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Making Reproductive Health Services Youth Friendly

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LIST OF ACRONYMS

AHI	Action Health Incorporated (Nigeria)
ARFH	Association for Reproductive and Family Health (Nigeria)
AVSC	Access to Voluntary and Safe Contraception
CORA	*Centro de Orientacion para Adolescentes* (Mexico)
CPI	Client Provider Interaction
FHI	Family Health International
HIV	human immunodeficiency virus
HRC	High Risk Clinic (Kenya)
IMSS	Mexican Institute of Social Security
INPPARES	*Instituto Peruano de Paternidad Responsable* (Peru)
INTRAH	International Training in Health
IPPF	International Planned Parenthood Federation
IPPF/WHR	IPPF/Western Hemisphere Region
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/CCP	Johns Hopkins University, Center for Communication Programs
JHU/PCS	Johns Hopkins University, Population Communication Services
NGO	nongovernmental organization
PATH	Program for Appropriate Technology in Health
PLA	participatory learning and action
PREA	Educational Program for Adolescent Mothers (Mexico)
PRIME	Program for International Training in Health
PSFN	*Prosuperacion Familiar Neolonesa* (Mexico)
RH	reproductive health
STD	sexually transmitted disease
TOT	training of trainers
UNICEF	United Nations Children's Fund
WAYI	West Africa Youth Initiative
WHO	World Health Organization

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EXECUTIVE SUMMARY

There is a growing recognition among reproductive health providers throughout the world that "youth-friendly" services are needed if young people are to be adequately provided with reproductive health care. Such services are able to effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining these young clients for continuing care. Whether services are provided in a clinical setting, in a youth center or at a workplace or through outreach to informal venues, certain youth-friendly characteristics are essential to effective programs. Basic components include specially trained providers, privacy, confidentiality, and accessibility.

As the life stage of adolescence becomes better defined and better understood, efforts to meet this group's age-specific needs have emerged, including providing reproductive health services—programs formerly reserved for older, married women. While younger, married women were allowed to receive such services in the past, limited consideration was given to any special needs because of their biological development and emotional maturity. Unmarried, young women and young men were effectively excluded.

More young people now need reproductive health care, especially prevention services. In many places, this need is a result of a longer period of nonmarital sexual activity, related to earlier menarche, later marriage, greater economic opportunities for women, increased urbanization, and liberalizing attitudes influenced considerably by modern mass communications. Furthermore, this sexual activity is occurring in the midst of an HIV pandemic that disproportionately affects adolescents and young adults.

Given that young people tend not to use existing reproductive health services, specialized approaches must be established to attract, serve, and retain young clients. From young people's points of view, they face many barriers to service use, including laws and policies that may restrict their access to affordable services and useful information, embarrassment at being seen at clinics, fear that confidentiality will not be honored, and concern that staff members will be hostile and judgmental. Many operational barriers also exist, such as inconvenient operating times, lack of transportation, and high cost of services.

Many of these barriers can be addressed by programs serving young people. Perhaps the single most important action any reproductive health program for young adults can implement is the selection, training, and supervision of staff members to work with adolescents, with a major emphasis on attitude, respect for young people, and the development of interpersonal skills to promote good provider-client communication. Other provider characteristics that programs should consider include an emphasis on privacy and confidentiality, the allowance of adequate time for discussion, and the availability of trained peers as a counseling option

For the clinical setting, facility characteristics that programs can establish or adapt include separate space or special times for teen clients only, convenient hours, accessible location, adequate space with sufficient privacy, and comfortable surroundings. A key aspect of any design of a youth-friendly program should be the involvement of young people in helping to determine the features that best relate to their needs and comfort level. Some of these design characteristics include allowing clients to receive services without appointments (as "drop-ins"), reducing overcrowding and waiting times, setting affordable fee schedules, developing publicity and recruitment activities that effectively inform potential youth clients, providing for males as partners and as clients themselves, and ensuring that most needed services are available on site and that good referrals are available for those needed services not offered. Many other adjustments are possible although perhaps less central, such as the availability of useful educational materials, group discussions or counseling options, delay of the pelvic examination, and outreach service alternatives.

Several program models have been developed to include youth-friendly characteristics in a clinical setting. Earlier programs were generally established for prenatal and postpartum care, in part because pregnant young women were already presenting for services. Such programs emphasized utilization of staff members specially trained to work with young women, and strengthened efforts to improve nutrition, to foster breast-feeding, and to provide contraception to delay the next birth. Limited evaluation findings show results and effects that include increased prenatal visits, longer duration of breast-feeding, lower rates of infant morbidity and mortality, and higher rates of postpartum contraception use. Specialized nutritional programs for pregnant young women resulted in improved birth outcomes. Postabortion programs for adolescents have also developed, showing an increase in subsequent contraceptive use and a decrease in abortion rates.

