Delivering sexual and reproductive health services to young people:
Key lessons from Marie Stopes International’s programmes
Marie Stopes International delivers quality family planning and reproductive healthcare to millions of the world’s poorest and most vulnerable women.

**Vision:** A world in which every birth is wanted

**Mission:** Children by choice, not chance

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**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
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<tbody>
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<td>CAP</td>
<td>Consolidated Appeals Process</td>
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<td>CERF</td>
<td>Central Emergency Response Fund</td>
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<td>CRHS</td>
<td>Comprehensive reproductive health services</td>
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<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<td>CYP</td>
<td>Couple year protection</td>
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<td>Direct Relief International</td>
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<td>European Commission Humanitarian Aid and Civil Protection</td>
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<td>EmOC</td>
<td>Emergency obstetric care</td>
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<td>FPA</td>
<td>Framework partnership agreement</td>
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<td>GBV</td>
<td>Gender based violence</td>
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<td>IDPs</td>
<td>Internally displaced populations</td>
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<td>MISP</td>
<td>Minimum Initial Service Package</td>
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<td>MSI</td>
<td>Marie Stopes International</td>
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<td>Non governmental organisations</td>
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<td>National Health Cluster</td>
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<td>Office of Coordination of Humanitarian Affairs</td>
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<td>Reproductive Health Access, Information and Services in Emergencies</td>
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<td>Reproductive health</td>
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<td>World Health Organisation</td>
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Executive summary

Young people – defined here as individuals between 10 and 24 years of age – need access to high-quality, age-appropriate, sexual and reproductive health (SRH) services, but the evidence demonstrating effective strategies to meet this challenge is still developing. Further study and dissemination of successful approaches can help governments, communities, health providers and young people themselves meet the needs of this diverse and growing group.

In 2012, Marie Stopes International reached more young clients than ever before: approximately 30% of our clients were under the age of 25. By sharing our approach, challenges and emerging successes, we aim to contribute to the wider understanding and debates on how best to meet the needs of young people.

Identifying and scaling up effective strategies to help young people make informed, healthy choices about their sexual and reproductive lives is critical. We know that too many young people have limited information about SRH and many others face discrimination when they do try to seek services. Alongside education, ensuring that young people have access to a comprehensive package of SRH services delivered in a supportive and respectful environment is key to empowering young people and preventing poor health, thus contributing to the Millennium Development Goals on maternal and child health, gender equity and HIV.

The international community has prioritised the introduction and scale up of ‘youth friendly’ approaches to education and service delivery. MSI has broad and growing experience of working with and reaching young people with SRH services. Our approach is informed by the knowledge that young people are a diverse group with varying constraints, choices, and preferences, and that young people need to be at the centre of developing new innovative models and solutions for delivering SRH services.

BOX 1: Defining young people.

‘Adolescents’ are defined in accordance with the United Nations definition, as individuals between 10 and 19 years of age

‘Youth’ is also defined in accordance with the United Nations definition, as an individual between 15 and 24 years of age.

In this report, we use the term ‘young people’ to refer to youths and adolescents, individuals between 10 and 24 years of age.

Source: UNFPA. State of the world population. 2003

This paper shares some of the strategies that MSI used to reach clients under the age of 25 in 2012. We made specific ‘youth friendly’ adaptations to our static clinics, called ‘centres,’ and outreach services to better respond to young clients’ needs. Through mainstreaming a ‘youth friendly’ environment in static centres – for example providing privacy in the waiting room, offering evening and weekend walk-in appointments, and integrating SRH services with general health services – our 620 static centres are working to ensure that young clients feel more comfortable and confident in seeking services. Our 370 outreach teams attract high numbers of married, young women seeking contraceptive services. But too often rural, single youth do not seek services because adults in their community are present at outreach sites. Strategies that bring services directly to these young clients in their schools and workplaces have proven successful. Flexibility to offer services in youth centres and mini-clinics provides further options for meeting young people’s needs in their own community.

Recognising that young people face high levels of discrimination and stigma, we work closely with communities to change attitudes about young people’s SRH. Many young people lack the confidence and knowledge to negotiate safer sex or plan ahead for contraceptive needs. Hence, education and counselling are key. We are working in partnership
with youth organisations, schools, governments and community leaders to empower young people to make informed, healthy decisions. Innovative use of technology offers promising new confidential ways to reach young people. Finally, we ensure that when young people do seek out services, they are met by highly qualified, non-judgemental providers offering services that are affordable to the many young people living at or below the poverty line.

By sharing our experiences and recommendations, we aim to contribute to a growing body of evidence offering strategies and solutions for how to deliver accessible, acceptable, affordable and high-quality SRH services for the world’s 3 billion young people.
Chapter 1: Introduction

1.1 The need for sexual and reproductive health services for young people

Globally, there are approximately 222 million women with an unmet need for contraception; 50 million of whom are under the age of 25. Nearly 16 million adolescent girls give birth every year – the majority of these births occur within the context of early marriage and 90% occur in developing countries. In addition, 7.4 million adolescent girls experience unplanned pregnancy, in part, due to a lack of access to contraceptives. In sub-Saharan Africa, for example, up to 68% of adolescents have an unmet need for contraception.

This issue is compounded by the fact that high failure rates and discontinuation in the use of contraception are more likely among adolescents, often due to preferences for short term methods of contraception, possible side effects and their appropriate management, the sporadic need for contraception and continued challenges in correct and consistent contraceptive use.

In many countries, pregnant girls are less likely than adult women to receive adequate antenatal health care or deliver their child with skilled professionals.

Pregnant girls face a higher risk of maternal morbidity and maternal mortality than adult women and girls between 15 and 19 years of age are two-times more likely to die during pregnancy than women 20 years of age or older. Preventable complications arising from pregnancy and childbirth are the leading cause of death amongst adolescent girls in developing countries. In addition, three million unsafe abortions occur annually amongst girls between 15 and 19 years of age.

