

# **Sexual and Reproductive Health of Young People: Expanding the Research and Program Agenda**

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There are many compelling reasons for investing in young people's health and development. For one, young people aged 10-24 constitute some 1.8 billion and represent 27 percent of the world's population. Second and more important, behaviors formed and choices made by this large population have lasting implications for individual and public health, will determine the health of this generation as adults as well as the health and futures of the nations to which they belong. Third, although cohorts of young people are healthier, more urbanized and better educated than earlier generations, they face significant risks related to sexual and reproductive health, and many lack the knowledge and power to make informed sexual and reproductive choices. Fourth, programs thus far that address young people's sexual and reproductive health needs have had varied success. Many have overlooked the fact that young people are not a homogeneous group, and the ways in which they experience vulnerabilities and the extent to which interventions designed to ameliorate them are successful vary enormously by such factors as age, sex, marital status, class, schooling, work status, family structure, poverty levels, rural-urban residence and cultural context. Moreover, and further confounding the situation, is the lack of evidence-based precedent about effective interventions.

A decade of research and program focus on young people has to some extent enhanced what we know about young people's sexual and reproductive situation and needs in significant ways, yet gaps remain. I do not propose to synthesize what is known or to reiterate recommendations that are well established and have been addressed by research or programs in the field. Instead, I propose to argue here for the need to supplement our knowledge and programmatic interventions with regard to three specific issues related to young people's lives that need attention: (a) an overlooked sub-population of married adolescent girls; (b) an overlooked behavior of sex without consent; (c) programmatic interventions that work (or do not) in enhancing young people's health and development.

## **An Overlooked Sub-Population: Married Adolescent Girls**

To address the vulnerability of young people, research and program attention has focused on raising age at marriage. Indeed, available evidence suggests that substantial declines have occurred in the proportions of young males and females who are married in most developing country settings and today, small minorities (under 10 percent) of young males marry in adolescence (Mensch, Singh and Casterline 2005). However, notwithstanding these secular changes and the undeniable influence of years of schooling on delaying marriage, large proportions of females continue and will continue to marry in

adolescence in many developing countries. For example, at the turn of this century, about half of all women aged 20-24 were married by age 18, and about one-fifth by age 15, in Ethiopia and India; notwithstanding impressive changes in educational attainment, marriage in adolescence will undoubtedly continue to characterize large proportions of girls in these settings over the next decade (UNICEF 2005; IIPS and Macro 2000).

Research and programs for young people have, however, focused disproportionately on the unmarried and on premarital sexual activity. Indeed, married adolescent and young women have received little attention as a vulnerable group with distinct needs because marriage is assumed to be safe (Clark 2004) and because married adolescents are assumed to face none of the stigma that unmarried adolescents experience in accessing contraceptive, pregnancy-related and other sexual and reproductive health services (Santhya and Jejeebhoy 2003). Emerging evidence highlights that neither of these assumptions are tenable. In fact, married adolescent females are different from both married adults and unmarried adolescents and face a host of obstacles in making informed sexual and reproductive health decisions, in accessing services and in exercising agency in their lives more generally.

