Changing Youth Behavior Through Social Marketing

Program Experiences and Research Findings From Cameroon, Madagascar, and Rwanda

by Josselyn Neukom and Lori Ashford

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Summary

Using the latest innovations in social marketing, Population Services International (PSI), a U.S.-based nonprofit group, created and implemented youth-oriented programs in Cameroon, Madagascar, and Rwanda to prevent unplanned pregnancies and sexually transmitted infections, including HIV/AIDS, among 15-to-24-year-olds. Research played a critical role in developing the programs' strategies and key messages. In addition to advertising products—a common feature of social marketing campaigns—the programs used a creative mix of commercial marketing and interpersonal approaches to motivate young people to either use condoms consistently or not have sex, learn their HIV status, and seek treatment for other sexually transmitted infections.

Working with the private sector, the programs made condoms and other reproductive health products and services—otherwise off-limits to unmarried youth—more accessible and "youth friendly." The programs combined several features that made them unique among adolescent reproductive health programs:

- The programs linked motivational campaigns directly with youth-friendly sources of condoms and reproductive health services.
- They were informed by research about the specific issues and barriers facing the target audiences, and were based on contemporary theories about behavior change.
- They communicated intensively and often with youth, providing motivational messages through television, radio, print media, and peer educators.
- Rather than preaching to youth about good behavior, the mass media campaigns treated youth as savvy consumers and portrayed safe behaviors as positive and socially acceptable.
- The programs used common logos and brand names to identify communication activities as well as products and services.

An external evaluator described this program as "an outstanding, well-conceived, managed, implemented and monitored sexual health intervention with significant opportunities to provide a learning laboratory for PSI's growing youth portfolio."[1] The programs contributed to measurable changes in youths' perceptions and behaviors.

- In Cameroon, youth of both sexes who were exposed to the program were more likely to know how to use condoms correctly and less shy to buy condoms. After 18 months of program activities, 69 percent of young men with high levels of exposure to the program reported using a condom the last time they had sex with a regular partner, compared with only 56 percent of those with low program exposure.
- In Rwanda, young people exposed to the program were more likely to believe condoms are effective for preventing HIV/AIDS, believe their friends and family support condom use, and know where to find condoms and how to use them. Youth of both sexes who were exposed to the program were also more likely to use HIV counseling and testing services: Eight percent of young women ages 15 to 24 with high program exposure had an HIV test, compared with only 2 percent of those with low exposure.
- In Madagascar, the number of youth ages 15 to 24 seeking STI treatment and other reproductive health services at youth-friendly clinics rose dramatically, from 122 youth in the first month to 716 youth (predominantly female) in the 24th month of program activities.

The programs achieved these results by making discussion about sex more common and acceptable, creating new social norms for safe behavior, and motivating youth to seek out and use reproductive health services. Still, some program objectives remain to be achieved, such as increasing condom use among sexually active youth in Rwanda, increasing condom use among young women in Cameroon, and increasing young men's use of reproductive health services in Madagascar. All three programs need to do more to motivate increasing numbers of youth to either abstain from sex or use condoms consistently (every time they have sex). A third round of surveys and additional analysis in 2003 will shed more light on changes in youth behavior in each country and the implications of these trends for future programs.

A health worker provides HIV test results and counseling at PSI's youth center in Rwanda.

TABLE 1
Characteristics of Youth Ages 15 to 24 in the Three Program Sites*

	Cameroon	Madagascar	Rwanda
Program site	**Douala and Yaounde (urban)**	**Tamatave Province (peri-urban)**	**Butare Province (peri-urban)**
Estimated number of youth in the program site	600,000	73,000	150,000
Percent who currently attend school	64	20	10
Percent who watched TV in the last week	81	32	6
Percent who report being sexually experienced (Male/Female)	69/66	78/79	14/16
Percent of sexually experienced youth who report having two or more partners in the last year (M/F)	35/16	43/11	16/4
Percent infected with HIV ** (M/F)	6/13	.07/.2	5/11
Percent of females using modern contraception***	39	37	4

*Except where noted, data reflect results of the 2000 household survey taken in each program area at the outset of program activities.
**National estimates as of December 2001 (UN Joint Programme on HIV/AIDS).
***National estimates from Demographic and Health Surveys (ORC Macro).

'Sometimes there are girls who, because they love a guy, want to hang onto him, and they submit to his desires so that the guy doesn't leave them.'

—Female Cameroonian student

The Context: Reproductive Health Challenges Facing African Youth

Only about one-fifth of the world's 1 billion young people ages 15 to 24 live in sub-Saharan Africa, yet they represent the vast majority of HIV infections in this age group worldwide. Every year, roughly 1.7 million African youth become infected with HIV. Moreover, young women in the region are twice as likely to be infected with HIV as young men. Young women face additional reproductive health risks. Between 10 percent and 18 percent of African women ages 15 to 24 give birth each year. Most pregnancies of unmarried women are unintended, and many of these end dangerously in illegal and unsafe abortions.

Many factors contribute to the alarmingly high rates of HIV infections as well as unplanned pregnancies in sub-Saharan Africa. These include early onset of sexual activity and delayed marriage, poverty, power imbalances between men and women, and various cultural practices. Young women are particularly vulnerable to HIV infection for both biological and social reasons. Their immature reproductive tracts are susceptible to infection, and they tend to have sexual relations with older men who may be already infected with HIV. Also, high rates of sexually transmitted infections (STIs), such as gonorrhea and chlamydia, fuel the spread of HIV because individuals who are already infected with STIs are more susceptible to HIV infection.

Young people have limited access to the reproductive health information, products, and services they need to protect their health. Youth programs in sub-Saharan Africa typically encounter a number of social, cultural, and economic obstacles. For example, conservative social values and protective adults often prevent youth—especially young women—from visiting a family planning clinic or buying condoms. Perceptions of invincibility, among young men in particular, and the unplanned nature of sexual encounters also impede prevention efforts among young people.

The Programs

In 1999, PSI, an international nonprofit organization with headquarters in Washington, D.C., received a grant from the Bill & Melinda Gates Foundation to improve the reproductive health of youth in sub-Saharan Africa using social marketing techniques. Social marketing improves the health of low-income peo-

ple by offering health products and services at affordable prices and motivating people to practice healthy behaviors, including correct use of the products sold. Social marketing programs typically receive donated products such as condoms and then sell them, attractively packaged under a brand name, in small shops and other outlets that low-income people frequent every day. The programs also rely on promotional and educational campaigns, working through a range of media, to encourage people to adopt healthy behaviors.

For this grant, PSI focused resources in three countries to maximize the potential to influence youth behavior. Through a competitive process, PSI/Washington selected innovative proposals submitted by PSI affiliates in Cameroon, Madagascar, and Rwanda. Each program faced a different set of challenges, depending on the severity of the HIV/AIDS epidemic, levels of sexual activity among youth, and youth exposure to the mass media and the school system (see Table 1).