Young people are also particularly at risk from HIV. Young people account for 41% of all new adult infections. Surveys in low and middle income countries reveal that only 33% of young men and 20% of young women have a comprehensive knowledge of HIV. In addition, condom use remains low amongst young people. In sub-Saharan Africa, less than half of young men and women surveyed reported using condoms at their last time of sexual activity.

Identifying effective strategies to reach young people with comprehensive SRH services and education is key to reducing high rates of HIV, STIs, maternal morbidity and mortality.
1.2 MSI’s strategy to overcome barriers and reach young people

As a leading provider of SRH services, MSI can play an important role in expanding access for young people to sexual and reproductive health and rights (SRHR). Since 2000, we have implemented programming with a specific youth focus in 30 countries. In addition to service delivery, we are active in comprehensive SRH education, regularly training government and private providers in ‘youth friendly’ techniques alongside advocacy campaigns to promote and protect the SRH of young people.

In 2012, MSI reached a record number of clients under the age of 25 – approximately 30% of all clients. The majority of these clients were 20-25 years old (23%), while 7% were 19 or younger. While this is positive progress, and a greater proportion of our clients are younger than regional averages for contraceptive use (see Figure 1), more work is needed to meet young people’s SRH needs at scale.

Our youth focused programmes are designed and implemented according to key principles that are supported by international frameworks. In line with the World Health Organization (WHO) guidelines on making services youth-friendly, we work to increase community acceptance of young people accessing SRH services as well as increase knowledge and acceptance among young people themselves. Recognising that access to services is a key barrier, we adapt our models to improve accessibility for young clients. Our different services delivery channels – static clinics, outreach services, community based engagement and strengthening the capacity of other providers – allow for a flexible approach to meet differing youth needs. Finally, we ensure that our services are effective by delivering excellence in clinical quality and follow-up through the continuum of care.

Strategic partnerships are key to MSI’s approach. We implement youth-friendly services in partnership with local youth organisations, governments and key community stakeholders. These partnerships capitalise on existing resources and expertise to increase the accessibility and use of SRH services by young people. Our collaboration with governments and other NGOs allows the organisation to achieve a wider-reaching impact than could be achieved alone.
Chapter 2: Ensuring accessibility: service delivery models that reach young people

2.1 What services should be offered to young people?

Simply put, young people want a package of services that meets their needs. A comprehensive, context-specific understanding of young people’s needs, preferences and realities is the foundation for defining both the appropriate service package as well as the best model for delivering services. Hearing directly from young people about what they need and how they want to access services has helped many MSI programmes design appropriate services packages.

As would be expected, there are wide variations in young people’s cultural and contextual preferences. In Malawi, young women have voiced their preference for more ‘discrete’ contraceptive methods, such as injectables. In both Asia and sub-Saharan Africa, young, single clients report a reluctance to use long-acting reversible contraception (LARC) as they perceive these methods to be for married women or women in long-term relationships. Many young women are unaware that LARCs can be removed at any time or believe myths that using LARCs cause infertility. Reports like these support the evidence that young women are more likely to rely on short term methods, which have higher discontinuation and failure rates than LARCs.15 As is true for all clients, counselling young women to ensure a complete, accurate understanding of the broad range of contraceptive options available is important for choice and for adherence to the method they choose.

Broadly, the United National Populations Fund (UNFPA) Framework for Action on Adolescents and Youth offers guidelines on the core package for young clients. In addition to clinical services, young people should be linked to appropriate social services through a robust referral network. This core package integrates SRH with HIV and general health services with clear linkages to gender-based violence counselling and critical social services (see Box 2).

**BOX 2: What services should be offered to young clients?**

- SRH (core): information, counselling and services for safe motherhood, contraception, post-abortion care, STIs, nutrition education and menstrual hygiene.
- HIV/AIDS (core): information, education and counselling for HIV, access to condoms, voluntary counselling and testing (VCT), STI diagnosis and treatment and anti-retroviral therapy.
- Gender-based violence counselling and management.
- General health services.
- Social services (through referrals); legal, psychosocial and career counselling, shelter and rehabilitation series, income generating services and other youth programmes and services.

Source: UNFPA, Framework for action on adolescents and youth Opening doors with young people: 4 keys. 2007
2.2 Offering integrated services

Integration of SRH services with other key services and counselling is important. Studies have shown that young people value convenience; offering multiple services together saves clients time and effort. Moreover, combining SRH services with general health services offers young people a measure of confidentiality when seeking contraception, post-abortion care or HIV services. At integrated service delivery locations, young clients could just as easily be seeking a general health service as a contraceptive method.

Our experience reinforces the growing consensus around how integrated service delivery supports improved uptake of SRH services for young people. Our general medical check-ups are popular among young clients. During these visits, young people have an opportunity to ask questions of a qualified provider and gain access to a full range of SRH services.

In Papua New Guinea, we have designed an integrated service package specifically for young people. Clients are provided with a ‘well-youth check,’ providing a range of critical services including a general medical check-up, HIV voluntary testing and counselling, STI screening, contraceptive counselling, pregnancy testing, breast or testicular check-ups and antenatal care if the client is a young mother. This package has proved highly popular. In its first year (2010-11) more than 1,400 young people received a ‘well-youth check’. This model was not without challenges, however, including a reported reluctance among some young people to attend the centre when adult clients were present. In cases like this, strong feedback mechanisms to ensure young people’s preferences are heard have allowed us to adapt client flow in centres to reduce young people’s exposure to adult clients and provide them with privacy in waiting rooms and other common areas.

In countries with a generalised HIV epidemic where governments and non-profit organisations have developed effective models for reaching young at-risk or HIV-positive individuals, opportunities exist for integrating contraceptive services into HIV programmes. Our outreach work in Zambia and Malawi delivering male circumcision for partial protection against acquiring HIV reaches a high proportion of young men under 19 years of age. Counselling young men on male circumcision offers a starting point for conversations about wider SRH issues, including condom use and contraception options for themselves and their partners.

2.3 Making centre-based services youth friendly

MSI’s network of 620 static clinics, called ‘centres,’ serve high-density urban and peri-urban areas where many young people live, work, go to school, socialise and raise their families. Adapting existing health services to be more youth-friendly helps increase uptake of SRH services among young people.