More challenging are programs designed as preventive health care, both because providers are hesitant to serve unmarried, young adults and because young people must be educated about their needs and convinced that services will treat them responsively and respectfully. Some programs attempting to put together a youth-friendly package of characteristics were established as demonstrations and were evaluated accordingly. Results were mixed, although mainly positive, including increased numbers of young clients and greater contraceptive use by this group.

Newer efforts have emerged that bring services to locations where young people are learning, working and socializing. Schools and factories have become venues for provision of some services, while outreach workers, often peers, bring services to the marketplace, sports field and village gathering places. Pharmacies and social marketing activities are beginning to target young adults as customers for reproductive health commodities. Telephone hotlines, mass media and other communication approaches help provide information, motivation and referral to service delivery points.

Yet many obstacles to providing youth-friendly services remain. Serving young people with reproductive health care is still a sensitive issue in many places. Providers, whose attitudes often reflect this societal concern, can resist serving young people or, if services are established, still prove unresponsive to adolescent needs. Costs and adjustments are required to make services appealing and relevant for adolescents, sometimes involving changes and expenses beyond the capability of facilities. Finally, laws and policies remain restrictive or ambiguous, compromising clear protocols for serving youth. While challenging, however, most of these obstacles can be overcome by a strong institutional commitment, careful staff selection and training, and reallocation of resources.

Given the central importance of training service providers, curricular materials and training activities are becoming more available. Much emphasis is being placed on provider-client interactions, especially by upgrading the counseling skills of those who work with young people. This upswing in training activity is a good omen for future prospects as it addresses the key variable in meeting the needs of clients.

While attention to provider skills and approaches is increasing, many other aspects of clinic operations that could be made more youth friendly have remained unaddressed. In part, more information is needed on how various program characteristics affect client satisfaction and reproductive health outcomes. With such evaluation findings more readily available, program planners can design and implement more effective services.

Attention in the future must also be given to policy environments that remain hostile to or unaccommodating of youth access. This, in part, also depends on better public education campaigns to support public policy reform of adolescent reproductive health matters. Public education, especially at the community level, carries an added benefit—support of newly established youth-friendly programs that will better attract, serve, and retain young clients that need their services.

I. DIMENSIONS OF THE CHALLENGE

A. Why do adolescents need specialized services?

Viewing adolescents as a specific group with their own needs is a relatively recent practice, especially in the developing world. Young, unmarried people in the past were not expected to need reproductive health (RH) services. If young women—no matter how young—were married, they received the same services as older women, except nobody assumed the young women needed pregnancy prevention. Most developing country societies expected women to bear children soon after marriage.

Significant social changes, which affect all societies to some degree, have prompted program planners and managers to consider specialized services for people in the adolescent or young adult age group. Some of these changes relate to broadened opportunities for women, who are now staying in school longer and entering the workforce in larger numbers. The age of marriage is rising in most countries. Combined with the decreasing age of menarche, those years create a longer time period when young women are single and are capable of becoming pregnant. Sexual activity during this nonmarital time has increased, fostered by other social changes such as urbanization and mass communications, thereby creating a new level of need for RH care.

Another impetus for placing a priority emphasis on the RH of this group is the alarming increase of sexually transmitted diseases (STDs), including HIV. Young people are contracting STDs out of proportion to their numbers. In particular, young women represent the fastest-growing cases of new HIV infection.[1]

Adolescence, or the transition to adulthood, is becoming more of a defined developmental stage in many countries. Thus, there is concurrently a greater understanding of this age group's biological, psychosocial, and health needs. Specific biological issues for adolescents apply equally to married or unmarried young people, especially young women. For example, incomplete body growth can cause problems during pregnancy and delivery among very young adolescents.[2] Also, because of immature reproductive and immune systems, young females are more susceptible to HIV transmission.[1]

Adolescent behavior, including experimentation and risk-taking, makes young people more vulnerable to pregnancy and STDs. Young people want to try new things, including sexual activities, often feeling invulnerable to negative consequences. Other psychosocial reasons, especially for female adolescents, place them at higher risk: wanting to please, having difficulty in refusing advances, and needing to provide sexual favors to meet various needs, such as for school money. Finally, there is emerging evidence that indicate that sexual abuse is a major issue for adolescents worldwide, with effects on the sexual and reproductive health of young adults.

For adolescents, concerns about sexuality and RH are new in their lives. In fact, the major defining biological aspect of adolescence is the process of attaining sexual and reproductive maturity. Given most societies' reluctance to approach the subject forthrightly, it is not surprising that young people view these new feelings and needs with some trepidation—and are suspicious of where to find answers.