### *Pregnancy-Related Disadvantages*

For large proportions of married adolescents, pregnancy follows soon after marriage and occurs during adolescence. Morbidity and mortality related to pregnancy and childbirth across all developing regions remain among the most significant risks to young women's health (National Research Council and Institute of Medicine 2005). More adolescent girls die from pregnancy-related causes than from any other cause (PRB 2000). Although there are exceptions, most studies that have explored age differences in maternal mortality conclude that adolescents are more likely to suffer death than women in their 20s; so too, peri- and neo-natal mortality are significantly higher among adolescent mothers than among those in their 20s and 30s (for example, UNICEF, 2001; Adhikari, 2003; Kulkarni, 2003). The precise mechanisms that place adolescents at greater risk than women in their 20s are unclear: whether age is the key contributory factor or parity or such preventable factors as poorer diets and nutrition and access to care including delayed abortion seeking (National Research Council and Institute of Medicine 2005). For example, we know that many adolescent girls who become pregnant have not reached physical maturity and are anemic. Despite the fact that many experience their first pregnancies in adolescence, however, there is little evidence that care seeking is more pronounced among them. In India for example, two-thirds of adolescent and older women received antenatal care and 42-43 per cent delivered with a trained attendant (Santhya and Jejeebhoy 2003). In Nigeria, adolescents receive even less care than older women: 52 per cent of pregnant adolescents (aged 15-19) received antenatal care compared to 65 per cent of older women (aged 20-34) and only 24 per cent were delivered with a trained attendant, compared to 38 per cent among older women (DHS). Finally, delayed resort to abortion in case of unintended pregnancy may also play a role in the pregnancy-related disadvantages faced by married adolescents (Alan Guttmacher Institute 2004).

### *Unmet need for Contraception*

Even though substantial minorities express a preference to delay or space births (see for example, Santhya et al. 2001), the proportion of married adolescents who use contraception remains small, with only 1 per cent of married females aged 15-19 in Nigeria, 3 per cent in Pakistan, 8 per cent in India and 11 per cent in the Philippines using any method of contraception (PRB, 2000; IIPS and ORC Macro, 2000; National Population Commission (NPC), Nigeria and ORC Macro, 2004). Indeed, evidence from Nigeria suggests that only 4 per cent of married adolescent females used a modern contraceptive compared to 24 per cent of unmarried sexually active females (Alan Guttmacher Institute 2004). As a result, unplanned pregnancy is considerable among this cohort: for example, some 15 per cent of births to adolescent girls aged 15-19 were reportedly unplanned in India (Pachauri and Santhya 2003). While married adolescents are less likely than older women to use contraception, among those who do practice contraception, discontinuation and failure rates are more pronounced than among older couples (Singh 1998). Unmet need for contraception tends to be expressed by larger proportions of young women than adult women: for example, 27 per cent of adolescents (aged 15-19) compared to 19 per cent of older women expressed unmet need in India (Santhya and Jejeebhoy 2003). Several factors account for unmet need in this population, ranging from lack of awareness of specific reversible methods or their sources to limited communication and negotiation skills among newly married young women and couples (see for example, Santhya and Jejeebhoy 2003; Pachauri and Santhya 2003).

### *HIV/STI/RTI Risk*

In settings where marriage marks sexual initiation for girls, but not necessarily for boys, early marriage may expose adolescent girls to the risk of acquiring STIs or HIV even while it may reduce the number of sexual partners (see, for example, National Research Council and Institute of Medicine 2005). A study in urban settings in Kenya and Zambia notes that married adolescent girls have higher rates of HIV infection than do sexually active unmarried girls, and attributes this finding to several factors: for example, married adolescent girls have sex more frequently than the unmarried, they are less likely to use condoms consistently and they are less likely to negotiate or be able to refuse sex (Bruce and Clark 2004; Clark 2004). Studies in Ethiopia and India also observe that married young women are especially vulnerable to infection. For example, among pregnant women in Ethiopia, those with the highest HIV prevalence were young women aged 15-24, with an estimated prevalence of 12.1 per cent (Erulkar et al. 2005). In India, evidence from a small facility-based study confirms that young married women are at risk of HIV (Gangakhedkar et al. 1997). Likewise, in a community-based study among married women aged 16-22 in rural Tamil Nadu, 18 per cent were diagnosed with an STI acquired for the most part from their husbands (Joseph et al. 2003).

### *Social Vulnerability*

Underlying the sexual and reproductive health vulnerabilities discussed thus far are the profound social and economic vulnerabilities that married adolescent and young women face. For many young women, marriage signifies a break from the natal family and peer support, entry into an unfamiliar household and partnership relations with a husband with whom little previous contact existed. Agency, moreover, is typically limited and their

lives are characterized by limited decision-making authority and control over economic resources in their new homes and seclusion practices that inhibit their mobility and access to health care (UNICEF 2005; Barua and Kurz 2001; Santhya and Jejeebhoy 2003; Kulkarni 2003; Erulkar et al. 2005a). This lack of agency, compounded by unequal gender norms and power imbalances inhibit young women's ability to communicate and negotiate with their husbands on sexual matters, seek appropriate care or decide whether and when to have children. However, few providers and programs have been sensitive to these significant obstacles, and as a result, have continued to address the needs of married adolescents as they would married adults.