In 2012, young clients sought contraceptive counselling, short term and long acting methods, STI screening and treatment, post-abortion care and general health services. A similar or greater proportion of our static centre contraception clients are young people than are national averages of young people using contraception. This is achieved through efforts to make young clients feel comfortable and aligns with our philosophy to put clients and their needs at the centre of everything we do.

2.3.1 Mainstreaming youth friendly services in existing MSI centres

Large-scale population-based surveys of young people conducted in Kenya and Zimbabwe asked young people to rate which aspects of facility-based SRH service delivery are most important to them. Confidentiality and a short waiting time ranked as the first and second most important drivers of ‘youth-friendliness.’ Affordability ranked third, and integration of SRH services with other medical services in a ‘one-stop-shop’ clinical visit ranked fourth. Opening hours that fit young people’s varied schedules was among the top ten most important aspects to Kenyan and Zimbabwean youth.

Based on the evidence, we have mainstreamed a youth-friendly approach in existing static centres through key initiatives to protect confidentiality and extend opening hours, in addition to offering integrated service packages at affordable prices. Confidentiality is critical. A young person’s journey through the MSI centre is an important component of protecting his or her confidentiality and ensuring that he or she feels comfortable during the visit. Not requiring clients to announce at reception the specific service they are seeking reduces possible embarrassment or fear of judgement for young clients. Not requiring clients to state their marital status is also important. Client flow that reduces the amount of time young clients spend in mixed-age waiting rooms helps as well. Ensuring that both general health and contraceptive services can be obtained in the same area of the centre and accompanying young people as they move between...
different areas of a centre – for example from laboratory services through the waiting room to the counselling room – is a third supportive measure for young clients.

Offering extended opening hours has been a successful strategy to make static centres more accessible to young people. Feedback from client exit interviews and other monitoring mechanisms demonstrates that young people find evenings, weekends and school holidays more convenient times to seek services. Accordingly, some of our centres open exclusively for young people in evenings and over weekends. These special hours may include fewer clinicians so as to control costs. In response to demonstrated evidence that young people disproportionately tend not to plan in advance,22, 23 extended opening hours accommodate walk-in clients with appointments on-demand.

Evidence generated on youth friendliness at static clinics supports the possibility that such measures increase service uptake. In their 2003 quantitative and qualitative study on youth friendly interventions at NGO operated centres in Lusaka, Zambia, researchers found that youth-friendly elements did improve the clinic experience for young people. The majority of the ten ‘youth intervention’ clinics served more young clients compared with the ‘non-intervention’ sites. The study also identified that community attitudes toward young people accessing SRH services had an even larger impact on the health-seeking behaviour of young people.24

2.3.2 Introducing new mini-clinics and youth centres
In a number of countries, MSI operates mini-clinics, small service delivery points typically consisting only of a waiting room and consultation / procedure room. Often located in urban slums and other underserved urban areas, mini-clinics are a versatile way to bring services closer to clients including urban youth. While studies have shown that locating clinical services within a youth centre does not guarantee use of SRH services by young people,25 our experiences in Zambia and Bangladesh show that uptake can improve with appropriate services and activities and community engagement.

Since 2009, MSI Zambia has run a mini-clinic from within a youth centre in Lusaka to better meet the needs of young people in the city’s slum neighbourhoods. The youth centre, run by the HIV organisation, Africa Directions, is a multi-purpose site designed to reach disadvantaged young people with HIV services and recreational activities. With the addition of MSI’s involvement, young people can access a full range of contraceptive and STI services in addition to HIV services, gender based violence counselling, general medical services and child immunisations. While the mini-clinic also offers services to adults, adult clients are allowed in the facility only for their clinical services, all recreational activities are youth-only to foster a sense of youth ownership and safe space. In 2011, 44% of the mini-clinic’s clients were young people demonstrating the promise of joining a mini-clinic with a youth centre to attract young clients.

In Bangladesh in 1998, we identified that while mini-clinics were effectively reaching adults, young people were not accessing services despite their great numbers in mini-clinics’ catchment areas. To identify the barriers that young people faced, MSI Bangladesh conducted a participatory needs assessment with local youth. This revealed the need for service availability in after-school hours, youth-oriented branding and communications, and a preference for young service providers and counsellors.

In response, we launched boys and girls clubs linked with existing mini-clinics. Called Moni-Mukta Ashor, meaning a meeting place of gems, clubs ran from 3-6pm daily, after the clinics had finished their routine clinical hours giving young people exclusive access to the facilities. During club / clinical hours, young people participate in ‘life skills’ training, health education sessions and recreational activities. In addition, a team of young male and female service providers, trained in adolescent SRH issues, provide one-to-one SRH counselling and clinical services three days per week. Services are highly subsidised to ensure that cost is not a barrier to uptake. Operating for more than ten years, the model has proved successful. Using the existing mini-clinic infrastructure and providing services three days per week, which allows providers to rotate between locations, keeps costs to a minimum while meeting the needs and preferences of young clients.

Bangladesh’s boys and girls clubs is an example adapting a youth centre model for the needs and opportunities of the context. To reach young people, youth centres have been established by MSI programmes in Bangladesh, Nepal, Malawi and Zimbabwe. These centres may or may not offer clinical services directly; often services are accessible through a referral linkage between the youth centre and an MSI static clinic. The youth centre model varies across settings depending on community needs. In Zimbabwe, four youth centres were introduced,
three attached to an MSI static clinic and one located near an MSI static clinic. We also established a network of youth volunteers to conduct community awareness around each youth centre. This approach resulted in considerable success; the number of young clients accessing services at the MSI static clinics increased nine-fold from 2006 to 2009.