Furthermore, adolescents are generally healthy and do not see health, as such, as an issue that needs a service response.[3] Placing a low priority on preventive care is especially pronounced in many developing countries where curative health care is the dominant mode. Prevention of undesired pregnancy and STDs has recently gained more interest—but primarily for older, married people.

Adolescents face fears, concerns, and lack of understanding about their own needs. Thus asking for or seeking guidance and services is very difficult, and they tend to avoid seeking needed care (see section II.A., below). Any program hoping to serve young people must factor in these multiple psychological and physical realities. The program must design services that can attract young people, while assuring them that they will be well treated and have their needs met. This challenge has become a major priority, given the dramatic consequences that STDs and unwanted pregnancies can have on young people's futures.

B. What services are needed by adolescents?

Adolescents, in general, are experiencing a relatively healthy stage of their lives, having survived infant and childhood vulnerabilities and illnesses. But they are also moving through a phase that brings dramatic physical and emotional changes, as well as new risks. A move toward greater independence and decision making along with experimentation with new lifestyles and activities creates a different set of health risks more closely connected to behavior. Accidents increase dramatically for this age group; smoking and substance use typically begin in adolescence or young adulthood although this behavior can have delayed health consequences.[24]

The defining event of adolescence, however, is reproductive maturation. The ability to reproduce and the sexual interest and activity that form the foundation of this biological function are universal among societies, although different cultures and different eras have developed various ways to manage sexual activities and channel them into socially acceptable behavior. This behavior usually meant sexual abstinence until individuals moved into socially sanctioned unions. With increased sexual activity among young, unmarried people and the emergence of the HIV/AIDS pandemic, greater health challenges have developed. At the same time, better health delivery systems have developed, methods to prevent pregnancy and STDs have improved, and communications to transmit vital information have become better. However, because of social discomfort in accepting the reality of adolescent sexual activity, an unwillingness exists to put these services at the disposal of the young people who need them.

Given the rapid changes that adolescents experience, a need exists for education and counseling services, especially related to development and maturation, boy-girl relationships, decision making about sex, gender issues, sexual abuse and exploitation, sexual and contraceptive negotiation, adoption of contraceptive methods, and pregnancy options should pregnancy occur.

Needed health services include prevention, treatment, and follow-up care. While it is unrealistic for most developing country clinics to include all of the following RH services, a comprehensive array would include:

- sexual and RH education and counseling (as noted above)
- physical examinations, including pelvic and breast examinations for females and testicular exams for males
- cervical cancer screening (e.g., Pap smears)
- STD screening, counseling, and treatment
- HIV testing and counseling
- contraceptive method choice, adoption, and follow-up
- pregnancy testing and options counseling
- abortion services (where legal) and postabortion care
- prenatal and postpartum care
- well-baby care
- nutritional services[17]

In developing countries, most clinics or service providers will have to limit the number of services provided. It is important, therefore, for clinics to carefully assess health trends and needs among their specific target populations to determine the priority of services. Also, referral arrangements should be made to cover those needs unable to be incorporated within a particular clinic site.

In addition to defining a minimum package, providers should recognize the differences among young people (gender, age, cultural, ethnic) and be prepared to adjust their responses to those differences accordingly. They should be sensitive to adolescents with special needs, particularly underserved, hard-to-reach youth. Such subpopulations of young people tend to engage in behaviors that put them at higher risk for pregnancy, STDs, and HIV infection. These subpopulations include the following:

- out-of-school youth
- street youth
- youth in foster care, residential treatment facilities, and other institutions
- youth using drugs, alcohol, or both
- sexually abused youth
- gay, lesbian, bisexual, and transgender youth

- commercial sex workers
- youth with mental and physical disabilities[17]

Another group often neglected for specialized services is young married people. This group is assumed to be adult, although their physical and emotional needs may more closely resemble the adolescent stage. They are too often assumed to be moving directly into parenthood no matter how young or ill-prepared biologically or socioeconomically. Specialized services to delay the first birth and to respond to other needs have become recognized as important for this group, especially in cultures where marriage occurs at very young ages.

C. How can services be delivered to adolescents?

Health services are usually thought of as offered at a fixed site to which clients come for care. This model is still dominant in hospitals, clinics, and health centers in virtually all areas of the world and is typically the one most developed by public health sectors. To a major extent, because this infrastructure is already available, a practical urgency exists to consider how such services could be adapted to better attract and serve a clientele of young people.

