical services, this could mean serving already pregnant adolescents for a time before expanding into primary prevention. Lessons learned from other projects should be utilized, with care, and available, relevant research should be a starting point for more inquiries and/or project planning. Measurable objectives should be clearly articulated and achievable. A one- or two-year project, for example, cannot hope to have an impact on the birth rate; a target for new contraceptive users, however, could be projected and met.

b. Target audience identification

From available or project-associated research, the prime target group should be selected to correspond with strategic objectives. This selection should be as specific as possible according to the demographic variables desired so that plans can be formulated for recruitment and service provision. For example, if out-of-school youth are shown to have the highest pregnancy and STD rates, this group might be made the prime target audience. Identifying a specific age range within this group could further help with the design of recruitment and service elements.

c. Needs assessment

In view of the vastly different preferences found among groups of young people, assessment should be conducted with representatives of the precise audience targeted for services. Especially important to determine are preferences and needs related to: clinic hours and location, services separated or combined with other age groups, integrated with what other services, provider gender, costs, type of counseling (peer vs. adult; directive vs. nondirective.)

d. Youth involvement

In addition to determining program preferences (as noted above), youth involved in the design stage will also foster their perceived "ownership" of the project, thereby enhancing commitment and participation. These should be young people who are representative of the target population. To the extent practical and desirable, youth can also be active participants in the implementation and evaluation phases, perhaps as an ongoing youth advisory council or as volunteers, and should certainly, in any case, be provided the opportunity to give feedback as the project proceeds.

¹ These actions, which occur prior to project implementation, usually apply to all young adult projects and not just clinical services. Because they are so crucial to project success, they are presented as part of this paper's key elements.

e. Community involvement

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

f. Parental involvement

Parental support (or absence of opposition) is significantly linked to their children's participation in clinic activities. Beyond this, parents can also play an active role in furthering clinic goals. Young people appear to want educational sessions that enable their parents to become more familiar with the realities of adolescent reproductive health. Parent groups in diverse regions have also indicated an interest in participation, both to educate themselves and to assist in the education of their children. As educated parents, they can contribute to helping their children receive and better utilize services.

g. Evaluation design and monitoring

The evaluation design should be appropriate to the level and nature of programming and evaluation criteria should be based on the program's objectives. Impact evaluations are very useful but not always appropriate or possible. A university unit or international NGO can assist in this process where outcome measurements are desirable but project staff lacks the technical skill to conduct such an evaluation. Well-designed process and formative evaluations can provide useful information. Sometimes it is important just to demonstrate that the project can be implemented and is feasible.

It is critical that mechanisms for monitoring be built into project design from the start. Service statistics should be kept by useful age groupings; for adolescents, this would ideally be in one- or two-year cohorts. Feedback opportunities for staff and clients should be established. It is key that administrators view evaluations as a means to learn about projects and improve their operations. In fact, involvement at all stages of the evaluation, including design and implementation, helps staff and participants regard the process as less threatening.

h. Continuation, expansion, or replication considerations

Original program plans should at least take into account what will happen at the end of the project term, both for concerns of continued funding but also for planning possible expansion or replication. Much can be observed and considered about the future if preliminary intentions have been identified. If expansion is desired, discussions with personnel of agencies designated to take on program tasks in the future should take place as early as possible in the original project's life.

2. Infrastructure Readiness

a. Delineation of responsibilities, guidelines, and standards

Given that staff will need to rely on subjective judgment in providing services in the absence of clear guidelines, such articulated protocols are very important. This is especially true with new or sensitive project areas, such as providing young adults with reproductive health care services. If the process of developing comprehensive guidelines is too daunting, a starting place could be the identification, and then clarification, of the most ambiguous or contentious areas of operation.

b. Staff hiring, selection, new assignments, and training

Even in existing project sites, hiring of new staff is sometimes necessary; this should be done with a view not just to their skills but also their interest in and positive orientation to young adults. As with any reassignment of staff or assumption of new work, staff should be fully briefed and oriented (even those who seem to have no direct connection to the new tasks) and any needed training (or retraining) provided. A chart identifying staff responsibilities could be made available to all staff.

c. Collaborative agreements

Projects that depend on referrals from and to various agencies or that must patch together an array of services from different sources should have clear operating plans for these transactions agreed upon in advance of the project's start.