In Nepal, MSI introduced 35 youth information centres. Five of these centres were attached to existing MSI static clinics, and the other 30 were run in conjunction with existing community-based organisations. At each youth information centre, a youth peer educator provided comprehensive SRH information and clinical referrals to young people. Clinical providers at static centres also received training to provide more youth-friendly counselling and clinical services. Between 2007 and 2009, 69,900 young people received information and SRH education at the 35 youth centres. During the same period, 24,000 young people received SRH services at an MSI Nepal static centre, 88% of these clients received contraceptive services.

Despite these successes, wider evidence from the literature on youth programming points to a mixed efficacy record of youth centres for reaching young people with SRH services.26, 27 Our experience demonstrates that youth centres can be valuable mechanisms for directly and indirectly supporting delivery of SRH services; however, limitations remain. Youth centres are typically not financially sustainable and, in some contexts, face challenges reaching underserved girls and young women. Additionally, there is limited evidence to demonstrate that youth centres actually increase the utilisation of SRH services among young people.28 Of the 11,974 young people that attended boys and girls clubs in Bangladesh from January 2008 to March 2012, only 19% received one-to-one SRH counselling and fewer than 19% were referred on for an SRH service. The majority, rather, attended clubs for recreational and educational reasons.

Studies show that youth centres are typically used by boys and young men including those outside the targeted age range.25 Our experience supports this finding, in Nepal and Zimbabwe MSI youth centres have been used predominately by young males and male youth-peer educators. This is in part due to the fact that young men tend to have greater freedom of movement than young women. To address this issue, we introduced targeted campaigns to encourage parents to grant permission for their daughters to attend youth centres. In Bangladesh, boys and girls clubs have separate times reserved for each gender. This approach has been helpful in encouraging girls’ attendance at the youth clubs and mini-clinics. However, young, married women remain unwilling or unable to access support services or clinical services through youth centres. This underscores the fact that the needs of youth populations are diverse and that youth centres alone do not ensure equitable access to SRH support and services.

Despite important limitations, mini-clinics and youth centres offer feasible models for improve young people’s access to services. Access to services is a key driver of youth uptake of SRH services. In fact, not knowing where to go for services was the most frequently cited reason for lack of uptake among young people interviewed in large scale population based surveys in Kenya and Zimbabwe.29 Dedicated, youth-friendly sites offer an opportunity to overcome key barriers including knowledge / awareness of where to go and young people’s fear of disapproval by communities/providers and discrimination from providers. In addition, these centres offer a critical platform for ‘life skills’ building that forms the foundation of young people’s uptake of SRH services.
2.4 Mobile outreach for young people

MSI’s mobile clinical outreach involves delivery of SRH services by a team of clinicians who make routine visits to rural and hard-to-reach public sector facilities that are otherwise unable to offer clients a full range of services, especially LARCs. Evidence shows that young people disproportionately under-use LARC methods, instead relying on short-term methods. Young people also have higher contraceptive discontinuation and failure rates than their adult counterparts. Mobile outreach serves to broaden the contraceptive method mix available to young people, making LARC an option for young clients wishing to delay childbearing or space their pregnancies.

Mobile outreach is an important channel of service delivery for MSI. In 2012, 44% of the couple years of protection (CYPs) delivered by MSI were delivered through mobile outreach. Despite the success in reaching underserved women, mobile outreach is more effective in reaching some cohorts of young clients than others.

Mobile outreach teams’ service delivery days are highly publicised events in the communities that these clinical teams visit. Scheduled visits are advertised in advance at the outreach site, typically lower level public health centres in remote and rural locations. In addition, community health workers are often engaged to raise awareness about family planning and alert the community to the timing of mobile teams’ visits.

Attendance by young, married women seeking out contraception for child spacing and limiting is strong. However, due to the public nature of attending an outreach day, unmarried young women can be dissuaded from attending outreach clinics due to fears of family, peer, community and provider disapproval. Providing young, married women with contraceptive and other SRH services is critical for better maternal and child health outcomes. Reaching unmarried youth, however, requires innovation and adaptation to the classic mobile outreach model.

Successful strategies for reaching underserved young people focus on bringing services closer to where they are and where they feel comfortable. Marketplaces, educational settings and workplace settings have proven to be promising locations to reach young people who may be unwilling or unable to attend an SRH centre alongside adult members of their community.

In Zambia, MSI delivers voluntary medical male circumcision services to young men seeking lifetime partial protection from acquiring HIV. Delivering services in a mobile outreach site located near a popular market brought a high number of young men seeking male circumcision counselling and the procedure. Building on this success, in consultation with local youth groups, MSI Zambia selected additional marketplace sites, intensifying service delivery during school and university holidays and on weekends.

Like markets, delivering services in educational settings, such as vocational colleges and universities, is an effective strategy to reach high numbers of young people in a setting in which they feel comfortable. Anecdotally, MSI’s experience shows that even where institutions of higher learning routinely offer clinical services for young people, many prefer the anonymity of service delivery from an outside organisation. In Ghana, MSI has relationships with all large universities and regularly delivers educational lectures, small group workshops and referrals for SRH services.

In comparison with institutions of higher education, delivery of SRH education and services in secondary schools remains challenging. Some countries, including Malawi and Zambia, explicitly prohibit delivery of SRH services in secondary schools. In others, such as Sierra Leone, MSI is exploring channels for advocacy to government on the benefits of sex education and family planning services for teenagers in school. Even where sex education is included in national curriculums, these topics can be censored by teachers due to teaching time constraints or because teachers do not agree with teaching these topics. Evidence shows that many teachers and other trusted adults do not routinely talk with young people about SRH topics because they disapprove of young people having sex.

To help combat these curriculum gaps, in Bangladesh and Nepal, MSI gained permission and developed sex education curriculums, training groups of teachers to deliver SRH lessons to students. Continued engagement with these teacher groups, as well as ongoing engagement with Ministries of Education, supports delivery of these lessons in schools.