An increasing number of channels and models, however, have proven successful (or have the potential) to serve youth with some RH services. Some models appear to accomplish their objectives more successfully and cost effectively than the fixed-site service model. In a comparison of fixed-site and peer-outreach services in Mexico, for example, an evaluation found that the Community Youth Program of the Prosuperacion Familiar Neolonesa (PSFN) was more effective in reaching their targets at less cost than the Integrated Youth Centers. In the former, PSFN used trained young adults and community counselors as outreach workers to provide sex education, family planning information, and contraceptive referral to young people. The Integrated Youth Centers combined education and family planning services with counseling, academic tutoring, and recreational activities in a fixed setting.[4] Peer-outreach programs have become creative in identifying and reaching youth in a variety of places where they congregate, including malls, bus-parks, "the street," recreational sites, sporting events, and fast-food and other eating or drinking places.[5]

Large clinics are sometimes located in areas not convenient for youth. A project implemented by the Association for Reproductive and Family Health (ARFH) in Nigeria addressed that problem by establishing satellite clinics in rooms donated by the community in locations where a large proportion of school-going and out-of-school youth are located.[6] School-linked clinics are another way to bring services to locations where large numbers of young people spend time. Importantly, workplace models have become more common as employers understand the benefits of a healthy workforce and delayed pregnancies among their young female employees.[5]

Other examples of models for reaching out to youth include the use of mobile vans and community-based distribution agents, and social marketing, which makes effective use of mass media and other communications to help reach young people with information and motivational

materials, along with methods available in convenient locations such as bars, stores, kiosks, and community centers. Drug stores or pharmacies can also serve as distribution points for information and methods, either as part of a social marketing campaign or individually and commercially. Hotlines, call-in radio shows, folk drama and other communication strategies can help provide information about reproductive health issues and available services.

Partnering with existing agencies that serve youth is a way to reach a significant number of young people already organized into programs and activities. In Africa, a family life education project (though not offering services) was implemented by the 29-country Africa Region Boy Scout Association.[7] The program, however, proved to be more challenging than anticipated and fell short of objectives and anticipated expansion activities.[8] An apparently more successful model implemented by International Planned Parenthood Federation (IPPF) in six countries, Youth for Youth, worked through a variety of nongovernmental organizations (NGOs) that reached young people in urban slums, in prisons, in schools, and in the military, as well as those already parenting.[9,10,11]

All of these approaches can and should consider ways to make provision of services more accessible and friendlier to their young clients or participants. Although drawn primarily from experience with clinical services, because most evaluations on service provision document this model, the youth-friendly characteristics described in the next chapter are applicable to the design and delivery of all service projects for young people. Clinical characteristics are more detailed and numerous than other models would adopt, but include several concerns essential to all the others.

The task of special training for those who interact with young people is highly relevant to every delivery approach. This preparation needs to underscore the provider's essential role in assuring trust, privacy and confidentiality, critical issues for young people. Another important challenge is ensuring that the service is conveniently available to young people. Finally, and universal to all, is the challenge to identify and respond to those needs that adolescents have for RH services so that what is provided—by any of these approaches—is relevant, sensitive, and important to their lives. Involving youth directly in determining and delivering services will help to ensure that those objectives are met.

II. CHARACTERISTICS OF YOUTH-FRIENDLY SERVICES

A. Why do adolescents avoid existing services?

Adolescents avoid using existing RH services for a variety of reasons, including policy constraints, operational barriers, lack of information, and feelings of discomfort. Major impediments to adolescent access and use include the following:

Policy constraints

Laws in many countries restrict access to certain kinds of health services (including access to specific commodities) according to age, marital status, or both.[12] RH services often discriminate against young people, sometimes by requiring a minimum age or parental consent. Even where the law does not specify restrictions, health facilities, health staff members and other providers (such as pharmacists) sometimes establish their own policies that prevent or diminish adolescent access. This situation occurs more frequently when laws or policies are unclear or unevenly enforced.

Operational barriers

Even when clinics and other service programs do not intend to bar adolescent clients from their services, operational policies or clinic characteristics can inadvertently serve to reduce access. Some barriers include:

- Inconvenient hours of operation[13,14,15,16,17]
- Lack of convenient transportation[12,15,16,17,18,19]
- High costs of services[12,14,16, 17,18, 19,20,21,22,23]

Lack of information

Young people are learning new information about their emerging sexuality and development. Often, their friends are the source of information. Thus young people tend to remain poorly informed—or even misinformed—about such matters. Situations that reflect this condition and comprise additional barriers to services include:

- Poor understanding of their changing bodies and needs[24]
- Insufficient awareness of pregnancy and STD risks [17,25]
- Little knowledge of what services are available [3,20,26,27]
- Lack of information of RH service locations[16,24]

Feelings of discomfort

Perhaps the most widespread explanation for young people's avoidance of clinics and service providers is their discomfort with real or perceived clinic conditions and attitudes of providers.

