

## **Chapter 5**

### **Examining the Gender Dimensions of Popular Adolescent Programming Concepts: What Do They Offer Adolescent Girls and Boys?**

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#### **Background**

Increasingly, public health attention has turned to the reproductive health needs of adolescents, particularly in developing countries. This attention has resulted from the realization that young people constitute a large proportion of these countries' populations, and that they are particularly vulnerable to negative reproductive health outcomes, including HIV infection, other sexually transmitted infections (STIs), unwanted pregnancy, and unsafe abortion. It is estimated that 60 percent of new HIV infections occur among this group, with girls affected to a far greater extent than boys (Pisani 1999; see also Chapter 10).

Existing reproductive health services are not always available and/or do not respond to the needs of adolescents because these services are largely provided through maternal and child health/family planning programs that primarily target adult married women. Service providers are often unwilling or unable to respond to the reproductive health needs of adolescents, either because of their own negative attitudes about sexually active unmarried youth or because they lack the knowledge and skills to handle young clients. Young people themselves might not feel comfortable in an environment dominated by adults.

Against this background, *four popular approaches to adolescent reproductive health have emerged: youth centers, peer education programs, school-based family life/sex education programs, and "youth-friendly" clinical services. Analyses of the effectiveness of these programs, and their differential attractiveness to subgroups of adolescents, generally*

*have been lacking.* However, some substantial progress has been made in the analysis of youth center effectiveness, and some provisional reviews of peer education programs have been undertaken. Results of these assessments are discussed in this chapter.

As we move programming for adolescents forward, it is important to maintain a critical posture toward well-defined and familiar interventions with respect to:

- their utilization
- their acceptability to the community
- their relative attractiveness to boys and girls
- the gender sensitivity of program design
- their attractiveness and appropriateness for younger and older adolescents
- the patterns of utilization of the services
- the reasons why youth initiate and sustain or discontinue participation
- staff attitudes toward male and female participants and sensitivity to gender dynamics
- how much staff know about sexuality, family planning, and reproductive health
- protection of adolescents' confidentiality
- fostering of a non-judgemental environment
- effectiveness in conveying information, increasing skills, and facilitating behavior change

We begin this discussion with a review of what we have learned about youth centers, which have been studied in Latin America and most recently in four African countries: Ghana, Kenya, South Africa, and Zimbabwe. A second, more limited discussion will look at the effectiveness of peer education programs, particularly from a gender perspective, and will offer some of the results of research to date.

## **Youth Centers**

One reproductive health information and service model that has received considerable attention is the youth center. This model involves either stand-alone reproductive health clinics targeting young people, or multi-purpose centers offering recreational and vocational services and life skills training, combined with reproductive health information and clinical services.

The rationale given for providing a broad array of services in one multi-purpose facility varies. Some view the non-reproductive health services at these centers as a means to attract young people to the centers, while packaging reproductive health services in a relatively discrete, politically acceptable way (Senderowitz 1997). Centers that offer an array of services also can be seen as responding to the broad developmental needs of adolescents (WHO 1999).

Assessments of youth centers in Latin America have shown mixed results from this approach. A study in Mexico demonstrated that youth centers reach relatively small numbers of youth and are often not cost effective (Townsend et al. 1987). The organizers of a program in Mexico, *Gente Joven*, found that their centers were reaching small numbers of youth, mostly those who were already highly motivated and knowledgeable about reproductive health issues (Marques, Paxman, and Bruce 1993). The documentation of *Gente Joven* also revealed an initial lack of attention to gender issues, later corrected by the program. The program organizers had assumed that boys and girls have similar perceptions of the program, and had vastly underestimated boys' and girls' differing perceptions of the meaning and consequences of sexual activity among the unmarried.