B. Project Implementation

1. Recruitment

a. Use of tested messages/materials

Recruitment should be based on what is known about the target audience, what aspects of the clinic will be most important to publicize, and how young people can best be communicated with. The resultant IEC materials can then be tested with the intended target group. Even the project name, major "sight or sound bites," and logo can be tested if feasible. For example, it has been suggested that the term "family planning" might not be suitable for young adults, since they are usually trying to avoid, rather than bring about, a family. Very importantly, given the probable discomfort of a first clinic visit, informing young people about what services exist and what they can expect is an important reassuring message in recruitment.

b. Word of mouth (person to person)

A proven recruitment strategy in many fields, including reproductive health, is the role of satisfied clients in telling their family and friends about the positive features of what they've experienced. This can be encouraged among clients or institutionalized by using trained peer

promoters. Other useful personal strategies include formal and/or informal presentations at schools, clubs, recreational settings, and other places where young people congregate.

2. Facility Characteristics

a. Convenient location

Young people need to be able to get to services on their own or by affordable transportation. The issue of being "too close to home," and thus being recognized by other clients, is a variable issue and must be assessed with the target group.

b. Separate hours/location (if important)

Given the mixed evidence on whether separate facilities or hours are important to recruiting or maintaining young clients, this should also be assessed. Such decisions also depend on the cost-benefit ratio of various plans. Separate facilities appear to be more critical in attracting young, first-time, and at-risk clients.

c. "Youth-friendly" environment

Young people seem to prefer a relaxing, comfortable atmosphere that is not overly "medical" in appearance, staffed by empathetic and knowledgeable professionals. IEC materials appropriate and appealing to the age group both set a good tone and can help educate the clients. Clinics could test benefits of changing the ambience, perhaps with guidance from their clients. For example, personnel might try using street clothes rather than medical white.

d. Comfortable and useful for young men

Since it is very important to involve men in contraceptive decisions and for them to receive reproductive care in their own right, facilities should take care not to be too female-oriented, either in environment or staffing. Outreach efforts for recruiting young men are crucial. Once they are attracted to the clinic, services must be relevant and useful for their needs.

3. Scheduling/Clinic Hours

a. Convenient hours

To serve young adults, both students and working youth, clinics must be open late afternoons, evenings, and/or weekends.

b. Drop-ins welcome/accommodated

Young people have a more difficult time than adults do in planning ahead, thus, making and complying with appointments can be difficult. Given these tendencies, and their hesitancy about going to a clinic at all, the possibility of "dropping in" when they are motivated will allow more young people to get services.

c. Confidential recontacts

Young people often fear that their parents will discover that they have received reproductive health services. Confidentiality must be maintained, including means to recontact young people for follow-up or return visits. Young people can be asked for their preferred way of being contacted.

4. Service Provision

a. Private consultation and examination rooms

Privacy and confidentiality are usually ranked near the top of concerns important to young people when seeking reproductive health services. Not only must the staff be trained in ways to treat matters confidentially, but also the facilities must provide consultation and treatment rooms that respect privacy and where discussion cannot be overheard. Even a curtain around an examination table provides some privacy from onlookers.

b. Counseling offered (by *trained* professionals)

Although the type of counseling preferred by the target group should be assessed (if such decisions can be acted upon), all counselors should be well-trained in the specific area of adolescent reproductive health concerns. Sufficient time should be made available to answer questions adequately.

c. Strong link between counseling and services

Counseling must have strong links to services so that there are not gaps in time or undue gaps in distance for the client to pursue the next step. Preferably he/she should be able to receive services in the same place at the same time as counseling.

d. Providers trained to work with young adults

In addition to appropriate content, adolescent developmental issues, skills, and attitudes must be addressed when training providers. Among the aspects of most importance to young adults are understanding and patient attitude, good listening skills, ability to be nonjudgmental and nonpatronizing, ability to keep confidences, and respect for young people. Naturally, providers must also be competent in their areas of specialty as it relates to youth. Because young people often need more time than adults do, clinics should allow for providers to spend more time with young clients.

e. Appropriate array of contraceptives available

Although choices of contraception depend on commodity availability and practices within a country or community, young adults should be helped to make informed, appropriate choices with full explanations regarding use and side effects. When OCs and other methods that do not protect against STDs are selected for pregnancy prevention, condoms must be discussed and

encouraged where there are risks for STDs and HIV. Emergency contraception, an effective fallback if young adults have experienced unprotected sex, should be widely available at health facilities.