Such perceptions could result from their own experiences, second-hand information from peers, or a general reputation about the services. Following are specific concerns that young people have suggested as reasons for their not seeking or using RH services:

- Belief that the services are not intended for them[23,26,28]
- Concern that the staff will be hostile or judgmental[12,13,14,15,16,21,24,25,28]
- Fear of medical procedures and contraceptive methods, including side effects[12,17,18,20]
- Concern over lack of privacy and confidentiality[12,17,18,20,23,25,28,29]
- Fear that their parents might learn of their visit[17,18,23,25,30]
- Embarrassment at needing or wanting RH services[13,16,17,20,23,28,29]
- Shame, especially if the visit follows coercion or abuse[31]

B. What do young people say they want?

Characteristics of RH service provision preferred by young people can depend on the type of client or the nature of a clinic visit. For example, having special hours or setting aside clinics for adolescents are variously ranked high and low in importance by teens.[32] Yet even where special hours were not high on the list for clinic choices, as in one U.S. study, young people who were virgins or were within two months of having had their first intercourse were more likely to enroll in a clinic with special teen hours.[32] In Jamaica, a special evening clinic for youth was found to attract many first-time clients.[33] It has been suggested that this separate service may be needed, especially by at-risk youth, to overcome their resistance to using the traditional health care system.[34]

Given cultural and other differences among young people, it is important to ask members of the intended audience specifically about their preferences for service. Below are examples of what some selected groups of young people in various settings have expressed as their preferred characteristics for services:

- In a Caribbean study, young people discussed an ideal center as one that offers many services, is open in the afternoon and evening with empathetic, knowledgeable, and trustworthy counselors, and does not look "like a clinic."[29]

- In a Youth Information Centre, established as a pilot project by the Planned Parenthood Association of South Africa, young people identified the most important factors in clinic choice as staff attitude (95%); environment (characteristics such as location, decor, and atmosphere) (89%); contraceptive method (85%); and operating hours (81%).[35]

- According to a study about adolescent access to RH information and services in Nicaragua and Kenya, researchers report that young people want confidential services (preferably outside their local area); good human treatment (including trustworthy, nonpunitive providers who specialize in dealing with youth); and counseling linked to services and centers especially for young people.[25]

- According to research with adolescents in Africa, Asia, Latin America, and the Caribbean, the International Center for Research on Women recommends that RH services be private, confidential, affordable, and accessible. Such clinics must be staffed with sensitive service providers.[36]

- In a U.S. study of adolescent's perceptions regarding their decisions to seek health care in general, fourteen of fifteen top-ranked items pertained to providers. Six of those concerned interpersonal factors such as honesty, respect, and confidentiality. Four of the top characteristics pertained to infection control (showing adolescent concern over HIV transmission).[37]

- In a U.S. teen clinic, the most important reasons given by young people for their initial attendance were that the clinic was for teens only and that the services were free. Other important factors included convenient scheduling and location, a friendly staff, a clinic used by their peers, and confidentiality.[38]

C. What are youth-friendly services?

Simply stated, services are youth friendly if they have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their youth clientele for follow-up and repeat visits. Some of the adaptations and additions needed to make services youth friendly have been identified by adolescents themselves. Other characteristics have been identified by service professionals, including some that have been implemented and evaluated as part of an overall effort to provide effective RH services for youth.

Although most of the following characteristics are based on a clinical setting, many of these characteristics apply to programs serving youth in any setting or with any approach. Health facilities, in particular, that hope to attract, serve, and retain adolescent clients have an array of adjustments and additions to consider. These concerns relate to provider, facility, and design characteristics. Some are relatively minor and others are more extensive. Furthermore, some potential changes may vary in importance to the target audience, which suggests that a needs assessment should be an important step before selecting those changes to be made. Ideally, youth involvement should be maintained, as suggestions for changes are important as the projects continue.

Provider Characteristics

Specially trained staff

Having a specially staff that is trained to work competently and sensitively with young people is often considered the single most important condition for establishing youth-friendly services.[20,26,39,40,41,42] Acquired skills must include familiarity with adolescent physiology and development, as well as appropriate medical options according to age and maturity.[43] At least as important are interpersonal skills so that young people can be at ease and can comfortably communicate their needs and concerns.[12,18,25,28,30,41] This objective is sometimes accomplished when providers are closer in age to, and/or of the same sex as, the client. The ability to communicate fluently in languages that young people speak who attend a given clinic is also important.[44] In addition to those providing counseling and medical services to adolescents, other staff members should be positive toward these clients and oriented to young people's special concerns. Particularly important are the attitude and performance of the receptionist, who is typically the first point of contact for the young person.[41,42] Refresher courses must be made available to keep staff members informed and their skills current.[42]

Respect for young people

While respect can be fostered within a training exercise, some providers bring to their job deeply entrenched biases against adolescent sexual activity or find it difficult to relate to adolescents in a respectful way. Given this reality, clinic managers should carefully consider such attitudes as they select trainees or those who will work with—or supervise staff to work with—young people.[18,22,41,42,45]