Research guided the design and evaluation of each country program. Focus group discussions and an initial round of surveys provided information on the barriers to safe behavior among youth, and these findings formed the basis for the programs' objectives and activities. Together, staff of PSI/Washington and the country affiliates worked intensively to design, oversee, and evaluate the programs. PSI delegated responsibility for implementing the programs to the field offices to ensure that programmatic decisions were based on in-depth knowledge of local opportunities and constraints. Each program was integrated with national contraceptive social marketing programs already underway.

Program activities began in 1999-2000, supported by a four-year, US$5 million grant. Each of the three affiliates managed about $1.1 million for field activities, and the balance of approximately $1.7 million supported research expenses, technical assistance from PSI's Washington office, and consulting fees to analyze survey findings and to develop and monitor program strategies. Collecting, analyzing, and using high-quality data required significant resources, but improved the quality of the program.

Program Framework and Evaluation Methods

The design, implementation, and evaluation of the youth programs were based upon PSI's behavior change framework, which incorporates elements of the most commonly used behavior change theories, including social learning theory (see Box 1), the health belief model, and the theory of reasoned action. Recent research has shown that many factors have a small impact on sexual behavior and condom use, rather than a few factors having a large impact.[2] PSI's program activities—as well as the indicators selected for monitoring program effects—were based on the assumption that healthy behavior depends on a combination of individual, environmental, and social factors, including:

- An individual's appreciation of the severity of sexually transmitted infections and HIV;
- An individual's perception that she or he is at risk;
- Self-efficacy—the confidence to take action to protect oneself;

BOX 1

Social Learning Theory

Social learning theory explains human behavior in terms of the dynamic interaction between personal factors (knowledge, expectations, and attitudes), behavioral factors (skills and self-efficacy) and environmental factors (social norms, access to information, products and services, and ability to influence others). Based on Albert Bandura's research, the social learning theory—also known as the observational learning theory—asserts that individuals learn not only through their own experiences, but also by observing the actions of others and the consequences of those actions. The theory argues that, in order to motivate young people to change behavior, youth programs must provide opportunities for young people to:

- Observe and imitate their peers practicing safe behavior (e.g., negotiating abstaining from sex);
- Practice new behaviors in order to increase skills and confidence required to maintain the behavior (e.g., putting condoms on a wooden model); and
- Receive positive reinforcement and encouragement to maintain the safe behavior.

'A shopkeeper, when you tell him you want a condom, starts to moralize. He reminds you that at your young age you shouldn't be doing that.'

–Male Cameroonian student

TABLE 2
Program Evaluation Plan: Surveys of Male and Female Youth Ages 15 to 24

	Cameroon	Madagascar	Rwanda	
	Yaounde and Douala	Tamatave Province	Butare Province	
Survey I	Household survey June-July 2000 2,097 youth	Household survey Nov.-Dec. 2000 2,439 youth	Household survey Oct.-Dec. 2000 3,111 youth	School survey Oct.-Nov. 2000 1,530 students[a]
Survey II	Household survey January 2002 3,536 youth	Household survey November 2002 2,526 youth	Household survey March 2002 3,109 youth	School survey April 2002 1,555 students[b]
Survey III	*Data collection scheduled for July 2003*	*Survey postponed due to adverse local conditions*	*Data collection scheduled for September 2003*	*Data collection scheduled for October 2003*

[a]Control group: 1,464 students in Gitarama town.
[b]Control group: 1,592 students in Gitarama town.

'For those girls who really understand their bodies, they can determine a certain number of days when they can do it with a condom and the other days without condoms.'

—Female Cameroonian youth

- Concerns about using products (e.g., whether condoms will work and whether they will reduce pleasure); and
- Support from family members, friends, and the community.

These factors can work together to influence a young person's sexual behavior and demand for condoms and related services. On the "supply side," other factors influence the practice of safe behaviors:

- The availability of convenient, affordable, and high-quality condoms and reproductive health services; and
- Youth-friendly outlets or locations where young people are welcome to seek products and services.

PSI's programs address both demand-side and supply-side constraints to behavior change, and specifically those constraints that the local research results show are most critical. At the outset of each country program, the staff used survey results of the first round of surveys (discussed in the next section), along with other research, to develop a logical framework for program activities. The frameworks outline the priority program objectives and corresponding evaluation indicators, including baseline and target values, to measure the impact of each country program.

Evaluation methods

The main tool for evaluating the youth program in each country was a sexual behavior and reproductive health survey, conducted in three rounds at 18-month intervals—at the beginning, middle, and end of the programs. (At the time of writing of this report, the first two rounds of household survey results are available in Cameroon and Rwanda.)

Each survey was a household survey of a random sample of young women and men ages 15 to 24 living in the project areas (see Table 2). In Rwanda, where many youth attend boarding schools, a school-based survey supplemented the household survey. The school-based survey was conducted both in a control site (an area with no program activities) and an intervention site (one with program activities), so that comparisons could be made between the responses of youth who were not exposed and youth who were exposed to the program's messages.

The evaluation consisted of two components:

- Examining trends in survey responses after controlling for sample differences and other confounding factors such as education and socioeconomic status; and
- Using "dose-response analyses" to examine whether youth who had higher levels of exposure to the program are more likely to practice healthy behavior than youth with low exposure to the program, after controlling for other factors.

In addition to the large surveys, PSI carried out smaller-scale research studies

to strengthen certain aspects of the program and explore specific challenges, such as why young men are less likely to visit clinics than young women. The PSI affiliate in Cameroon conducted in-depth interviews to assess the appeal of mass media campaigns among Cameroonian youth. PSI/Madagascar used "mystery client" studies to evaluate the quality of care provided at the youth-friendly clinics that the program supported.

Washington-based PSI researchers designed the overall evaluation plan for the program, developed a standard questionnaire, supervised research activities in the field, analyzed data, and reported on findings across countries. Local research organizations adapted the standard questionnaire based on local research findings, collected the survey data, and wrote part or all of the survey reports.

Social Marketing Interventions

The youth-focused social marketing programs in Cameroon, Madagascar, and Rwanda used commercial marketing techniques to motivate 15-to-24-year-olds to practice safe behaviors, including consistent condom use or abstinence, voluntary counseling and testing for HIV, and STI treatment. The programs' activities built on social marketing concepts but did much more than advertise products: They developed young people's motivation, ability, and intent to practice safe behavior.

Each country program had a slightly different emphasis:

- In Cameroon, the *100% Jeune* program launched an extensive multimedia campaign targeted at sexually active youth in two major cities and developed a network of youth-friendly condom

Peer educator uses drama to emphasize STI and unplanned pregnancy risks to youth in Cameroon.