From 1996 to 2000, assessments of youth centers were carried out in the four countries in sub-Saharan Africa. The assessments were conducted by the Population Council in collaboration with local family planning associations: Family Planning Association of Kenya (FPAK), Zimbabwe National Family Planning Council (ZNFPC), and Planned Parenthood Association of Ghana (PPAG). In South Africa, the Council collaborated with the Reproductive Health Research Unit (RHRU) in reviewing youth centers of the Kwa Zulu Natal Provincial Department of Health (KZN PDoH), the UNFPA/DfID-funded Youth and Adolescent Reproductive Health Program (YARHP), and the loveLife Program, a

collaborative effort with lead implementers Planned Parenthood Association of South Africa (PPASA), Advocacy Initiatives, Media Training Centre, and Health Systems Trust. Many of these organizations had been running youth centers since the 1980s, but relatively little had been done in the way of research and evaluation of these centers.

Twenty-six youth centers were included in the assessments in Africa (two in Kenya, three in Zimbabwe, nine in Ghana, and 12 in South Africa). While the facilities varied from center to center, all but four centers are reproductive health facilities integrated with recreation and/or vocational activities and/or library facilities. Four centers—one in Ghana, one in Zimbabwe, and two in South Africa—are reproductive health/family planning clinics targeting youth. The centers in Kenya, Zimbabwe, and Ghana target in- and out-of-school boys and girls aged 10 to 24 years. Those in South Africa have a range of target ages: 12 to 17 (in the loveLife program), 10 to 20 (in the KZN PDoH program), and 10 to 24 (in the UNFPA/DfID YARHP program).

The main objective of the assessments was to examine the overall functioning, utilization, and effectiveness of the youth centers. In Kenya and South Africa, researchers sought to assess the centers' associated costs and to understand community perceptions of the centers. Additionally, most of the centers in South Africa included peer education programs that were attached to the centers. The study in this country examined the preparedness and operations of peer education programs.

## **Evaluation Methodology**

The research methods used to assess youth centers in the four sub-Saharan countries varied from country to country, and were dependent on the information needs of managers, as

well as on time and budgetary constraints. In all countries, “mini-”situation analyses of youth centers were conducted, and service statistics were reviewed. In Kenya and South Africa, costs of the youth centers were analyzed retrospectively, and a community survey was conducted in the areas surrounding the youth centers. The following table is a summary of the data sources for assessments in each country.

**Assessments of Youth Centers in Four Countries  
in Sub-Saharan Africa: Data Sources**

<b>Kenya</b> two centers: Nairobi and Mombasa	<b>South Africa</b> twelve centers: all provinces	<b>Zimbabwe</b> three centers: Harare, Bulawayo, and Mutare	<b>Ghana</b> nine centers: Accra region, Eastern region, and Ashanti region
<p style="text-align: center;"><b>Situation Analysis</b></p> <ul style="list-style-type: none"> <li>- Inventory of centers</li> <li>- Observation of client flow</li> <li>- Exit interviews with youth at centers and youth participating in outreach activities</li> <li>- Interviews with center staff and volunteers</li> <li>- Interviews with staff from referral clinics</li> <li>- Interviews with personnel from collaborating agencies</li> </ul>	<p style="text-align: center;"><b>Situation Analysis</b></p> <ul style="list-style-type: none"> <li>- Inventory of centers</li> <li>- Observation of client flow</li> <li>- Exit interviews with youth</li> <li>- Interviews with center staff</li> </ul>	<p style="text-align: center;"><b>Situation Analysis</b></p> <ul style="list-style-type: none"> <li>- Inventory of centers</li> <li>- Observation of client flow</li> <li>- Exit interviews with youth</li> <li>- Interviews with center staff</li> </ul>	<p style="text-align: center;"><b>Situation Analysis</b></p> <ul style="list-style-type: none"> <li>- Inventory of centers</li> <li>- Observation of client flow</li> <li>- Exit interviews with youth</li> <li>- Interviews with center staff</li> </ul>
<b>Retrospective Analysis of Service Statistics</b> 1993–96	<b>Retrospective Analysis of Service Statistics</b> June–Aug 2000	<b>Retrospective Analysis of Service Statistics</b> 1994–96	<b>Retrospective Analysis of Service Statistics</b> 1997–98
<b>Community-Based Survey of Youth Center Catchment Areas</b>	<b>Community-Based Survey of Youth Center Catchment Areas</b>		
<b>Cost Analysis</b>	<b>Cost Analysis</b>		