Privacy and confidentiality honored

Privacy and confidentiality rank extremely high among young people.[13,20,25,37,46,47,48] Privacy must be arranged for counseling sessions and examinations; young people must feel confident that their important and sensitive concerns are not retold to other persons.[39,42] A common fear expressed by young people is that the nurse will tell their mothers that they came to the clinic for RH care.[25]

Adequate time for client and provider interaction

Young people tend to need more time than adults to open up and reveal very personal concerns.[23] They usually come to the clinic with considerable fear, often with a worry about being pregnant, and require strong reassurance and active encourgement to speak freely.[12,46] Time is needed to bring myths (such as girls cannot get pregnant at first intercourse) to the surface, to discuss them, and to dispel them.[44] When possible, clinicians and counselors should plan from the start to schedule more time with young clients than with adult clients.[20] In addition to responding to client concerns, providers should be able to cover questions about body image and development, sex, relationships, sex and condom negotiation, as well as to clearly explain

contraceptive method options and their possible side effects and management; this discussion is crucial to the compliance and retention of the adolescent client.[49]

Peer counselors available

Evidence shows that many young people prefer talking with their peers about certain sensitive issues[50,51] (although they also tend to believe that health care professionals *know more* about the technical issues). It is productive, therefore, to have peer counselors available as alternatives or supplements to some aspects of the counseling activities.[42] One U.S. study showed that trained peer counselors (ages 17–18) in a clinical setting more positively fostered contraceptive compliance among sexually experienced young people than counseling efforts by young nurses (ages 26–29).[52]

Health Facility Characteristics

Separate space and special times set aside

Creating separate space, special times, or both for adolescent clients appears more important for certain clients, such as young teenagers, first-time clinic users, nonsexually active clients, and marginalized young people who are especially suspicious of mainstream health care.[12,18,30,33,34,38,41] A separate service can also facilitate providers' efficiency in arranging specialized youth-friendly features.[18,11,41] Before considering such a special adjustment, a strong needs assessment among a diverse group of probable clients should be conducted.

Convenient hours

Having clinics open at times when young people can conveniently attend is fundamental to effective recruitment.[18,24,27,29,40,48,53] Such times include late afternoons (after school or work), evenings, and weekends.[42,54] While young people who need urgent care may be willing to leave school or work for such services, those who need prevention services but may be unaware of how important they are, are more reluctant to give excuses and to take the time off.

Convenient location

Existing facilities cannot address this variable, but new operations can consider location as a factor when determining a service site.[13,18,11,48,55] Young people sometimes express a desire to go out of their neighborhoods so they will not be seen by family and neighbors.[18,25,42] At the same time, young people do not want to or cannot travel too far to reach service sites. In any case, the location should be in a safe surrounding and, ideally, should be available by public transportation.[41]

Adequate space and sufficient privacy

Adequate space is needed to assure that counseling and examinations can take place out of sight and sound of other people.[42] This need requires separate rooms with doors and policies that support minimal interruptions and intrusions. A provider-youth client study in Zimbabwe showed that, although counseling occurred in a separate room in most clinics (92%), people could overhear 23% of the sessions and could see what was happening during 32% of the sessions. More than one-third (36%) of the sessions were interrupted by other staff members.[46]

Comfortable surroundings

The service environment may vary in importance and details with the specific target audience to be served. In general, young people prefer a setting that is comfortable, has posters or decor that relate to their taste and interests, and does not present an overly sanitized environment.[30,41] In Chile, program planners converted a cluster of homes into a clinic. To maintain a "demedicalized" ambiance at the clinic, the health care providers wore street clothes instead of "medical whites."[56]

Program Design Characteristics

Youth involvement in design and continuing feedback

A fundamental principle in design of youth-friendly services is to ensure participation of young people in identifying their needs and preferences for meeting those needs.[22,25,42,57,58] Some characteristics, such as privacy, confidentiality, and respectful treatment, are nearly always top priorities. Other features, such as the separateness of the clinic from other services and the importance of peer counselors, may vary according to the overall culture or the specific norms of the target population. In addition to creating an environment more likely to meet their needs, involving youth in the design of the program and in continuous feedback will enhance their "ownership" of the program. This feeling of ownership will motivate young people to recruit their peers and to advise on needed adjustments.[17,59]

Drop-in clients welcomed and appointments arranged rapidly

Because adolescents are present-minded and rarely plan ahead, the possibility of receiving services without an appointment can increase adolescent access.[17,22,24,41,50,53,60] If an adolescent is turned away and told to return at another time, or if the adolescent must wait several weeks to be seen after making an appointment, there is a significantly greater likelihood that the potential client will not show up. With young people, it helps to "seize the opportunity" when they show an interest in getting RH care. A U.S. program succeeded in serving young people by drastically cutting waiting times for appointments. The "You First" approach gave teens priority consideration for family planning appointments, guaranteeing an appointment within 48 hours.[61]

No overcrowding and short waiting times

Having to wait a long time to be served in a clinic, particularly with an increased chance that someone will see them there, is unappealing to the adolescent client.[17,29,41] Young people may choose to not even endure the wait initially, but if they do, this situation will be a barrier to their return. This kind of experience is more than likely told to peers—prospective clients—and gives the facility a bad reputation that dissuades future clients.