### *Interventions for Married Adolescents*

At least two models have been implemented in India for married adolescents. One focused specifically on enhancing contraceptive use and reducing unmet need for contraception through a series of home visits to young women to build awareness and provide contraceptive supplies. Group meetings were also organized for young women as well as husbands and other family members to raise community level awareness of contraception, pregnancy-related care and STI prevention and to dispel misconceptions. Key performance indicators suggest that a narrowly-focused intervention that aims to enhance contraceptive use can indeed succeed even in a poor and traditional setting. End-line evaluation was not however available (Wilder, Masilamani, Daniel 2005). The other model was much broader and addressed young women's health as well as their social vulnerabilities. It provided information on sexual and reproductive matters and sources of care; facilitated changes in existing health services so as to sensitize providers about the special needs of newly-wed women and encourage them to make home visits; enabled more intimate and trusting relationships between spouses; and formed social networks to provide a legitimate space for married adolescents to make contacts outside the home, build support systems and, in some cases, gain exposure to vocational skills, savings and other activities. Significantly, many husbands were themselves unaware of contraception and pregnancy-related care, but had been excluded by both socio-cultural norms and programs. Many husbands expressed an interest in expanding their knowledge and in supporting their wives. Activities therefore focused on building awareness among them, enhancing spousal interaction and encouraging young husbands to be supportive partners. What is particularly notable about this intervention is that it has used, for the most part, the available health and social infrastructure. For example, existing health service personnel themselves implemented the program, and links were made with existing programs intended to develop self-help groups among women (Ram et al. 2006). Both interventions are reported to be promising, but evaluations are pending that will determine the extent to which they are effective and acceptable and may be advocated as best practices appropriate for replication and expansion.

### **An Overlooked Behavior: Sex without Consent among Young People**

Although researchers have paid increasing attention to risky consensual sex among young people in developing countries, less emphasis has been placed on sexual experiences without consent, and most programming -- 'Abstinence, the need to Be faithful and Condom use' (ABC) messages, for example-- assumes that sexual activity is always voluntary. The issue of sex without consent among young people has considerable gender

and public health implications (Heise et al. 1999; National Research Council and Institute of Medicine 2005; Jejeebhoy et al., forthcoming 2006) and programs require a special focus on their experiences and needs. While experiences of non-consensual sex may occur at any age, young people are particularly vulnerable to unwanted sex as the circumstances of their lives and the resources at their disposal are quite different from those of adults. For example, they may be not as well equipped as adults to avoid non-consensual sex and in reality, may have fewer choices when they do experience such incidents. The situation is further compounded by unequal gender norms on the one hand and the lack of an appropriate legal and institutional framework in developing countries to address these issues on the other.

Indeed, the issue of non-consensual sex is so poorly addressed that definitions and terminologies remain unclear, and evidence on levels and patterns come largely from small and unrepresentative case studies. Non-consensual sex among young people encompasses behaviors that range from unwanted touch to unwanted penetrative sex; and from exercise of force to non-contact forms of abuse that may be experienced through threats, emotional manipulation and deception. Above all, the victim lacks realistic choices to prevent or redress the situation without facing severe physical or social consequences (Jejeebhoy and Bott 2006 forthcoming).