BOX 2

Cameroon: The *100% Jeune* Program

PSI's affiliate in Cameroon, *Programme Marketing Sociale au Cameroon* (PMSC), implemented a multichannel communication program to motivate and enable sexually active, urban youth to use condoms consistently or not have sex. The program targeted approximately 600,000 youth ages 15 to 24 in the country's two largest cities, Douala and Yaounde.

100% Jeune's peer educators, journalists, comic strip artists, radio personalities, and scriptwriters were all young Cameroonians who understand the typical concerns and challenges of adolescence. Describing personal experiences in their own language, peer educators and other youth helped PMSC develop messages and activities that resonated with urban youth and offered practical solutions to common reproductive health problems. Linked by the *100% Jeune* brand, all communication activities were designed to promote images of youth who challenge social norms to protect their health.

Television and radio spots were produced by local advertising agencies and pretested to ensure they were understandable and culturally acceptable. The 60-second spots, aired repeatedly for periods of four to six weeks, modeled positive behaviors such as young women buying condoms without embarrassment.

Call-in radio shows, organized weekly by young Cameroonians, included interviews with featured guests, interviews with ordinary youth on the street, questions from youth listeners (by phone as well as mail), and plenty of popular music.

Twenty peer educators reached about 10,000 in-school and out-of-school youth each month in Douala and Yaounde. Their face-to-face sessions with youth included role plays and other interactive techniques to build skills such as how to negotiate abstinence or use condoms correctly.

A serial radio drama, "Solange: Let's Talk about Sex," tackled difficult issues such as cross-generational sex (sex between older men and younger women), HIV testing, and parent-child relationships, in 18 segments aired on public and private radio stations.

A monthly youth newspaper, *100% Jeune Le Journal,* included articles about reproductive health, letters from readers and responses from peer educators, sports, music, comic strips, and tear-out color posters. Teams of independent street vendors sold as many as 80,000 copies of the 12-page paper each month, generating revenues that helped support the program.

Youth-friendly condom sellers received training and promotion from PMSC so that they could be identified as *100% Jeune* outlets. More than 40,000 condoms were sold to youth through *100% Jeune* outlets in 2002.

BOX 3

Rwanda: *Centre Dushishoze*

Centre Dushishoze (dushishoze means "think about what you're doing" in the local language) was the first center in Rwanda to provide youth with quality, affordable reproductive health services in an integrated and youth-friendly setting. Located in Butare, it was also one of the first clinics to use rapid HIV-test technology. The multipurpose center is a popular place for youth to spend free time and seek reproductive health information and services in a safe, discreet setting.

The program also includes a range of creative media campaigns and interpersonal communication activities to motivate youth to practice safe behaviors. Because more than 90 percent of the 15-to-24-year-olds in this province live in rural areas and few attend secondary school, this site presented an opportunity to test the effectiveness of social marketing techniques for reaching out-of-school and rural youth.

Reproductive Health Products and Services

Centre Dushishoze offers reproductive health services and skill-building opportunities in an entertaining and educational setting. Five full-time medical professionals provide voluntary testing and counseling for HIV, treatment of STIs, emergency contraception, pregnancy tests, and reproductive health counseling between 8 a.m. and 8 p.m., six days per week. The center charges youth a lower fee for services than other health clinics in the area.

Every young person who visits *Centre Dushishoze*—even those who come initially to play games or watch movies—participates in motivational health education and risk-assessment exercises led by the peer educators. Basketball, volleyball, ping-pong games, movies, a well-equipped library, and special events such as juggling lessons and dance competitions help attract youth to the center. The center also added four month-long skill-building courses in hair styling, embroidery, auto mechanics, and English, which helped increase the number of female clients seeking reproductive services at the center.

Centre Dushishoze's peer educators collaborate with PSI/Rwanda's community-based and commercial Prudence Plus condom sales agents to identify and promote youth-friendly condom sellers in rural areas. PSI/Rwanda also transports rural youth to the center for reproductive health services and special events.

Advertising and Behavior Change Communication

The program does not use mass media because of young people's limited access to television and radio in Butare. Instead, peer educators, print materials, and mobile video-unit shows motivate youth to visit the center, seek HIV counseling and testing and STI treatment services, and practice safe behaviors. The program's peer educators and medical professionals provide small-group and individual counseling sessions for youth at the center as well as at churches, clubs, schools, and rural community centers.

A peer educator gives a prize to a young man in Madagascar for participating in a skit about negotiating abstinence.

vendors near schools and other convenient locations (see Box 2, page 7).

- In Rwanda, a multipurpose youth center, *Centre Dushishoze*, provided voluntary HIV counseling and testing, STI diagnosis, and other reproductive health services for the first time in an integrated setting (see Box 3).
- In Madagascar, PSI developed and promoted the *TOP Réseau* network of youth-friendly, private-sector clinics providing testing and treatment for STIs along with other reproductive health services (see Box 4).

Each program made reproductive health products and services more convenient and accessible to youth, and motivated young people to use them. Consistent with social marketing principles, the programs sold products, services, and youth-oriented newspapers to increase the likelihood that they would be valued and, therefore, used.

In addition to the strong research component, PSI's programs combined several features that made them unique among adolescent health interventions:

Using a wide variety of communication channels. All three countries used a multiplicity of communication channels to encourage youth to use these youth-friendly products and services and practice healthy behaviors. The *100% Jeune* program in Cameroon used peer education, television and radio spots, a monthly magazine, call-in radio shows, and serial radio dramas to create a whole social movement supporting condom use among sexually active youth. The reinforcing communication elements virtually blanketed young people with positive motivational mes-

BOX 4

Madagascar: The *TOP Réseau* Franchise

TOP Réseau (Network), one of the first youth-friendly clinic franchises in a developing country, offers confidential, convenient, and affordable reproductive health services to 73,000 15-to-24-year-olds living in Tamatave province. The network's services and related communication activities aim to prevent HIV/AIDS and unplanned pregnancies by motivating sexually active youth to treat STIs and to use condoms consistently or not have sex.

The *TOP Réseau* franchise consists of 13 for-profit and two nonprofit clinics with 27 medical providers who offer STI diagnosis and reproductive health counseling services.

All franchise clinics meet minimum "youth-friendly" standards, including well-trained and nonjudgmental providers, flexible hours during evenings and weekends, welcoming décor, and discreet physical locations. *TOP Réseau* clinics charge youth a subsidized price of US$1.45 for STI diagnosis and other reproductive health services.

Training, Supervision, and Support

PSI/Madagascar provides franchise members with training, supervision and support, clinic promotion, and materials to guide counseling sessions. Regular meetings for doctors, a monthly technical newsletter, and opportunities for continuing education motivate providers to comply with franchise requirements. PSI employs a full-time medical supervisor who visits each clinic twice a month, and PSI uses mystery client studies and exit interviews of clients to monitor adherence to service delivery standards.