Affordable fees

Cost can be a significant barrier to the potential adolescent client. A fee schedule must be designed so that services are free or affordable. They can be established on a sliding scale, possibly including credit and flexible payment options.[17,22,27,11,38,41] Some studies have shown that adolescents want to pay *something* for services or else they will not value what is provided.[12,25]

Publicity and recruitment that inform and reassure youth

Not only must adolescents know that clinics and other service programs exist and where they are located, but they must also know what services are provided.[13,19,24,54] Importantly, they must be reassured that they are welcome and will be served respectfully and confidentially.[13,17,19] Communicating this information can often be done as part of a community relations or mobilization effort. In this effort, programs explain their services to local youth and other groups who can then provide support and referrals.[38,40,41,48,54,61] Outreach in the community is particularly important in reaching out-of-school youth.[50] Recruitment is often best handled by young people themselves, both formally (such as distributing printed information or making presentations) and informally (by word of mouth).[17] Satisfied clients are usually the best recommendation for use of particular services.[13,38,42,48]

Boys and young men welcomed and served

Although not possible in all societies, welcoming male partners can prove beneficial where feasible. For a young woman, the accompaniment of her boyfriend to the clinic can be an important element in the decision to seek services.[17] This support should not be dampened by his feelings of discomfort.[41] Furthermore, opportunities exist to foster shared responsibility for decision making and contraception when young men are present, as well as to serve the needs of males for RH information, counseling, and service.[17,19,40,41,62] It may be necessary to develop clinic programs designed especially for young males that are sensitive to male values, motivations, feelings, and cultural influences while encouraging equitable male and female relationships.[17,41,63] Other outreach programs, especially involving condom distribution and STD/HIV prevention have shown success in targeting or reaching males.

Wide range of services available

The more health needs of young people that can be met within the facility or program, the greater assurance that they will receive the care they need. Whenever it is necessary to send young people to another location for another service, there is an increased risk that they will not actually show up. While it is not always possible, attempts should be made to identify and provide the most needed RH services as "one-stop shopping." These services should include sexual and RH counseling, contraceptive counseling and provision (including emergency contraception), STD and HIV prevention, STD diagnosis and treatment, nutritional services, sexual abuse counseling, prenatal and postpartum care, abortion services (where legal), and postabortion care.[12,17,20,22,34,48,56,63,64]

Necessary referrals available

It is desirable, but almost never possible, to provide services that meet all the needs of adolescents, including some types of specialized health care and related social services.[27,65] Thus, it becomes very important in addressing the adolescent's overall needs to be able to refer to responsible agencies.[12,40] Effective working arrangements should be established to ensure youth receive the services they are referred to and assure that referral sites provide appropriate, youth-friendly treatment.

Other Possible Characteristics

Educational material available on site and to take

Some young people prefer to learn about sensitive issues on their own, using written or audiovisual materials, because their discomfort level can be too great to retain information during a face-to-face session. Such material can be used while clients are waiting to be seen, as with an innovative computer-based health education program used by clients in a Peruvian clinic.[45] Some materials should be available to take home, too, so young people can refer to them later, particularly if the topics are complicated (such as symptoms of STDs).

Group discussions available

While not all young people are comfortable in a discussion format with their peers, this type of information exchange can be very productive. It helps adolescents to realize that they are not unique in their fears and can provide peer support to obtain needed care or seek solutions to problems.[19,38,48,45]

Delay of pelvic examination and blood tests possible

Some young women have a significant fear of the pelvic examination, blood tests, or both. It is thought that this fear deters many young women from going to clinics and obtaining contraception when they first need it.[17] In an experimental program in the United States called "Smart Start," increased numbers of teens came to a clinic when they had the option of delaying the requisite pelvic examination for 6 months while still being able to obtain oral contraceptives

or other nonprescriptive contraceptives.[66] Delaying the pelvic examination can encourage young women to return for family planning services.[43]

Alternative ways to access information, counseling, and services

Given the challenge of attracting young people to fixed clinic sites, clinics can increase their reach by other means of contact with clients. Telephone hot lines, for example, can be operated by trained counselors from the clinic site, but clients need not come to the clinic for information or counseling.[22,30] Or counselors (peer or adult) and outreach workers (including community-based distribution agents) can go into the community to deliver services. For some young clients, one of these models will serve as an intermediate approach to on-site clinic use until they become more comfortable or their situation becomes more urgent.[5] Clinics can also set up smaller branches or satellite clinics closer to where young people congregate[6] or that are linked to schools.