Delivering SRH services in workplace settings has proven to be an effective strategy for reaching young people in sectors that employ a high number of young workers. Evidence from Bangladesh shows that clinical outreach in workplace settings can be provided in a cost-effective way through health insurance schemes that are co-funded by employers (see Box 3).
BOX 3: Clinical outreach in factories: the health card scheme

Since 1996, MSI has conducted outreach in garment factories to reach young migrant women in Bangladesh. It is estimated that between 70 and 80% of garment factory staff are women and over 70% are young adults. These migrant workers are highly vulnerable to poor SRH. Many lack sufficient knowledge of SRH and internal migration often exposes them to greater SRH risks. We introduced clinical outreach and a social insurance scheme – “the health card scheme” – in the districts of Dhaka, Chittagong, Khulna and Tongi. Under the scheme, factory owners agree to contribute 15 Tk (20 cents/11p) per worker per month for health services delivered to their employees on the factory site. The clinical outreach team visit factories participating in the scheme twice a month and provide free SRH and general health services to workers.

The health card scheme allowed us to reach a large number of young workers efficiently and cost effectively. At the project’s peak in 2003, 11,299 young people in 180 factories accessed services delivered by our outreach teams. In 2005, the scheme recovered 81% of total operating costs. This model is, however, dependent on the continued profitability of the garment sector and attitudes of factory owners. A decline in the number of factories participating in the scheme was due to factory closure. More positively, some factories recognised the benefit of health services for their employees and decided to replace outreach teams with permanent health services on site. Despite these challenges, this model remains one of the more successful strategies used by MSI to serve young women in Bangladesh. In 2012, MSI continues to deliver clinical services under the “health card scheme” in 65 factories.

Our experience in Bangladesh was not without challenges. Initial resistance by factory owners took more than a year to overcome. A sustained advocacy campaign and the support of national and international industry associations helped to a broad network of individual factory owners. Time constraints and requirements for minimal disruption to factory production meant that outreach teams needed to deliver both education and services in the same visit. By introducing a peer education programme, workplace education could happen before and between provider visits.

Leveraging the organisation of existing youth groups has helped MSI reach young people in a number of countries. In Zambia, MSI offers sex education and contraceptive counselling to in and out of school youth through football tournaments organised by Grass Roots Soccer. MSI staff in Zambia note, however, that while recreational activities reach large numbers of young people, mobilisation and service delivery spike during the immediate period after an event but do not produce a sustained increase in service uptake among young people.

Single, out of school youth are a particularly challenging cohort to reach. In Ghana, poor girls and women from the country’s rural north travel from their villages to seek work in the capital, Accra, often working as porters in markets. Locally known as Kayayei, these girls and women have little or no access to education and often lack even basic shelter, sleeping in the markets at night. Many are the victims of sexual exploitation, violence and human trafficking. Through outreach to these girls and women, MSI Ghana makes regular visits to the main Accra markets to deliver counselling and services. At the same time, the team is developing structures and referral systems to enable survivors of sexual and gender-based violence to receive support and services. MSI Ghana works closely with the Society for Women Against Aids in Africa to reach the Kayayei communities and receives support from the Domestic Violence and Victim Support Unit of the Ghana Police Service to help increase access to information and services. A combination of direct service provision together with coordinated stakeholder action is enabling MSI Ghana to improve the lives and health of one of the country’s most vulnerable groups of young women.
2.5 Engaging community-based distributors

Reaching young people who are not in school or formal work poses a number of challenges. Many of these youth are unmarried and therefore unwilling or unable to access SRH services on community outreach days. Others may not think they need SRH services. In fact, single youth report infrequent sex as the main reason for not seeking contraceptive services. To reach these groups, MSI successfully uses community-based distributors (CBDs) and youth behaviour change communication (BCC) agents to engage young clients.

Trained CBDs conduct counselling with clients and distribute short-term contraception, condoms and emergency contraception. Typically living in the communities that they serve, CBDs are available for ‘on-demand’ counselling and services and are therefore the first line in access to information and prevention of mistimed pregnancy. This ‘on-demand’ availability helps meet the needs of young people who disproportionately don’t plan ahead and often have sex at infrequent intervals.

CBDs in Burkina Faso conduct health talks in schools and community centres, subsequently meeting young people in private settings for one-to-one counselling. As a snapshot, in December 2011, significant proportions of clients reached by CBDs were young people – 44% in urban areas and 17% in rural locations. These CBDs also report that the majority of clients to whom they distribute short-term methods are single, young people.

CBDs have also been used to facilitate young people’s access to MSI outreach days. In Burkina Faso, where unmarried young people frequently report unwillingness to attend outreach clinics where adults are present, community agents contact young people whom they know wish to seek services. They then help arrange a visit to the outreach site during times when outreach is less busy, for example at the end of the day. These young people can be seen quickly and more confidentially during these times. While this approach has worked well in Burkina Faso, it relies heavily on community knowledge and relationships and may be difficult to implement at scale.

In Malawi, CBDs initially reported difficulty reaching single young people because CBDs were older married women who tended to serve their peers, other older married women. In response, MSI’s team recruited 350 young male and female CBDs, training them to deliver basic counselling and distribute condoms and oral contraceptives. Between 2006 and 2009, the first years of the programme, MSI’s young CBDs provided 30,022 pill cycles to 16,808 young women and 827,000 condoms. Research shows that most of what young people know about sex and related topics comes from their friends and the media, rather than parents or teachers. Therefore, this peer-to-peer engagement builds on existing dynamics that form the basis of young people’s understanding about sex and sexual health.

Engaging young people as CBDs is not without challenges. Low retention rates – particularly among female CBDs – is common. In Malawi, MSI incorporated income generating activities within the CBD role to help motivate retention. Across all CBD programmes, it is important to invest in recruiting and training new CBDs to help ensure high quality engagement with clients and mitigate low retention rates.

In Sierra Leone, using community BCC agents to provide counselling and community awareness of service delivery days yielded strong increase in client uptake on outreach among adult and young clients (see Box 4).
**BOX 4: The inclusion of young people as behaviour change assistants within clinical outreach teams**

Between December 2010 and March 2011, MSI piloted the inclusion of young people as BCC assistants in existing clinical outreach teams in Sierra Leone. This pilot aimed to increase the awareness and utilisation of family planning services by young people. Through our partnership with the youth led development organisation, Restless Development, we recruited BCC assistants from an existing pool of young men and women already trained in BCC and community awareness raising strategies.