PSI/Madagascar also designed "Boite à Image" (box of images), a flipchart to standardize reproductive counseling sessions with youth. The tool guides counseling sessions and reminds providers to emphasize key messages, such as the importance of completing STI treatment. Every client with STI symptoms receives an STI prevention kit containing condoms, instructions, and referral cards for the client's partners.

Advertising and Health Promotion

Mass media and face-to-face communication activities promote *TOP Réseau* clinics and motivate youth to practice safe behavior:

- Ten peer educators reach about 2,000 youth each month, providing small group and individual counseling at diverse locations in the community.
- Television and radio spots highlight the risk factors for contracting STIs and the consequences of insufficient treatment.
- A television talk show with youth, "Ahy Ny Safidy" ("It's My Choice"), discusses avoiding unplanned pregnancy, negotiating condom use, and what to do when you or your partner has an STI.
- Peer educators working in mobile video units bring health films, discussions, and demonstrations of correct condom use to youth in rural areas.

In May 2003, PSI/Madagascar received an award from the Global Fund to Fight AIDS, Tuberculosis and Malaria to expand and replicate the *TOP Réseau* network in three new provinces, including Antananarivo and Tuléar.

sages and images. In Rwanda, where young people had much less exposure to the mass media, the program complemented peer education with mobile video shows, print materials, and billboards.

Moving beyond knowledge to action. Recognizing that knowledge is not enough to propel action, communication activities aimed to encourage youth to recognize and internalize the risk of contracting STIs or HIV, build skills and self-confidence to negotiate safer sex, and make healthier behavior more socially acceptable. The program emphasized the multiple benefits of condoms, including protection from pregnancy, STIs, and HIV/AIDS. In Rwanda, where reported levels of sexual activity were lower, youth who were not yet sexually active were encouraged to postpone sex for as long as possible.

Using high-quality media productions with a common brand name. The programs treated youth as sophisticated consumers, using, for example, full-color magazines and popular slang language and working with local commercial advertising agencies to create appealing campaigns. Mass media productions, radio call-in shows, youth-friendly health care providers, condom sellers, and peer education activities shared a common logo and brand name.

Addressing gender stereotypes and other sensitive issues. Television and radio spots dealt with complex issues such as male and female stereotypes and expectations (e.g., men should be strong and women submissive). The spots portrayed positive images of confident women who defy stereotypes to protect their reproductive health, and of men who accept and respect

' … She gave me a condom, I said that I wouldn't use it. If she had insisted, I would have used it.'

–Male Cameroonian youth

Female youth discuss their reproductive health concerns with a peer educator in Rwanda.

'You see, most of the time youth get information on sex-related questions from others their own age, because they're more comfortable talking to other youth. But often they don't get correct information from their friends, who don't know any more than they do.'

– Female Rwandan student

these young women. Print materials discussed sensitive topics such as coerced sex and the consequences of untreated STIs. Interactive media, such as call-in radio programs and television talk shows, encouraged young people to talk openly about sexual health issues, which would have otherwise been considered taboo.

Integrating reproductive health with other youth concerns. The programs did not view youth as one-dimensional but took a more comprehensive and consumer-oriented approach, recognizing the economic and social aspirations of youth. Articles describing the consequences of incomplete STI treatment were sandwiched alongside interviews with popular local musicians in Cameroon's youth newspaper. Peer educators discussed pregnancy risks with young women attending embroidery and auto-mechanics classes at *Centre Dushishoze* in Rwanda.

Use of Peer Educators

Peer educators—young people trained to discuss sensitive issues with their peers—were a central component of the youth programs in Cameroon, Rwanda, and Madagascar. The peer educators' objectives were twofold: to build young people's confidence, skills, and commitment to practice safe behavior; and to ensure that the various program elements responded to typical concerns of youth. The peer educators were paid and served both in-school and out-of-school youth.

The peer educators' main role was to facilitate small group discussions, but they also helped ensure that program messages and activities resonated with youth. They evaluated whether the condom sellers and clinics were youth friendly; responded to questions from youth on the live call-in radio programs; and reviewed scripts for television and radio programs. The peer educators also helped tie various program elements together by encouraging their audiences to read the youth newspaper, listen to the call-in radio show, and seek health services from the clinics and condom sellers certified by the program as being youth friendly.

The peer educators complemented mass media activities by serving as role models who demonstrated—and helped other youth develop—practical solutions to typical reproductive health challenges. Drawing on their own experiences, they led small-group discussions about typical problems and concerns facing youth. They guided participatory exercises to help youth gain the confidence and skills needed to negotiate safer sexual practices. Their main purpose was not to deliver information, but to motivate young people to adopt new and healthy standards and behaviors.

PSI maintained the quality of peer education by recruiting peer educators carefully, training them intensively, and monitoring their performance regularly.

BOX 5

Peer Education Strategies That Work

Peer education is a common approach for helping youth adopt responsible behaviors, but reaching large numbers of youth effectively remains a challenge for many programs. Recognizing this challenge, PSI organized an external assessment of peer education activities in Cameroon, Rwanda, and Madagascar in 2001.[1] Based on visits to the program sites in Cameroon and Rwanda and a review of international literature on the subject, the assessment suggested the following guidelines for youth peer education:

Work with small groups of youth on a repeated basis. Working with groups of 20 youth on an ongoing basis, for at least 15 to 30 hours, may be necessary to achieve fundamental and sustained behavior change. Although large diverse audiences can be ideal for raising awareness of reproductive health issues, they are not always suitable for intensive interpersonal activities. Participatory techniques designed to encourage audience members to personalize information, gain confidence, and practice new behavioral skills are most effective when used with a small number of participants who share common demographic and socioeconomic characteristics. Small homogenous groups allow peer educators to cover more material, engage participants more fully, tailor messages appropriately, and effectively address concerns and questions.

Maximize the use of structured participatory exercises. These exercises should be designed to motivate participants to internalize risks and make the commitment to practice healthy behavior. Social learning theory asserts that young people learn by observing and imitating a behavior and receiving support to maintain the behavior. Based on this scientifically tested theory, peer education activities should avoid didactic presentation and instead aim to:

- Teach young people behavioral skills, including communication, negotiation, and refusal skills, and correct condom use;
- Use influential, respected role models;
- Provide an opportunity for young people to practice skills and receive feedback;
- Ensure that young people believe they have the confidence and self-efficacy to initiate new behaviors;
- Motivate young people to immediately apply the skills they have learned and practiced;
- Praise young people for correctly applying new skills.[2]

Make extra efforts to reach the most vulnerable youth. Out-of-school youth, orphans, street youth, and commercial sex workers are more likely to engage in high-risk behaviors, and therefore have a greater need for HIV prevention programs, including peer education services.