## **Youth Center Assessments: Summary of Findings**

Facilities varied enormously from center to center. In some cases, centers were well-funded and well-equipped; in others, facilities were more modest, with limited recreational and vocational resources. Some centers had been running for many years, while others (especially those in South Africa) were relatively new.

While the assessments covered a range of issues, they focused largely on reproductive health services. This is because most, if not all, of the programs had health objectives, and because such facilities were established in recognition of the fact that many young people are sexually active, but have limited access to reproductive health information and services.

Below is a summary of findings from the assessments of youth centers in Ghana, Kenya, South Africa, and Zimbabwe:

1. Coverage—the number of youth served—of youth centers is often low.
2. Youth centers are often stigmatized by the community and by youth themselves.
3. Youth centers that integrate recreational activities and reproductive health services tend to be dominated by boys.
4. The individuals visiting youth centers tend to be older youths or even adults.
5. At centers that integrate recreational activities and reproductive health services, a low proportion of clients come for the latter.
6. Vertical reproductive health clinics for youth reach a relatively large number of girls.
7. Condom provision needs to be strengthened.
8. Youth center staff are highly knowledgeable, but often judgmental.
9. Confidentiality and judgmentalism on the part of providers are the main concerns of youth who receive counseling.
10. Youth who go to the centers are not necessarily better off than those who do not go to the centers in terms of reproductive health knowledge, nor are they more likely to practice abstinence.

**1. Coverage—the number of youth served—is often low.**

With such a large percentage of the African population living in rural areas, facilities-based programs are, perhaps, inadequate for reaching a significant proportion of youth. Even in urban areas, the awareness that youth centers exist is often low. In Kenya, for example, only 11 percent of boys and 6 percent of girls residing in the catchment areas of the youth centers were aware of them. In South Africa, 29 percent of boys and girls residing in the centers' catchment areas had visited a center at one time or another.

**2. Youth centers are often stigmatized by the community and by youth themselves.**

Youth centers run by family planning organizations tend to be stigmatized in the eyes of the community and of young people. Many youths (especially girls) do not want to be associated with family planning organizations because such an association would suggest that the young person is sexually active, or because young people brand youth centers as places for those with STIs.

**3. Youth centers that integrate recreational activities and reproductive health services tend to be dominated by boys.**

In Kenyan centers that integrate recreational activities and reproductive health services, males outnumbered females by 2 to 1. In Zimbabwe, these centers were also dominated by males 2 to 1.

The preponderance of boys in youth centers that integrate recreational activities and reproductive health services can be attributed to a number of factors. In Zimbabwe and Kenya, anecdotal evidence suggests that parents do not want their daughters visiting youth centers where boys are “hanging out.” In Kenya, youth center managers admitted that girls were sometimes harassed in the centers' unregulated, mixed-sex environment. Girls reported

that when they did use the centers, they participated mostly in vocational and skill-building activities rather than recreational activities.

**4. The individuals visiting youth centers tend to be older youth or even adults.**

The average age of those visiting youth centers in Ghana was 18, with 95 percent of the visitors within the target age of 10 to 24. In Zimbabwe, the average age of those visiting youth centers was 21, serving virtually no youth below the age of 15. In Kenya, 86 percent of youth center clientele were over age 20—clients averaged 24 years—and 26 percent were older than the upper limit of 24 years.

Utilization of reproductive health clinics within youth centers is not necessarily by youth. In Ghana, 43 percent of clients using these services were older than the target age of 24. In Zimbabwe, 45 percent of clients at clinics for youth were older than 24.