#### *Magnitude of Forced Penetrative Sex among Young Females and Males*

Evidence, almost entirely from small and unrepresentative studies, suggests that a large number of adolescent girls and even boys report non-consensual sexual experiences. For example, unwanted sexual relations are reported from under 5 per cent to over 20 per cent among young females and generally less than 10 per cent among young males (Jejeebhoy and Bott 2006). Among the sexually experienced, a recent study of adolescents (10-19) from slum sites in Addis Ababa notes that of the sexually experienced, one quarter of females and 18 percent of males reported they were coerced into their first sex (Erulkar et al 2005a). In the Philippines, a national study shows that 27 percent of young sexually experienced females did not want to have sex the first time but went along and 4 per cent reported that first sex was forced (Natividad and Marquez 2004). Coercion is also experienced by young women within marriage, as evident in several studies conducted in South Asia; in these largely qualitative studies, several recently-married, usually adolescent women typically described their first sexual experience as traumatic, distasteful, painful and frequently forced (Santhya and Jejeebhoy 2006 forthcoming).

#### *Attempted Rape, Unwanted Touch or Fondling/Molestation*

Young people may also experience non-penetrative non-consensual sexual experiences, such as unwanted touch or fondling, molestation and attempted rape. Findings from small studies in different settings in Africa and South Asia demonstrate the extent to which focusing solely on forced sexual intercourse can obscure the full picture of non-consensual sexual experiences among young people (see, for example, Ajuwon et al., 2001; Ajuwon, 2006 (forthcoming); Patel and Andrew 2001; Stewart et al. 1996). Evidence suggests that compared to the number of victims of non-consensual penetrative sex, considerably larger proportions of male and female adolescents or youth have experienced unwanted sexual touch, verbal intimidation, harassment or threats, and

‘unsuccessful’ attempts at forced penetrative sex. In a case study from Nigeria, for example, while 15 per cent of young females and 8 per cent of young males reported a forced penetrative sexual experience, 27 per cent and 10 per cent, respectively, reported attempted rape, assault and other attempts at forcing sex; and 44 per cent and 23 per cent reported unwanted sexual touch (Ajuwon, 2006, forthcoming).

#### *Outcomes and Help-seeking Behaviors*

The implications of non-consensual sexual experiences for young people’s rights, their health and development and the risks they pose in the transition to adulthood are often severe and multi-faceted. The experience of non-consensual sex has adverse short- and long-term health, behavioral, emotional, psychological and social consequences. Health consequences include unwanted pregnancy and consequent abortion, gynecological and sexually transmitted infections, including HIV (see Koenig et al. 2005; Mulugeta et al. 1998; Patel and Andrew 2006; Worku and Addisie 2002). Findings suggest close associations between early non-consensual sexual experiences and the experience of sexually transmitted infections, and subsequent risky behaviors, including unprotected sex, multiple sexual partners, subsequent consensual risky sex and drug and alcohol abuse (see Jejeebhoy and Bott 2006 forthcoming for a review). Mental health outcomes are also reported, including feelings of worthlessness and powerlessness, depression and suicidal thoughts (Mulugeta et al. 1998; Patel and Andrew 2006; United Nations ESCAP et al. 2001; Worku and Addisie 2002). A few researchers have explored help-seeking behaviors of young people who experience non-consensual sex. What we know is that young people perceive few help-seeking options in practice. Most stay silent and do not seek help, whether from family, friends, healthcare providers or the police (Gupta and Ailawadi, 2006 forthcoming).

#### *Interventions Thus Far*

Research from developed countries (notably the United States) has found that programs aimed at preventing the perpetration of non-consensual sex by equipping young people with skills to avoid unwanted sex have almost always failed (for example, see reviews by Chalk and King 1998; Finkelhor and Strapko 1992; Meyer and Stein 2000). Clearly, while life skills and sexuality education programs may be necessary, they are not sufficient to protect young people from sex without consent. Equally necessary are approaches that aim to address underlying norms, values and behaviors of young men who may be potential perpetrators. While programs aimed at promoting gender equity and non-violence among boys and young men have been launched in developing-country settings, few have as yet been evaluated (Barker 2003; EngenderHealth 2003; Guedes et al. 2002; Levack 2001; White et al. 2003).