Reach greater numbers of youth by partnering with other organizations. Programs that have a few highly trained, paid peer educators are not economically or logistically feasible on a large scale. Reaching sufficient numbers of youth face-to-face on a repeated basis requires collaboration among many organizations. One option for expanding coverage is to use experienced peer educators as trainers and supervisors of a wider network of volunteer peer educators linked to schools, youth clubs, and other organizations.

Use management tools to make activities more systematic and effective. Training manuals with graduated session plans and supervision checklists can help reinforce training exercises and improve the quality of the peer education. Practical tools such as standardized guidelines for peer education sessions can reduce variability, maximize audience participation, and ensure emphasis on key messages. For example, a checklist can enable supervisors to assess the following aspects of peer education sessions:

- Was the sexual information provided in a session simple, accurate, and relevant to a given audience?
- Were the meeting place and seating arrangements suitable?
- Could the audience hear and understand the peer educator facilitators?
- To what extent did peer educators use facilitative instead of didactic approaches?
- Did the session include at least one experiential learning activity (role plays, process drama, or condom use practice exercise)?
- Did peer educators give the audience sufficient opportunity to participate in discussion and experiential learning activities?
- Was audience participation widespread and balanced, (i.e., equal numbers of females and males participating), and genuine (i.e., questions about personal experiences rather than scientific details)?
- What were the key messages—were they clearly emphasized?
- Were audience members encouraged to personalize sexual health risks?
- Did peer educators talk about how to find health products and services?

Recruit true peers. In order to be credible, youth peer educators must be true peers—similar age range, sex, marital status, and sexual experience—to the program's target audiences. Recruitment and training should emphasize the ability to listen, guide discussions, and talk about sensitive topics. A good peer educator does not preach, but instead listens and responds to the audience. They must be perceived as empathetic and genuine—but not perfect. A major challenge is to recruit and train peer educators who are poised and self-assured and, at the same time, comfortable deferring to experts when appropriate.

References

1. David Wilson, "PSI Youth Sexual Health Programme: Cameroon, Rwanda, Madagascar," unpublished report, April 25, 2002.
2. David Wilson, Social Learning Theory Checklist, from "PSI Youth Sexual Health Programme: Cameroon, Rwanda, Madagascar."

A good strategy for gaining support of parents and professionals is to work with a few sympathetic 'champions' of adolescent reproductive health.

Out-of-school youth in Madagascar practice correct condom use.

The programs paid peer educators as contract employees, generally at a salary equivalent to an unskilled laborer, about US$150 to $200 per month. New recruits attended four to five days of group training sessions on communication skills and reproductive health issues, followed by practice sessions in facilitating group discussions.

Each country program hired a peer education supervisor who monitored the content and quality of peer education sessions and guided the development of new activities. Peer educators completed written forms for each session documenting the audiences they worked with and assessing participation. The program also used periodic "consumer audits"—confidential interviews with or written surveys of the youth audience members—to assess the clarity and appeal of the peer education sessions. Based on these monitoring efforts and an external evaluation of the program, managers adopted strategies to improve the quality of peer education (see Box 5, page 11).

Involvement of Parents and Other 'Gatekeepers'

Because promoting condoms and discussing sexual health among youth are controversial in most countries, PSI's youth programs reached out to parents, teachers, community leaders, and medical professionals to gain their support. (These groups are often called "gatekeepers" because their support enables program activities to proceed.) Initially, all three programs encountered resistance from parents, educators, and health care professionals who were uncomfortable providing reproductive health information and services to unmarried youth. Identifying a few supportive individuals, informing them, and using them as examples in the community led to more widespread acceptance of the program.

In Madagascar and Rwanda, community coordinators conducted outreach sessions with parents, religious leaders, and other community leaders to promote parent-child dialogue on reproductive health. Outreach sessions with parents used role plays and other participatory exercises to help parents learn how to discuss sensitive issues with their children. In Cameroon and Madagascar, the affiliates trained a select group of condom sellers and clinic staff to develop youth-friendly provider networks. In Cameroon in 2002, the PSI affiliate developed and aired a 60-second spot on television to implore parents to discuss HIV/AIDS with their children. In addition, all three countries involved government officials and community leaders in the design and monitoring of program activities.

The programs' proactive attempts to gain support from gatekeepers appeared to pay off. After being briefed on levels of sexual activity among 15-to-24-year-olds, the Cameroonian Minister of Health defended PSI/Cameroon's television spots depicting youth negotiating condom use when critics complained about public promotion of condoms for unmarried youth. In Rwanda, provincial government representatives served on a steering committee for the youth center and donated land upon which the youth center was built. Parents who visited *Centre Dushishoze* during special adult outreach days were more likely to understand the center's objectives and activities and, subsequently, encouraged youth to spend time at the center. In Madagascar, teach-

ers and school administrators who learned about reproductive health risks from *TOP Réseau* doctors later welcomed the peer educators to their schools. In Cameroon and Madagascar, the initial training and promotion for a small number of condom sellers and medical professionals led to numerous requests from others interested in joining the youth-friendly networks.

Impact on Youth Behavior

After 18 months of program activities, researchers conducted follow-up surveys in Rwanda and Cameroon to measure the impact of the interventions on young people's behavior. (Madagascar is discussed separately on page 16.) Because two different random samples of youth responded to the pre- and post-intervention surveys, the results reveal changes in the overall community, not in specific individuals. PSI researchers conducted additional statistical analysis of the survey results to isolate the effects of PSI's programs from other changes occurring in the communities. Although many of the research results raise questions that require further investigation, a number of positive findings have emerged, and the results have influenced the next phase of PSI's youth programs.

Program Results in Cameroon

Survey results in Cameroon revealed the considerable reach of the *100% Jeune* multimedia program in the two urban areas where it was implemented. In 2002, 26 percent of youth spontaneously recalled hearing about *100% Jeune*. In the same year, most other reproductive health programs in Cameroon had less than 5 percent recall, indicating that they had limited reach. Table 3 shows prompted recall (which is higher than spontaneous recall) of specific program elements. About one in eight youth had attended at

TABLE 3

Percent of Youth Ages 15 to 24 Who Recall Exposure to Cameroon's *100% Jeune* Program Elements

	Percent
Ever read *100% Jeune Le Journal* magazine	74
Saw a *100% Jeune* television spot in the past 3 months	71
Heard a *100% Jeune* radio spot in the past 3 months	65
Heard a *100% Jeune* call-in radio show	47
Heard of "Vendeurs Amis des Jeunes" (youth-friendly) condom outlet in the past 3 months	32
Heard "Solange" radio drama in the past 3 months	26
Ever attended a *100% Jeune* peer education session	12

TABLE 4

Effects of Program Exposure in Cameroon on Youth Perceptions and Behavior

Indicator	Relationship With Program Exposure	
	Males	Females
Self-Efficacy		
Not shy to buy condoms	Positive	Positive
Knows correct condom use	Positive	Positive
Perceived Social Support		
Believe parents support youth using condoms	None	None
Discussed STIs or HIV/AIDS prevention with friends	Positive	Positive
Perceived Condom Access		
Knows condom source no more than 10 minutes from home	Positive	Positive
Perceived Health Risks		
Desire to postpone childbirth by 2 years or more	None	Positive
Perceive moderate/high risk of HIV/AIDS	Positive	None
Bought Condoms		
Purchased condoms in the last year	None	Positive
Condom Use		
Used often/always with a regular partner	Positive	None
Used in last sex with regular partner	Positive	None
Used in last sex with casual partner	None	None
Sexual Behavior		
Sexually experienced (ever had sex)	None	None
Use of Family Planning		
Currently uses a modern family planning method (among sexually active youth only)	Positive	None

Note: The analysis controlled for differences in the surveyed population, including age, school enrollment status, socioeconomic status, and area of residence.