**5. At centers that integrate recreational activities and reproductive health services, a low proportion of clients come for the latter.**

In Mutare, Zimbabwe, only 4 percent of visitors to the youth center came for reproductive health counseling and services during the data collection period; 65 percent came to use the library; and 34 percent came for recreation. In Ghana, only 14 percent of youths reported having ever visited a youth center for family planning services; only 12 percent reported having ever come for other reproductive health services.

**6. Vertical reproductive health clinics for youth reach a relatively large number of girls.**

In every vertical reproductive health clinic for youth, females outnumbered males coming for reproductive health services, even where utilization was low, such as in integrated models. The preponderance of female clients in these clinics is probably a result of the fact that the clinics tend to emphasize family planning methods—and most of these methods require girls to come back repeatedly for supplies of pills or periodic injections.

One PDoH clinic in South Africa saw 219 clients in one week, all of them female. Clinics such as these—which become, in effect, female spaces—might be better at attracting girls for reproductive health services than are mixed-sex centers that combine these services with recreational activities.

### **7. Condom provision needs to be strengthened.**

Most youth center programs have health objectives; many of them have been designed in response to the alarming rates of HIV infection among young people (see Chapter 10). Nevertheless, condom provision needs to be strengthened in many of the centers. In the South African centers, for example, only 2 percent of clinical consultations involved provision of condoms. Among sexually experienced youth center clients who used condoms, only 52 percent had obtained condoms from the centers; many had obtained them, instead, from public-sector health facilities.

### **8. Youth center staff are highly knowledgeable, but often judgmental.**

Staff and volunteers in youth centers were highly knowledgeable about reproductive health issues, particularly HIV/AIDS; however, many were reluctant to provide contraceptives to unmarried young people and were often unclear about provider-client confidentiality. For example, when providers were asked how they would respond to an unmarried girl requesting family planning services, one in Kenya responded:

*I would reverse her mind and tell her not to have sex. There are risks involved in early sex like STDs, HIV, and early pregnancy. I would take her to the FPAK clinic to get information on the dangers of unprotected sex.*

A provider in Ghana responded:

*I will advise her against it by stressing the complications of early sex. I'll ask her to undertake other activities such as sports, games to overcome the desire and use up energy in her system. The last resort will be to prescribe condoms to be used by her friend.*

With the exception of staff in South Africa, such reluctance to acknowledge premarital sexual activity and to provide contraceptive methods to sexually active youth was fairly typical among service providers and volunteers interviewed in the assessments.

**9. Confidentiality and judgmentalism on the part of providers are the main concerns of youth who receive counseling.**

While 95 percent of youth counseled at centers in Ghana felt that the counselor would keep their discussion confidential, only 62 percent of youth in Zimbabwe and 41 percent of youth in Kenya felt the same. In Ghana, 43 percent of counseled youth found the counselor to be judgmental; 22 percent of counseled youth in Zimbabwe and 36 percent of these youth in Kenya felt the counselor was embarrassed by what they talked about during the counseling session.

**10. Youth who go to the centers are not necessarily better off than those who do not go to the centers in terms of reproductive health knowledge, nor are they more likely to practice abstinence.**

In order to estimate the effect of youth center programs on young people in South Africa, researchers divided respondents interviewed in the centers' catchment areas into two groups: those who had been to a center in the past three months and those who had never been to a center. The aim was to ascertain whether those who had been to the centers were better off in terms of reproductive health knowledge and sexual behavior than those who had not been to a center.

In terms of age, gender, and schooling status, there was no difference between those who had been to the centers and those who had not. This suggested that there was little or no selectivity bias between young people going and not going to the centers. There was little difference in reproductive health knowledge between the two groups. There was also little difference in average age at sexual initiation between female visitors to centers and nonvisitors. Females' median age at sexual initiation was 18.4 for visitors and 18.8 years for nonvisitors.