f. Comprehensive reproductive health services — including STD/AIDS prevention, nutrition, and prenatal and postnatal care

Whenever possible, comprehensive services should be available so that the client can be assessed on the basis of overall reproductive health needs and provided necessary services in one place. STD and HIV prevention, and STD diagnosis and treatment, are particularly important for the young adult population. If such consultation became a routine part of primary health and family planning care, more young adult needs could be met without requiring the young person to initiate the subject or seek a second provider. The syndromic approach should be used for STD diagnosis, which allows treatment on the first visit. Risk reduction and partner management must also be addressed. Providers must be well trained to work with the young adult population on this challenging task.

Nutrition should be a key aspect of reproductive health care given the effects of malnutrition on reproductive outcome. Ideally, young people should get good nutritional counseling before becoming pregnant; counseling and supplementation (if needed) become even more consequential for the pregnant young woman. Prenatal and postnatal care not only enhances birth outcomes but also present a key avenue for other reproductive health care, especially contraception and STD prevention. Breastfeeding should be encouraged, and young women should be assisted to learn techniques; young fathers should be helped to be supportive.

g. Integrated, holistic approach

Although more complex and costly, providing young adults with integrated services, which address social and emotional as well as medical concerns, is considered desirable, especially in Latin America and the Caribbean. Cost-benefit ratios in light of priority objectives would be needed to determine if the additional expenses are justified.

5. Costs

a. Affordable fees

Costs for services should be affordable to the young adults using them. Assessment should be made of how fee schedules should be set. In some situations, young people would rather pay something instead of getting the service free; in this way, they are likely to value the quality of the service more.

V. CRITICAL RESEARCH QUESTIONS

Very little high-quality research has been done on reproductive health services for young adults. In order to make basic decisions, therefore, about which models to design to achieve specific objectives, program planners are in a virtual wasteland. Furthermore, there is scant evidence beyond testimonials and expert opinion about effects of individual clinic characteristics, various training approaches, and diverse service offerings. And very importantly, few calculations have been made comparing the relative costs of different models and project components within each.

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

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

A. Stand-alone versus built-in services

Cost-benefit ratio and effectiveness of stand-alone services compared with specialized services offered within an existing facility.

B. Counseling for contraceptive use

When young adults are presenting for reproductive health care other than contraception (pre- and postnatal and post-abortion care and STD care), what are the most effective moments, in what format, and how many sessions are needed to best assist young adult women to adopt a contraceptive method?

C. Constellation of services

For integrated programs, what services (and service providers) are most vital to attracting and effectively meeting young adults' reproductive health needs?

How can family planning clinics be assisted to provide effective STD and HIV prevention services?

How can young mothers be most effectively influenced to breastfeed?

What nutritional supplements should be provided to which groups of adolescents in clinical settings? How can compliance be enhanced?

D. Youth involvement

What specific benefits (outcomes) result from various levels of youth involvement?

E. Recruitment of young adults to service programs

What message formats, through what channels, are likely to be most effective in getting information about reproductive health services to young adults? What information is most important for young adults to know in advance of visiting a clinic?

What messages can be effective in influencing young people to seek STD treatment promptly?

What different messages and channels are needed for different youth populations (e.g., in/out-of-school, male/female, married/unmarried, younger/older, etc.)?

F. Training

What training objectives should be established for various young adult reproductive health care providers? What is the essential content of training courses? Strategy? Minimum hours for training?

What types of refresher courses are needed? With what periodicity?

What training components must be designed and used to assist providers in dealing with sexual abuse and violence?

G. Facility characteristics

What clinic elements (e.g., atmosphere, assurance of privacy, drop-in scheduling, hours, costs) are considered most important for young adults?

H. Counseling

What special responses are most effective in helping young people who have been victims of coercive sex?

In what circumstances and for what concerns do young adults prefer peer or adult counselors? What are the relative costs (financial, time, turnover) and benefits?

What are the outcome differences between directive and nondirective counseling?

I. Contraceptive availability

How do compliance and pregnancy prevention vary as related to contraceptive method availability, choice, and cost?

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