BCC assistants conducted peer-led research to inform our marketing campaigns to promote positive SRH behaviours among young people. An existing WHO knowledge, attitudes and practices (KAP) survey was adapted so that it was more suited to young respondents included in focus group discussions led by the BCC assistants. Over 140 young people took part in the survey, which revealed a lack of knowledge amongst young men regarding contraception and young women's lack of empowerment to purchase or insist on the use of condoms. As a result, we developed a successful marketing campaign centred on the key messages: “Young man, impress the girls and know your contraceptive options” and “Girls, sex is sweet, but so is life; insist on a condom and enjoy both.”

BCC assistants conducted educational activities to raise awareness of SRH issues and services provided by MSI’s clinical outreach teams. Educational activities included drama, songs, events in schools, sporting activities and stakeholder meetings. The BCC assistants coordinated their activities with the schedule of the outreach team, to ensure demand for services could be immediately met. BCC assistants also tailored their activities to raise awareness of specific services and educate young people on particular SRH issues. Examples included encouraging pregnant adolescents to give birth with skilled attendants at health facilities. In addition, BCC assistants supported the clinical outreach team to conduct health talks, manage the client flow and answer client questions.

To ensure cost did not remain a barrier, fees were removed for all services delivered by the clinical outreach team. The addition of the BCC assistants and the removal of fees contributed to a 48% increase in the number of young clients seen by three outreach teams between December 2010 and March 2011.

**FIGURE 2**

Number of young clients and percentage of young clients at MSI outreach sites in Sierra Leone, September 2010 – March 2011.
Chapter 3: Supporting acceptability: community awareness and youth education

Adapting service delivery models to effectively reach young people is critical. However, a supportive environment is an important precursor to service uptake among young people. MSI works to support a conducive environment through changing attitudes and developing awareness amongst community leaders, religious leaders, parents, and guardians, helping to reduce the fear of community disapproval that many young people face. The importance and time commitment of these activities cannot be underestimated. For example, in Zambia MSI engaged in 54 community stakeholder meetings before inroads could be made to reaching the communities’ young people with essential services.

3.1 Creating an enabling environment for youth services

MSI uses a broad range of strategies to sensitise and encourage the community acceptance of youth access to SRH services. These approaches include:

- **Media**: In Bangladesh, MSI works to orientate journalists on SRH issues and disseminate key adolescent health messages through print media. MSI has developed short films promoting parent-child dialogue on SRH issues, airing these films at community venues.

- **Participatory theatre**: In Bangladesh and Sierra Leone MSI trains young people in participatory theatre, organising dramas on SRH issues to community audiences.

- **Parent workshops and parent-youth debates**: In Nepal and Bangladesh, mothers and fathers are educated separately on SRH issues including how they can support their daughters’ and sons’ health. In Nepal, parent–youth debates encouraged dialogue between parents and their children.

- **Parent peer-educators**: In Bangladesh, MSI trained a network of volunteer parent peer-educators to educate and support other parents in the community on issues relating to their children’s SRH.

- **Educating parents through existing opportunities**: In several countries, MSI outreach providers include in their one-to-one counselling of adult clients information on the importance of their young adult children’s SRH.

- **Community stakeholder groups**: In Bangladesh, Nepal and Zambia, MSI organises advisory groups of community stakeholders to inform and educate their neighbours on young people’s health needs and help ensure community buy in to programme activities.

3.2 Comprehensive education and youth branding

Young people’s behaviour is strongly influenced by their environment, including the attitudes and actions of their family, friends, community, media and cultural norms. Young people need ‘life skills’ that help them navigate difficult issues and make healthy choices. Young people often lack the confidence, information or skills to plan ahead for contraceptive needs before a sexual encounter, negotiate condom use with partners, and proactively seek assistance when they need it.

Youth centres and peer educators offer opportunities to deliver community based ‘life skills’ programmes that have shown results for improved service uptake.

In addition to ‘life skills’ and sex education, SRH services need to be communicated in a way that helps young people see the relevance to their lives. In our experience, many sexually active single young people do not identify with the terms ‘family planning’ or ‘maternal health services’ since they are not yet a mother or planning a family. In response, we communicate our mission, ‘Children by Choice, not Chance’ as simply ‘by Choice, not Chance’ to reflect the different motivations and realities of young people.

Evidence shows a deep disparity in knowledge of contraceptive methods between young people and adults. Figure 3 demonstrates this knowledge gap.
between one of the hardest to reach groups – very low income 15-19 year olds – and the average for all women in sub-Saharan Africa and south Asia. Therefore, youth education involves not only communicating about contraception in a way that resonates with young people but also conveying accurate, comprehensive information about their contraceptive method options.

Youth-oriented communications and branding are best designed by listening to the voices and solutions of young people. In Bangladesh, Timor Leste and Papua New Guinea, MSI develops communications campaigns and branding strategies in consultation with the young people we aim to reach. All aspects, from informational brochures to product packaging to service components are developed through organised consultation including youth focus groups and exit interviews that sample young client’s opinions. In Pakistan, MSI has even developed a separate branding strategy for its interactive website aimed at young users, thereby helping to remove any stigma associated with accessing information from an organisation known for family planning.