FIGURE 1

Cameroon: Changes in Attitudes and Behavior Among Young Men

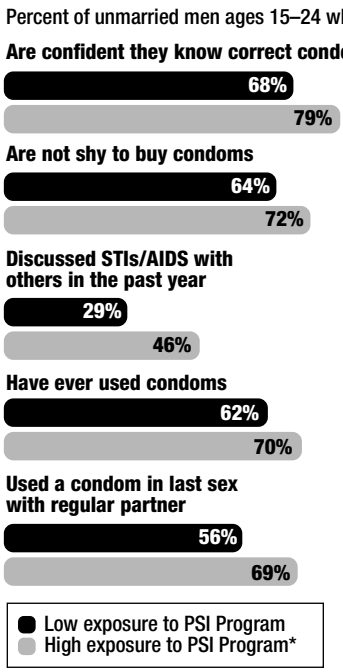
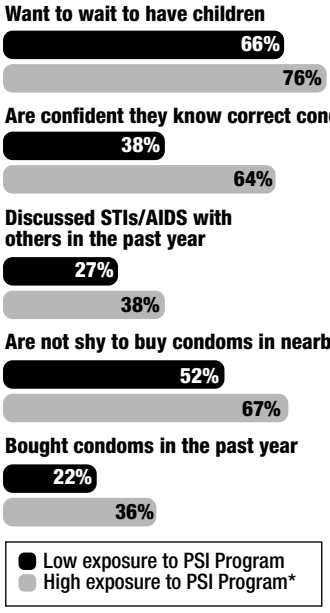


FIGURE 2

Cameroon: Changes in Attitudes and Behavior Among Young Women



Note: Changes shown are statistically significant at p≤.05. Analysis controlled for age, residential area, level of education, school enrollment, socioeconomic status, and number of sexual partners.

*High exposure to the *100% Jeune* program is defined as having two or more of the following: a) often or always listens to the *100% Jeune* call-in radio program; b) heard at least 10 episodes of the "Solange" radio drama; c) often or always reads the *100% Jeune* newspaper; d) attended a *100% Jeune* peer education session. Youth with medium exposure fulfilled one of these criteria, and all other youth are categorized as low.

least one peer education session; more than one in 20 youth had personally spoken with a peer educator; and exposure to the mass media programs was high, ranging from half to two-thirds or more of youth. Three out of four youth had read at least one issue of *100% Jeune Le Journal*—a high figure that corresponded with the magazine's high sales figures.

After adjusting for differences in the survey samples, a comparison of the first and second surveys in Cameroon revealed significant changes both in the predictors of condom use and in reported condom use among young men and women in the community overall. The most notable changes (among both sexes) included:

- Increased knowledge of a nearby condom source;
- Reduced shyness about buying condoms;
- Greater confidence in one's knowledge of correct condom use;
- Increased perception of parental support for condom use;
- Increased discussion of HIV and other STIs with friends; and
- Among women only, increased perception of personal risk and greater perceived support from peers for using condoms. (Data not shown.)

Consistent with these changes, sexually active young people reported higher levels of condom use in last sex and consistent condom use during this time period. These increases occurred in the overall youth population in the urban areas where the PSI program was active.

One would anticipate that youth with greater exposure to the program would be more likely to practice safe behavior than those who were less exposed. Further statistical analysis of the Cameroon survey data, including "dose response" analysis, shows the extent to which exposure to the *100% Jeune* program affected young people's perceptions and behaviors (see Table 4, page 13).

Data for both young men and young women show that high levels of exposure to *100% Jeune* is associated with reduced shyness about buying condoms, greater confidence in how to use condoms correctly, improved access to condoms, and greater discussion of AIDS and other STIs with friends (see Figures 1 and 2). In addition, the program motivated young men to internalize their risk for HIV/AIDS. In contrast, other potential influences on condom use, such as perceived parental support for adolescent condom use, do not appear to be related to program exposure in Cameroon.

The Cameroon program had different effects on the behaviors of young men and young women. Among sexually active males, program exposure was associated with greater use of condoms and modern family planning methods. Sexually active females exposed to the program were more likely to buy condoms compared with those who were not exposed to the program, but were not more likely to report using them. Although the program involved both male and female youth in managing the activities and delivering the messages, the program's messages may have resonated more with young men. These results may suggest the importance of developing and pretesting messages for males and females separately. The results may also reflect the fact that young women may be having sex with older men, and that can hinder their ability to negotiate using a condom.

Exposure to the program in Cameroon was not associated with changes in levels

of sexual activity, number of sexual partners, or STI treatment for either males or females. These results are consistent with the program's focus on motivating sexually active youth to use condoms. Because levels of sexual activity are already high among urban youth in Cameroon, the *100% Jeune* program will continue to emphasize improved understanding and internalization of STI and HIV risks and the need to use condoms consistently. Further research will assess the program's impact in these areas, and explain why the program had different results among young men and young women.

Program Results in Rwanda

Survey results in Rwanda revealed the reach of various program elements, including peer education, a monthly newspaper, and advertisements for *Centre Dushishoze*. In 2002, 18 percent of youth spontaneously recalled hearing about *Centre Dushishoze*, compared with less than 8 percent for most other reproductive health programs in Rwanda. Table 5 shows prompted recall of specific program elements. Compared to Cameroon's urban program sites, the Rwanda program had more limited reach because of limited access to the mass media, low literacy levels, and lower population density.

After adjusting for differences in the survey samples, a comparison of the first and second surveys in Rwanda revealed statistically significant changes in the predictors of condom use in the community where the program operates. The most notable changes (among both sexes) included:

- Increased likelihood of knowing someone who has died from HIV/AIDS;
- Increased discussion of STIs and AIDS during the past year;
- Increased confidence in condoms as an effective way to prevent HIV/AIDS;
- Increased knowledge of a nearby condom source; and
- Increased knowledge of where to find HIV testing and counseling services. (Data not shown.)