### **Programmatic Interventions for Young People: What Works?**

Typically, interventions aimed at influencing young people’s sexual and reproductive health have focused on building awareness (family life and sex education, some may add a component on negotiation skills and gender sensitization) in schools settings, in out-of-school forums or through the mass media. Programs have also focused on enhancing access to services, for example, through the provision of youth-friendly services within health facilities or the creation of youth centers. However, few interventions conducted in

developing countries have been rigorously assessed, and those that have are overwhelmingly school- rather than community-based. Furthermore, these evaluations report mixed findings (Speizer et al. 2003; National Research Council and Institute of Medicine 2005). Interventions have generally been more successful in influencing knowledge and attitudes than changing behavior (although no evidence of increased sexual risk-taking was observed). Evidence supporting the efficacy of community- and facility-based interventions, including youth-friendly services and youth centre interventions, is also unclear. Indeed, one study in Ethiopia reports that youth centers reached only 12 per cent of adolescents and peer education reached 20 per cent, with boys more than twice as likely to have been reached as girls (Erulkar et al. 2005).

#### *Limitations of Existing Interventions: Coverage, Duration, and Content*

By and large, programs for young people have significant limitations. First, most are small pilot projects intended to serve a limited population and are often not replicable. Second, interventions have been relatively short in duration (from a few weeks/months to 2 years as observed in a review of interventions, Speizer et al. 2003), which may not be a sufficient period to test for changes in such behaviors as age at marriage or condom use. Third, the content of the sex education components of these interventions is often questionable, as it focuses on the biology of reproduction rather than such issues as relationships and communication (Aggleton and Crewe 2005). Fourth, interventions are overwhelmingly school-based, and exclude the large proportions of adolescents in many developing country settings who have discontinued schooling and can only be reached through community-level initiatives, undoubtedly a challenging task. And finally, few have recognized the special and different needs of young people in rural and urban poor communities.

#### *Limitations of the Scope of Existing Interventions*

There is a growing recognition that effective interventions to improve the sexual and reproductive health of young people may lie outside a narrowly defined sex education and clinical agenda and there is a need to integrate health with other significant aspects of young people's lives. There are a few interventions that have focused on a broader livelihoods approach that aims to build agency and livelihood skills among youth (thus far females) while imparting sexual and reproductive health information, counseling and services; this approach also incorporates the stated preference expressed by youth for programs that incorporate elements beyond sex and reproduction, as discussed above (Mensch et al. 2004; Ganju and Jejeebhoy 2004). The approach has been premised on previous research that suggests that girls who have opportunities to work or have participated in livelihoods programs are more likely than others to report self-esteem, social mobility, participation in family discussions about marriage and delayed marriage (Amin 1999; Assaad and Bruce 1997; Jejeebhoy and Halli 2005). It is also premised on research among adult women, which suggests, likewise, that those who have participated in livelihoods or credit programs, or who have decision-making authority or control over resources, are more likely than others to report better health outcomes in the family, increased age at marriage and smaller desired family sizes (Sebstad and Singh 1998; Schuler and Hashmi 1994). The assumption is that integrated programs not only expand their life and livelihood opportunities, but will also enhance their ability to forge

equitable relationships with husbands and make health-related decisions and informed choices, including in the sexual and reproductive health arenas (see for example, Assaad and Bruce 1997; Pathfinder/Futures/CEDPA/USAID, 2001).

Essentially, the integrated approach focuses on delivering technical and life skills, transforming the ways in which girls view themselves, building social networks and developing critical financial and income-generating capacity (Population Council and ICRW 2000). Findings from a few pilot studies implemented in India (Kalyanwala et al. 2005; Mensch et al. 2004; Levitt-Dayal et al. 2003; Pathfinder/Futures/CEDPA/ USAID, 2001) have suggested that integrated projects are not only more likely to engage the interest of participants, but also to enhance their awareness of sexual and reproductive matters and enhance certain aspects of their agency. Indeed, findings from at least one such program suggests that compared to a group that received only family life education, the group that also received vocational skill-building opportunities fared significantly better not only in terms of agency but also in terms of post-intervention tests of sexual and reproductive health awareness (Mensch et al. 2004).