Part of effectively communicating with young people involves making serious and often scary topics like unplanned pregnancy and STIs more accessible and acceptable to discuss. MSI uses ‘edutainment’ as a mechanism to communicate sensitive topics to audiences of young people and normalise discussion of sex and relationships. Edutainment activities like

### FIGURE 3
Knowledge of methods: comparison between poorest, unmarried 15-19 year olds and average for all women, sub-Saharan Africa (MSI countries, 2012)

<table>
<thead>
<tr>
<th></th>
<th>IUDs</th>
<th>Implants</th>
<th>Female sterilisations</th>
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<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorest, unmarried 15-19 year olds</td>
<td>13%</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td>Average for women aged 15-49</td>
<td>40%</td>
<td>49%</td>
<td>46%</td>
</tr>
<tr>
<td>Knowledge of methods: comparison between poorest, unmarried 15-19 year olds and average for all women, south Asia (MSI countries, 2012)</td>
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<tr>
<td>South Asia</td>
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<tr>
<td>Poorest, unmarried 15-19 year olds</td>
<td>40%</td>
<td>3%</td>
<td>98%</td>
</tr>
<tr>
<td>Average for women aged 15-49</td>
<td>71%</td>
<td>6%</td>
<td>97%</td>
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</tbody>
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comedies, sports shows, dramas, videos and music routinely attract large numbers of in and out of school youth and can be presented in conjunction with a youth focused outreach counselling and service delivery day.

Helping young people gain the life skills, knowledge and confidence around their sexuality and sexual health needs is critical to improve the acceptability of SRH services for all young people.

3.3 Leveraging technology to reach young people

MSI’s use of eHealth innovations – the application of internet and mobile phone technology to health programmes – is a new and promising approach to increase access for young people. Growth in mobile phone access in developing countries has grown exponentially, rising from a world-wide total of one billion mobile phone subscriptions in 2000 to six billion in 2012. Young people are more technology savvy than ever and leveraging this aptitude and interest has great potential.

In settings where mobile phone coverage is high, MSI uses mobile technology to convey confidential information, counselling, and follow-up services. In Timor Leste, we run a toll free youth hotline – Kiss Info Line – designed to provide high quality SRH information to young people and refer callers to a range of SRH services provided by MSI and other outlets. The hotline is advertised on the radio and through television campaigns. Within the first five months of operation – August to December 2011 – the line received 1,608 calls, 81% of which were from callers under 25.

Our website in Pakistan and infoline in South Africa offer additional examples of the power of internet and mobile technology to reach young people (see Box 5). However, eHealth innovations have proven more effective for reaching young men than young women, due to a disparity in access to internet and mobile phones. The early success of Time Leste’s hotline was driven by young men (84% of callers). Similarly, our website in Pakistan is accessed predominately by young men. Until patterns of gender and income equity in utilisation of technology improve, MSI sees eHealth innovations as a promising way to reach many young people but not suitable for groups that remain unable to access this technology.

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**BOX 5: Using eHealth innovations to increase access to SRH information for young people.**

**Infoline service in South Africa:**
In 2011, MSI introduced a mobile phone infoline to increase young people’s access to SRH information via their mobile phone. On accessing the infoline, individuals are prompted to answer a series of automated text message questions to ascertain the nature of their enquiry; for example: “I think am pregnant” (next tab) “I haven’t done a pregnancy test” (next tab) “I want to speak to a consultant” (send). Each query is received at our call centre and responded to appropriately; either the client is called back (or sent the toll-free number of the call centre by text message) or a pre-prepared template answer is sent via text message. The infoline is primarily promoted to young people in low-income, peri-urban settlements, where seven of our mini-clinics are located. In the first 38 weeks of operation (June 2011 – March 2012) 32,923 queries were received by the mobile infoline, the majority relating to pregnancy (9590, 29%) and requests for information for family planning (6203, 19%).

**SRH Matters website in Pakistan:**
In 2008, MSI set up the website – SRH Matters – in Pakistan. The website is bi-lingual (Urdu and English) and targets individuals of reproductive age in urban areas. Visitors to the website can submit questions via an online form, which are answered within 24 hours by a psychologist or doctor employed by MSI as consultants. To promote efficiency, pre-prepared answers have been developed to common questions. Between July and December 2011, the website received 24,983 visits. At its peak approximately 75 questions were submitted daily. The majority of visits are by males between 18 and 25 years of age and females between 24 and 30 years of age.
Chapter 4: Cross-cutting issues: quality and equity

Regardless of where a service is offered – in a static centre, on outreach, or through a community-based distributor – cross cutting issues of quality and equity require careful attention.

Delivering and maintaining high quality youth-friendly SRH services is essential for increasing utilisation of SRH services by young people. Young people are more likely to access and return to a service delivery site where they feel their needs are being met in a confidential manner by non-judgemental staff. Young people's choice of service provider is influenced by their peers, therefore it is critical to cultivate a reputation among young people for accessible, affordable, non-judgemental services.

4.1 Equipping providers with youth-friendly skills

Our experience supports the position that delivering youth-friendly services require specific skills that often need to be taught, monitored and reinforced. We train clinical, administrative and counselling staff in skills, attitudes and technical knowledge to deliver youth friendly services. Across MSI, youth-friendly training is mainstreamed into introductory and refresher trainings and, for specific providers, delivered as a comprehensive specialist training. This training includes values clarification to support staff in developing a positive attitude toward young people seeking out important SRH services.

In Nepal, in the absence of a national curriculum, we deliver a seven-day training package of SRH services, which features technical modules on youth services. In Malawi, we collaborate with young people themselves to inform service providers on their needs and preferences. Representatives from a local youth club participate in youth friendliness training alongside clinical providers.

In Malawi, Nepal and Time Leste, government stakeholders have engaged us to strengthen youth approach in public and private sectors. In Malawi and Nepal, we have delivered youth-friendly training to government providers as well as to large groups of pharmacists, owning and operating pharmacies that are often the first port of call for young people seeking contraceptive products.

Monitoring high-quality services delivered in a non-judgemental fashion is important. We use mystery client visits to randomly verify that youth-friendly principles are adhered to in our service delivery outlets. In addition, exit interviews are routinely conducted to solicit feedback directly from young clients. Suggestion boxes located in centres, feedback forms, and the proactive inclusion of young people as participants in evaluations provide opportunities to not only ensure that MSI providers and administrative staff are meeting young clients' needs but also improve our approach.