Consistent with these changes, reported levels of sexual activity declined between 2000 and 2002 in the overall

TABLE 5

Percent of Youth Ages 15 to 24 Who Recall Exposure to Rwanda's *Centre Dushishoze* Program Elements

	Percent
Ever seen billboards advertising *Centre Dushishoze*	24
Ever attended a PSI peer education session	8
Ever read *Indatwa Z'ejo* magazine in the past 3 months	3
Seen mobile video advertisements for *Centre Dushishoze* in past 3 months	3

TABLE 6

Effects of Program Exposure in Rwanda on Youth Perceptions and Behavior

Indicator	Relationship With Program Exposure	
	Males	Females
Condom Efficacy		
Believe condoms effectively prevent HIV/AIDS	Positive	Positive
Self-Efficacy		
Not shy to buy condoms	None	Positive
Knows correct condom use	Positive	Positive
Perceived Social Support		
Believe friends support condom use	Positive	Positive
Believe parents support youth using condoms	Positive	Positive
Discussed STI/HIV/AIDS in past year	Positive	Positive
Perceived Condom Access		
Knows condom source within 10 minutes from home	Positive	None
Perceived Health Risks		
Desire to postpone childbirth by 2 years or more	None	Positive
Perceive moderate/high risk of HIV/AIDS	None	Positive
HIV Testing		
Had HIV test in past year	Positive	Positive
Condom Use		
Ever used condoms	Wrong direction	None
Often/always use condoms with a regular partner	None	None
Used in last sex with regular partner	None	N/A*
Sexual Behavior		
Sexually experienced (ever had sex)	Wrong direction	None

*Results omitted due to small number of cases.
Notes: The analysis controlled for differences in the surveyed population, including age, school enrollment status, and area of residence. Data on condom use and sexual behavior is based on a small number of cases (only sexually active youth) and therefore must be interpreted with caution.

FIGURE 3

Rwanda: Changes in Attitudes and Behavior Among Young Men

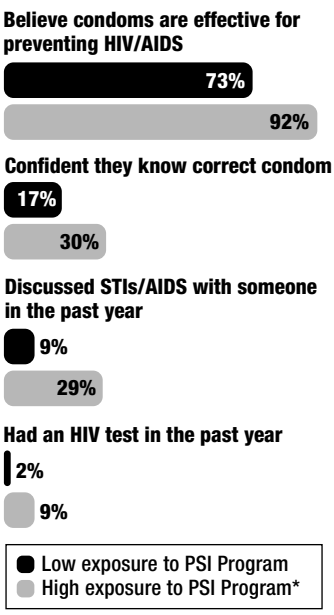
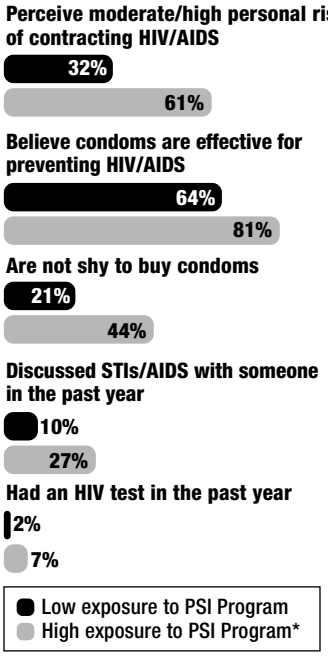


FIGURE 4

Rwanda: Changes in Attitudes and Behavior Among Young Women



Note: Changes shown are statistically significant at p≤.05. Analysis controlled for age, residential area, level of education, school enrollment, socioeconomic status, and number of sexual partners.

*High exposure is defined as exposure to two or more of the following program activities: 1) having ever seen a *Centre Dushishoze* billboard; 2) ever attending a peer education session or speaking with a peer educator; 3) hearing about *Centre Dushishoze* from friends; 4) reading the "Indatwa Z'ejo" newspaper in the previous three months; or 4) seeing the mobile video show or commercials for *Centre Dushishoze* in the previous three months.

youth population. Reported purchase of and use of condoms also increased for both sexes, and young men were more likely to report use of modern contraceptives. Although these results are positive, underreporting of sexual activity cannot be ruled out: Researchers suspect this underreporting occurs in most surveys conducted in Rwanda. According to the UN Joint Programme on HIV/AIDS, estimated HIV prevalence among 15-to-24-year-olds in Rwanda is 8 percent to 13 percent, suggesting that more young people (especially young women) are sexually active than is reported, and that rape and nonconsensual sex may be occurring.

The 2002 Rwanda survey revealed no statistically significant changes in reported condom use in last sex, consistent condom use, or the percentage of youth who had received an HIV test. While young people *exposed* to the program were much more likely to have had an HIV test (discussed below), these increases were not sufficient to have had an impact on the overall population in that area.

Further statistical analysis of the Rwanda survey data, including "dose response" analysis, shows the extent to which exposure to the PSI program elements affected the changes described above (see Table 6, page 15). Data for both young men and young women show that high levels of exposure to the program are associated with improved perceptions regarding the efficacy of condoms, knowledge about correct condom use, and perceived social support for preventive behaviors (see Figures 3 and 4). In addition, youth of both sexes who were exposed to the program are more likely to have received an HIV test. Among females, exposure to the program was associated with greater perceived reproductive health risks and decreased shyness to buy condoms. For males, the program also improved access to condoms.

One of the most puzzling results is the correlation between exposure to the program and increased levels of sexual activity and decreased levels of condom use among male youth (see Table 6, page 15). The reasons are unclear. Unfortunately, the low levels of reported sexual activity overall resulted in too few cases for analyzing condom use among the sexually active youth exposed to the program. During the remaining grant period, the Rwanda program will focus on motivating youth to abstain from sex or use condoms, improving young people's perception of HIV risk, and improving self-efficacy to negotiate safe behaviors—especially among females. Further research will assess the program's impact in these areas.

Preliminary Program Results in Madagascar

In Madagascar, political instability and severe weather led staff to postpone the second survey that would have taken place after 18 months of program activity. The results of the survey were thus not available at the time of this publication. Nevertheless, data on client visits from the service sites reveal increased activity following the program's youth-focused activities. The number of 15-to-24-year-olds seeking STI treatment and other reproductive health services from the *TOP Réseau* network rose dramatically in the first two years (see Figure 5), from 527 in the first quarter of 2001 to 2,202 in the fourth quarter of 2002. These clients were predominantly female; only

11 percent were male in December 2002. Program data showing doctors' reports of syndromes identified and treatments prescribed also revealed that the percentage of STI symptoms accurately treated by network doctors increased from 50 percent to 90 percent.

FIGURE 5

Madagascar: Youth Ages 15 to 24 Visiting *Top Réseau* Clinics

Future communication efforts in Madagascar will focus on motivating greater numbers of high-risk males and their partners to treat STIs and use condoms consistently. A second survey among 15-to-24-year-olds in Tamatave, conducted in November 2002, will be used to assess the program's impact on youth behavior.