#### *Limitations of Existing Evaluation Designs*

Methodologies used to evaluate interventions—both those focused on raising awareness and enhancing access to services, and those that incorporate a more expanded focus -- have been limited in several respects and, as yet, insufficient data exist to assess the relative effectiveness of different approaches (National Research Council and Institute of Medicine 2005). Indeed, a recent review of interventions to build awareness and increase access to services found only 41 evaluations in developing countries that were based on scientifically sound designs, of which half were school-based programs and only 9 were community- or facility-based (Speizer et al. 2003). Likewise, a recent assessment of three livelihoods programs conducted in India highlight the methodological limitations of these programs (Kalyanwala et al. 2005). Major constraints in current designs are: (a) many lack a control group and hence it is impossible to tell the extent to which participation in a program may be responsible for changes observed, if any; (b) conversely, many lack a baseline benchmark and simply assess the situation among two groups, presumed to be similar except for the introduction of an intervention in one at a single point in time; (c) even where a quasi-experimental design is implemented, failure to follow up an adequate number of baseline participants—youth are a mobile population -- undermines the conclusions; (d) many evaluations use short-term indicators (for example, pre- and post-test awareness levels), and do not adequately indicate influence on behavior, attitudes or access to appropriate health care that may require observation after a sufficiently long period of time post-intervention (see, for example, Singh et al. 2005); and (e) such issues as selection bias have not always been adequately controlled. Conclusions therefore remain tentative, providing evidence of promising rather than best program practices.

### **Looking Forward**

#### *Addressing the Needs of Married Adolescents*

Two issues are highlighted: first, despite increasing age at marriage, significant proportions of women will continue to marry in adolescence in many developing



countries. Second, the situation of married adolescent girls is very different from both those of unmarried adolescent girls and married adult women, posing different vulnerabilities and suggesting therefore different strategies for enhancing sexual and reproductive health. Programs that aim to enhance awareness of good health practices must therefore be designed in ways that acknowledge and address the limited agency and access to reproductive health services experienced by married adolescents. Formative research is needed that explores: (a) maternal mortality among adolescents and the relative roles of biology and social norms that contribute to maternal mortality and the risks faced by this group; (b) health seeking practices and obstacles to timely care on sexual and reproductive matters; (c) factors underlying the considerable unmet need for contraception expressed by young women and men; (d) the context of sexual initiation within marriage among both young women and their husbands, with regard to safety and wantedness; (e) risk and experience of infection within marriage; and finally (f) intimacy and communication among the newly married. At the same time, there is an urgent need to develop and test the extent to which alternative intervention models are indeed effective and acceptable, and can be confidently advocated as a best rather than a promising practice.

#### *Putting Sex without Consent on the SRH Agenda*

Sex without consent among young people is a poorly understood subject and research on this issue involves a host of methodological challenges. The research agenda in this highly sensitive topic is therefore huge and multifaceted (Jejeebhoy, Shah, Thapa 2006 forthcoming). Formative studies are needed that more fully investigate how young people perceive, experience and react to non-consensual sex, the context in which such experiences take place and the role of the family and institutional environments in protecting young people from sex without consent. At the same time, research is needed that explores the consequences of non-consensual sex for young people's lives, and notably their sexual, reproductive and mental health. More information is needed on help-seeking behaviors and preferences, and the factors inhibiting youth from disclosing coercive experiences to parents or other influential adults. Studies also need to explore in depth the suggestion that the school, the home and the health facility may not always be a safe haven against non-consensual sex.

Although non-consensual sexual experiences may be a key factor underlying the compromised sexual and reproductive health of, and the spread of infections including HIV experienced by young people in developing countries, intervention models are particularly scarce that aim to prevent sex without consent. Operations research must answer several key questions: How can girls and young women be protected from sex without consent? How can boys and young men best be brought up and taught to reject the perpetration of sex without consent. Do existing interventions for youth—life skills programs, school system-level activities and health sector modifications, for example— influence attitudes to and experiences of sex without consent?