In addition to provider knowledge and attitudes, providers' profiles matter to young clients. MSI staff have consistently cited the importance of providers' age and gender for improving acceptability among young people. In Bangladesh and Nepal, MSI offers young men a male SRH counsellor and young women, a female counsellor. Continuity of provider matters too. Young people need time to build rapport and trust with providers in order to disclose sensitive information. Therefore, ensuring that young people have consistent access to the same providers training in a youth-friendly approach can help support young people's willingness to seek services.
4.2 Making services affordable

Cost remains a barrier between many young people and the services they need and want. In a large-scale population-based survey in Kenya and Zimbabwe, researchers found affordability to be the third most important aspect of ‘youth-friendliness,’ as reported by young people themselves. Unmarried young people in particular are often financially dependent on adults and may fear reprimand or disapproval if requesting money for SRH services.

In Sierra Leone, the introduction of free intrauterine devices (IUDs) in March 2010 sparked increased demand for this method such that Marie Stopes Sierra Leone removed fees from all contraceptive services from October 2010 onward, contributing to substantial rise in demand among young people for all methods of family planning (see Figure 2).

Providing free or highly subsidised services presents several challenges including financial sustainability for private providers and difficulties targeting subsidies to the young people who need them with minimum ‘leakage’ to higher income groups and / or adult clients. We have successfully used voucher programmes to better direct subsidies to high need groups, including young people. As a demand-side financing mechanism, vouchers convey purchasing power to eligible clients allowing them to choose their provider (from among those participating in the scheme) and their service of choice. Voucher programmes offer an incentive to providers to make services more youth-friendly, as multiple providers compete with one another to attract young clients with vouchers and the payments from MSI that these voucher services attract. Voucher programmes have been shown to increase contraceptive choice for young people.

In Sierra Leone, the introduction of a voucher programme to subsidise LARC among MSI’s social franchisees has contributed to a significant increase in the proportion of young people who are using the service; from 53.7% (73 young people of a sample of 144 clients) to 66.1% (222 young people of a sample of 244 clients) between August 2010 and June 2011. Similarly, during a one-month pilot of a similar voucher programme in Malawi, 47% of clients who used vouchers to obtain subsidised LARC were between 15 and 24 years of age. Approximately 50% of these young people accessed contraceptive services for the first time. We continue to expand our use of voucher programmes to target underserved young people.
Chapter 5: Conclusion and recommendations

Effective strategies to deliver SRH services to young people at scale are critical. Services need to be tailored to the diverse needs and realities the young people face. They must also reach the most disadvantaged and highly vulnerable young people and promote equitable access.

Designing and implementing strategies to bring youth-friendly services to excluded and underserved populations has provided MSI with best practices and common lessons learned across contexts. The following recommendations stem from tried and tested approaches across low resource settings.

Mainstreaming youth-friendly programming in existing facilities

• Youth-friendly services can be integrated into existing service delivery channels by emphasising confidentiality and convenience, for example through extended opening hours, avoiding wait time for young people in rooms with adult clients, not requiring young people to announce services they require at reception, and ensuring service providers are trained in a non-judgemental youth-friendly approach.

• Mini-clinics are a promising way to provide services for young people. They are relatively easy to integrate with existing non-SRH services and have lower operational costs than larger centres.

• Although youth centres can increase the uptake of services among youth and serve as an important place for educational activities, youth centres have a mixed record of reaching young women and can be utilised by non-target groups. However, depending on the context, youth centres may be an important modality to reach young people.

Bringing services close to young clients

• Mobile outreach services tend to be utilised more by married clients than unmarried clients and as such may miss opportunities to serve high need young people. However, clinical outreach can be targeted to locations where young people spend their time, e.g. schools, social and workplace settings. Permission to reach young people in these settings can take substantial advocacy efforts; engagement and sensitisation well in advance of the start date of service provision is recommended.

• CBDs can play multiple roles, including educating young people and providing them with short-term contraceptive methods and referrals for LARCs. Programmes that have recruited young people as CBDs have seen growth in provision of short-term methods. Evidence shows that young people gain most of their information about sex and reproductive health from other young people, recruiting young CBDs leverage this dynamic of peer-to-peer communication.

• Using technology to reach young people is a promising way to educate and refer for services. eHealth innovations such as the SRH website in Pakistan or the mobile infoline in South Africa are low cost, confidential ways to inform and refer young people.
Investing in communications and partnerships

• SRH services can be made more relevant to young people through effective branding and communications on popular media outlets. Media is a proven source of young people’s information on sex and reproductive health. Involving young people themselves in the development of media communications helps ensure that efforts reach the intended audience.

• Community involvement strengthens the effectiveness of SRH programmes. Investing in community relationships and awareness raising helps change opinions in support of young people’s access to services.

• Forming partnerships with existing international and local youth focused organisations provides options for service delivery points, referral mechanisms and education on SRH topics.

Making services affordable

• Appropriate pricing strategies are instrumental for increased uptake among young clients. Several MSI programmes have seen service utilisation increase when fees are either removed or reduced. Voucher programmes can effectively target subsidies to high need groups, including low income young people.

Young people are not a homogenous group – their needs vary depending on their location, age, sex, marital status, sexual orientation, level of education, source of income and cultural influences. Involving young people in the design and implementation of youth-friendly approaches is key to any effective operational strategy. Involving young people not only helps ensure that services meet their needs; it also reinforces their agency and responsibility in making choices about their sexual and reproductive health. These choices impact their health outcomes and their futures. By putting the needs of young clients at the centre of MSI’s strategy and operations, our health providers will continue to improve and increase service delivery to young people.

Quality is key

• Providers make a significant difference in determining whether services are acceptable to young people. High-quality, youth-friendly training for service providers requires that programmes provide youth friendly training to staff. This includes values clarification to ensure non-judgemental and confidential care is provided.

• Allowing the opportunity for feedback directly from young clients serves as an important monitoring mechanism. Using comment boxes, client exit interviews and mystery clients helps ensure that young friendly components are implemented in a consistent manner.
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Marie Stopes International
1 Conway Street
Fitzroy Square
London W1T 6LP

t: +44 (0)20 7636 6200
f: +44 (0)20 7034 2369
e: info@mariestopes.org
w: www.mariestopes.org

Registered charity number: 265543
Company number: 1102208