One statistically significant difference between visitors and nonvisitors was that those who had not been to a center were *more* knowledgeable about a girl's fertile period than were those who had been to a center. Boys who had visited a center seemed to have initiated sex earlier than those who had never been to a center: males' median age at sexual initiation was 16.6 years for visitors and 18.7 for nonvisitors.

### **Peer Education Programs**

Peer education is another popular approach in programming for young people. Peer educators are trained to cover sensitive subject matter related to sex and reproductive health. Peer education is based on the assumption that young people are most comfortable getting information on sexuality issues from people their own age—i.e., their peers—than from older people (Kerrigan and Weiss 2000).

A number of challenges have faced those implementing peer education programs. These challenges have included recruiting, training, supervising, retaining, and specifying the role of peer educators (Kerrigan and Weiss 2000). Few studies have assessed the quality and functioning of peer educators in the context of programs for adolescents. One study of peer education programs in Ghana and Nigeria found that the program reached males and females

differently, with male contacts outnumbering female contacts by 3 to 2. The researchers speculated that girls have greater concerns about confidentiality and are more selective regarding whom they talk to about sensitive issues. This led the researchers to conclude that peer education might not be as appropriate for girls compared to boys (Oyediran et al. 1997).

### **Peer Education Assessment: Summary of Findings**

An assessment of peer education programs in South Africa yielded the following insights (Erulkar, Beksinska, and Cebekhulu 2001):

1. Most young people—especially girls—preferred to learn about reproductive health from someone older than themselves.
2. A considerable number of volunteer peer educators dropped out of programs after training.
3. Topics that peer educators covered with girls were different from those they covered with boys.
4. Like providers, peer educators were highly knowledgeable about HIV/AIDS but less knowledgeable about fertility and family planning issues, and were often judgmental.

#### **1. Most young people—especially girls—preferred to learn about reproductive health from someone older than themselves.**

When young people were asked the preferred age of the person from whom they would receive reproductive health information, 75 percent reported that they would prefer someone older than themselves; only 20 percent preferred someone their own age. A greater proportion of girls (81 percent) than boys (65 percent) preferred an educator who was older than themselves.

**2. A considerable number of volunteer peer educators dropped out of programs after training.**

Seven peer education programs were examined in South Africa as part of the youth center assessments. In all, 526 peer educators had been trained in the year prior to the study; nearly half (247) dropped out of the program over the course of the year. One reason for the high drop-out rate could be that the peer educators work as volunteers, which makes it difficult for them to commit time to the program on an ongoing basis.

The high rate of drop-out among peer educators places a tremendous strain on the budgets of programs, which must keep training new peer educators to replace dropouts. Indeed, despite the fact that all peer educators were volunteers, *preliminary cost data from youth centers showed that centers with peer educators spent a significant percentage of their budgets) on the peer education program, much of it on training costs.* (Beksinska et al. 2002) Peer educators' high drop-out rates also have quality implications, as programs are likely to be staffed by newly trained, inexperienced, and less knowledgeable peer educators. In Kenya, Family Planning Association of Kenya's (FPAK) "Friends of Youth" program initially experienced a 50 percent dropout rate among their volunteer community-based educators for young people. When managers made modest increases in the educators' honoraria, FPAK retained all of its youth educator staff throughout the three-year intervention period, resulting in a highly motivated, experienced, and knowledgeable group of educators (for project description, see FPAK and Population Council 2000).

**3. Topics that peer educators covered with girls were different from those they covered with boys.**

The most common topics covered by peer educators were STIs (in 29 percent of contacts); teen pregnancy (21 percent); condoms (19 percent); HIV/AIDS (17 percent); and

family planning (17 percent). Peer educators were significantly more likely to talk to boys than to girls about STIs, including HIV/AIDS, and they were significantly more likely to talk to girls than to boys about family planning methods.