At the same time, interventions are needed in other areas. For example, interventions are needed for young males that build alternative norms of masculinity and sensitize boys against the perpetration of sex without consent. Moreover, programs are needed to enable health care providers to identify and support survivors of sex without consent (see Bott et

al. 2006 forthcoming); sensitize teachers to the incidence of sex without consent and enable them to identify and counsel youth who face threats of sexual violence or have experienced it (see Mirsky 2006, forthcoming); and work with parents to offer children a supportive environment and promote gender egalitarian norms among their sons and daughters.

### *From Promising to Best Practices*

As discussed above, there is a dearth of rigorous evaluations of sexual and reproductive health interventions for youth in developing countries, and findings of the few available evaluations are mixed. Urgently needed are rigorously designed and tested intervention models that not only pay attention to the content and delivery of the intervention but also measure effectiveness and acceptability --in short, that will enable a shift from the implementation of promising to best practices in addressing young people's needs. In order to inform the field, multiple inputs are required.

First, where awareness-building programs are implemented, their content and duration need to be addressed. We need, for example, a better understanding of (a) the content of the multiple available modules and curricula focused on young people's sexual and reproductive health and a consensus on the critical dimensions of these; and (b) an optimal time-frame for interventions that accepts that behavior change is a gradual process.

Second, there is a need to explore interventions beyond narrowly-defined and standard awareness building and service provision models. Indeed, many have argued for multiple-component community-based strategies, that is, for programs to focus holistically on enriching young people's and specifically young girls' lives (National Research Council and Institute of Medicine 2005). These include programs that, for example, focus on developing positive masculinity or that enhance school quality, recognizing that school attendance and attainment may have an important and positive influence on young people's health but that such aspects of the school experience as sexual coercion and unequal treatment of girls in the classroom can mitigate this influence. In particular, they also include programs that implement the broader livelihoods approach discussed earlier, that have revealed promise in several instances (Kalyanwala et al. 2005; Mensch et al. 2004; Levitt-Dayal 2003). Research would need to explore the following: What is the relative experience of the narrower versus the broader approaches discussed? Are multiple-component programs more effective than others in influencing sexual and reproductive behavior change? Are they more acceptable? In short, program models need to be tested that go beyond sex education, family planning, information provision and service delivery to well-tested integrated interventions that are sensitive to the disparate needs of heterogeneous groups of young people.

Finally, there is an urgent need to redress the paucity of rigorously evaluated interventions. First, even if cross-sectional designs are implemented, it is critical that data are available over a sufficiently long period of time so as to enable the assessment of impact. For example, changes in some attitudes and many behaviors (for example, delayed marriage and first birth, circumstances of first sex for those who had not yet experienced sexual relations) may not be visible at the conclusion of a short intervention.

What is needed is a study design that builds in such time lags. Second, methodologies need to go beyond the standard boundaries of sexual and reproductive health knowledge, attitudes and behavior, and encompass changes in other aspects of young people's lives, in particular, agency, gender role attitudes, confidence about discussing life choices with parents or other mentors and school continuation. Third, designs must recognize the mobility of youth and incorporate strategies that enable adequate follow-up of intervention participants. Finally, research capacity in many developing countries is limited, and there is an urgent need to develop a cadre of researchers who have advanced multi-disciplinary research and human development perspectives within key countries who can design and implement these studies.

### *Summing up*

This paper's focus on three areas of relatively poorly addressed or understood aspects of young people's sexual and reproductive health and development should not detract from the fact that in general, young people's situation and needs and the life choices they make remain poorly understood and served and that the attention paid to young people over the last decade must be sustained. What I have argued for here is an expansion of the agenda to incorporate an overlooked sub-population and an overlooked behavior on the one hand; and for more inclusive and scientifically evaluated interventions on the other.

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