Program Lessons

The program experiences and research findings from the first two years of youth-focused social marketing programs in Cameroon, Rwanda, and Madagascar provide valuable lessons on how to motivate young people to practice healthy behavior.

1. Social marketing programs can change social norms and behaviors. Using positive images of confident young women buying and discussing condoms—and of men who accept and respect these women—the *100% Jeune* program in Cameroon challenged the harmful gender stereotypes that prevent women from asking their partners to use condoms. Sexually experienced young men who had frequent and repeated exposure to the program were significantly more likely than others to report using condoms the last time they had sex. Young women exposed to the program were less shy than others about buying condoms and more knowledgeable about how to use them.

Health worker discusses STI prevention with a couple visiting one of PSI's youth-friendly clinics in Madagascar.

BOX 6

Common Perceptions About Social Marketing and Youth Programs, Compared With PSI's Experience

Common Perception	PSI Experience
1. It is socially unacceptable—and unrealistic for programs to expect—that girls ask their partners to use a condom.	1. Programs can create new social norms by endorsing and encouraging "positive deviants," i.e., youth who are willing to challenge standard behaviors to protect their health.
2. Youth centers do not reach many young people and therefore have little impact on their sexual and reproductive health.	2. Youth centers can succeed if they respond to the preferences and needs of youth—e.g., by offering health services that youth want and opportunities to develop employable skills, and by operating during evenings and weekends.
3. Youth should be involved in and manage the design, implementation, and evaluation of youth programs.	3. Adults need to assist youth in settings where youth do not have the skills or experience required to manage and evaluate programs.
4. Peer education is a practical and effective strategy for youth programs.	4. It is practical and effective, but difficult. Reaching large numbers of youth with high-quality, face-to-face communication requires the concerted efforts of several organizations as well as intensive management and evaluation. This is especially true when large numbers of youth are out of school.
5. Mass media can only raise awareness about a social issue or a product, not propel action.	5. Creative and research-based mass media activities can help shift social norms and contribute to behavior change.[1]

1. Dominique Meekers, Sohail Agha, and Megan Klein, "The Impact of the *100% Jeune* Youth-Centered Social Marketing Campaign in Cameroon," forthcoming working paper (Washington, DC: PSI).

2. There is no "silver bullet" to motivate youth to practice safe behavior. The factors that motivate young people to use condoms appear to vary from one group to another. In Cameroon, young people's perceived risk of contracting STIs and their self-efficacy (confidence to take action) were the strongest predictors of condom use among sexually active youth of both sexes.[3] However, in Madagascar, where HIV prevalence is substantially lower, the belief that condoms are an effective family planning method most influenced young men's use of condoms, and self-efficacy among young women had the strongest influence on condom use. To gain insight on the factors that might influence behavior most, programs should explore the perceptions and needs of target audiences before designing messages and activities.

3. Repeated exposure to multiple communication channels (television, radio, print materials, peer education) may be necessary to change youth behavior. One-off exposure to a program is usually not sufficient to prompt youth to critically assess their health risks and contemplate changing their behavior. Young men in Cameroon who had high exposure to two or more *100% Jeune* program elements were more likely to report condom use than young men who had less exposure. Future programs should aim to reach audiences with reinforcing messages and images—on a repeated basis—using a variety of communication channels.

4. Program design should take into account environmental and contextual factors. School enrollment rates and access to the mass media affect a pro-

gram's ability to communicate mutually reinforcing messages using a variety of different channels. Using television and radio to disseminate messages and images to large audiences combined with communicating in person in schools—or another organized network—is ideal. Also, well-developed commercial infrastructure allows programs to deliver products, information, and services to youth conveniently and affordably. PSI's experience confirmed that a high rate of school enrollments, popular mass media, and a vital commercial sector all enhanced program reach.

5. Promoting condoms for both family planning and STI prevention is beneficial, but young people need particular reinforcement regarding STI risks. In recent years, youth programs have highlighted the fact that condoms prevent pregnancy as well as STIs and HIV/AIDS, so that young people who want to use a condom can talk to their partner about preventing pregnancy to avoid the stigma associated with STIs and HIV. However, focus groups with youth in urban Cameroon revealed that young people who are mainly concerned with preventing pregnancy use condoms only sporadically—during their self-determined "fertile period." Thus, ensuring that condoms are used consistently requires reinforcing messages to help sexually active youth understand and internalize STI/HIV risks.

6. Improving the accessibility and quality of reproductive health care for youth requires frequent training sessions and rigorous supervision. A mystery client study conducted in the *TOP Réseau* clinic network in Madagascar found that annual trainings, bimonthly supervision visits, and a technical newsletter were not sufficient to standardize quality of care. Ensuring consistent adherence to youth-friendly STI diagnosis and treatment protocols requires regular refresher training courses as well as practical tools (PSI/Madagascar developed a flipchart for providers to refer to). Programs need recurrent—quarterly or biannual—training sessions to improve the consistency of youth-friendly service provision, especially when working with independent providers.

7. Integrating health programs with opportunities for personal development can attract females to youth centers. In Rwanda, the number of young women seeking HIV counseling and testing and other reproductive health services at *Centre Dushishoze*, the multipurpose youth center, increased dramatically when embroidery, auto mechanics, hairdressing, and other skill-building courses were offered. After introducing these courses, female clients visiting the center increased from 10 percent to 40 percent of all youth clients.

8. Putting in practice standard guidelines for program design, marketing, and research requires highly specialized skills. Behavior-change programs that are evidence-based need staff with the ability to direct and analyze research, convey complex behavioral concepts to research and advertising agencies, and apply best practices in youth programming. These specialized skills are not widely available in developing countries. Future programs should devote resources to build local capacity in this area.

9. Though cooperation from parents and other influential adults is critical, program activities must be designed with input from youth to achieve results. There is a

Billboard advertises *TOP Réseau* clinics as a source of confidential, youth-friendly reproductive health services in Madagascar.

To achieve behavior change, programs need to reach the target audience repeatedly, and through a mix of communication channels.

subtle yet important distinction between soliciting support from adults and basing youth programs on the perceptions and values of adults. More information is needed about the extent to which parents and other adults influence adolescent behavior, and how to most effectively promote dialogue between adults and adolescents on reproductive health.

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Photographer: Piers Benatar/Panos Pictures UK

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PSI is an international nonprofit organization dedicated to improving the health of low-income populations around the world. PSI operates AIDS prevention, family planning, and maternal and child health social marketing programs in more than 70 developing countries. PSI uses commercial marketing techniques to provide affordable health products and services through private sector outlets, along with a variety of communication techniques to encourage healthy behavior among target populations. AIDSMark is a 10-year, worldwide program, started in 1997, that uses social marketing to combat the spread of HIV/AIDS and other STIs.

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