**4. Like providers, peer educators were highly knowledgeable about HIV/AIDS but less knowledgeable about fertility and family planning issues, and were often judgmental.**

Ninety-six percent of peer educators knew that a healthy-looking person can be infected with HIV; the same proportion knew that having sex with a virgin will not cure AIDS (a myth that circulates in some places). However, only 11 percent of peer educators knew the fertile period of a female's monthly cycle, and only 44 percent knew that injectable contraceptives do not impair fertility later in life.

Peer educators were read a series of scenarios and asked how they would respond to specific requests from young people—for example, they were asked what they would do if a young girl approached them for a family planning method. Many of the peer educators' responses were judgmental and some were unrealistic as well. For example, one responded:

*She is very young. I would advise her to stop everything. She must abstain. If she has already done it, she must have one partner; she must use condoms. I would take her to the youth center to attend workshops and learn more about relationships and sex.*

**Youth Center and Peer Education Program Assessments: Conclusions**

To date, most evidence related to the effectiveness of youth centers and peer education programs has been anecdotal; few studies have systematically measured the functioning and efficacy of these programmatic approaches. The studies in Ghana, Kenya, South Africa, and Zimbabwe discussed above sought to systematically measure the utilization of youth centers, as well as patterns of utilization among male and female visitors.

These studies found that youth-center utilization patterns differed for boys compared to girls. Boys outnumbered girls at integrated-service, mixed-sex youth centers. Often the same small group of boys frequented centers mainly for recreational purposes. Older boys tended to dominate, making youth centers unfriendly places for girls in many cases.

While reproductive health services were underutilized in most youth centers, girls used them more than boys. The most successful reproductive health clinics for youth were those that focused on clinical services and served a mostly same-sex clientele.

When asked to identify the most critical aspects of “youth-friendly” reproductive health services, young people in South Africa rated “provider characteristics” as being most important. Unfortunately, while providers are often highly knowledgeable, especially about HIV/AIDS, they often display judgmental views regarding the provision of reproductive health services to unmarried young people.

The youth center is just one approach to reaching young people with reproductive health information and services—and studies have found this to be a costly approach that reaches relatively few youth (Townsend et al. 1987; Senderowitz 1997). In addition to improving youth center programs, *program managers should continue to explore other cost-effective and culturally sensitive ways of reaching young people, taking into account the separate and special needs of boys and girls and the sensitive nature of reproductive health services for young people, married and unmarried alike, particularly in Africa.*

Peer education is a popular approach in the context of youth programs, but it, too, remains largely unexamined regarding its effectiveness, relative appropriateness to adolescent girls and boys, and cost.

The study in South Africa revealed that the majority of young people prefer to get reproductive health information from individuals who are older than themselves rather than

from their peers, contrary to what is assumed. This preference is greater among girls than among boys, which could explain gender differentials in the performance of some peer education programs. The high drop-out rate among volunteer peer educators remains a significant threat to programs, compromising the quality of staff and demanding disproportionate program expenditures to train replacements. While peer educators are often knowledgeable about HIV/AIDS, they often lack sufficient knowledge about fertility and family planning and sometimes reveal judgmental attitudes about premarital sex.

Studies that have focused on peer education programs have often ignored critical issues, such as how these programs benefit boys and girls differentially, and how volunteerism affects their cost and quality. Perhaps the dearth of studies in this area has contributed to lack of programmatic innovation, including experimentation with other types of educators or mentors for young people. Few programs seem to consider that boys and girls might prefer different types of mentors and might prefer a choice of mentors with different profiles, depending on the nature of the support they require.

*As we move forward with adolescent programming, we must do so in a way that is analytical, circumspect, and self-critical, taking into account the diverse needs of girls and boys in different contexts, living under different conditions.* One generation of adolescent programming is now giving way to another; at this critical juncture, we must expand our thinking beyond a first-generation effort that has been rather formulaic and often driven by assumption rather than research. Programmatic models that are popular and effective in one locale may be entirely inappropriate and costly in another. Furthermore, concentrating all resources in one or another programmatic model may compromise the overarching effort to give young people more information about, and decisionmaking power over, their sexual lives and reproductive health.

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