Mystery Study Uncovers Provider Attitudes Toward Youth[14]

As part of a study to measure access to family planning education and services for young adults in Senegal, the *Comité d'Etude sur les Femmes, la Famille et l'Envionnement en Afrique* (CEFFEVA), in collaboration with Family Health International, used a mystery client component in their assessment. The mystery clients consisted of 10 young women and two young men who had previously come to *Association Senegalaise pour le Bien Etre Familial* (ASBEF), the local IPPF affiliate, to request information for school-related projects. The mystery clients had participated in focus group discussions (as part of the larger research study) and had volunteered for the mystery client task.

Before beginning their research, the young participants obtained permission from their parents. In preparation, they were briefed on contraceptive methods and on the purpose of the activity to clarify their roles. They were instructed on how to complete a questionnaire that summarized the impressions of their visit. The following points were covered: accessibility of services, reception, provider attitudes, counseling, and client satisfaction.

The mystery clients visited seven clinics in Dakar (clinics within hospitals, polyclinics, and family planning clinics); between two and four visits were made to each clinic, always by a different person. Two or three visits were made by each client, who provided various explanations for the purpose of the visit. These purposes included the need to receive family planning information for themselves, to receive family planning information for someone else, to get information for classwork, and to receive a family planning method.

After each visit, the mystery client completed the questionnaire outside of the clinic and gave it to the research team along with a brief oral summary of the visit. During the discussion, the research staff member reviewed details of the visit, clarified information in the questionnaire, and obtained impressions from the mystery client.

FINDINGS FROM THIS STUDY INCLUDE THE FOLLOWING:

Family planning services were not well marked and were difficult to find within larger facilities; requests for directions caused discomfort for the clients, especially when they were treated rudely.

Clarity about available services was lacking; mystery clients were not sure what contraceptive services were available or whether the services were limited to married couples only.

Negative feelings were communicated to the young people, such as when staff members tried to refer them to other clinics or advised them to "focus on their studies;" they also perceived negative feelings from other adults in the clinic and sensed that these clients were biased against them.

Judgmental attitudes were conveyed regarding information on contraceptive methods; when information was given, it typically ended with advice or moralizing, such as "you should abstain until marriage" or "methods are bad for your health."

Clients had difficulty obtaining contraceptives; six mystery clients requested contraceptives for their own use, but none received them.

III. PROGRAM EFFORTS TO INSTITUTE YOUTH-FRIENDLY SERVICES

Projects to make services friendlier for youth are becoming more numerous and reflect efforts to increase adolescent use and to improve the suitability and effectiveness of the services provided. In general, these services can be divided into two categories: prenatal, postpartum, and abortion services and prevention and health promotion services. Despite the increase in these projects, evaluation is still very limited on how effective such projects are—or can be. Furthermore, most demonstration activities have looked mainly at the overall effects of the program design and, therefore, cannot attribute results to specific youth-friendly components. Even at this stage of program development, however, much can be learned from past experiences, available evaluation results, and current efforts to move the field forward.

A. Prenatal, postpartum, and postabortion services

These services generally adapt existing services to attract more young clients and to serve them better according to their special needs. These services create a clinical setting comfortable for the young client and an approach to address those areas that require additional support for the young, pregnant, and parenting woman. For example, special consideration is given to encourage good nutrition, foster breast-feeding, and provide appropriate contraception to delay the next pregnancy.

Because of the immediate, apparent needs of pregnant, young women, programs of special care for this group were developed earlier than those for their nonpregnant peers or for young people seeking preventive care. Many of these efforts were set up as demonstration projects or models and, therefore, included evaluations.

Prenatal and postpartum programs

- In **Mexico**, a hospital-based program implemented by the *Asociación Mexicana de Educación Sexual* provided family planning information and counseling at both prenatal and postpartum sessions to women under 20 years of age who were delivering their babies at a public hospital. Education and services were offered through a special adolescent clinic in the hospital. Changes were made to the approach after an evaluation found that counseling and education sessions were not effective during the immediate postpartum period. A second evaluation of this project showed that young adults who had attended an educational session received a greater number of prenatal check-ups and planned to space their births more than the clients who did not attend (86% vs. 64%).[67,68]

- In another hospital-based program in **Mexico**, the Educational Program for Adolescent Mothers (PREA) conducted by the *Centro de Orientacion para Adolescentes* (CORA—Adolescent Orientation Center), participants attended postpartum and one or more subsequent sessions on family planning. An evaluation showed that PREA participants breast-fed longer and had a higher rate of contraceptive use than the control group.[69]

- In **Chile**, multidisciplinary teams have worked to improve birth outcomes and postpartum practices among high-risk young women in hospitals and clinics. Medical records show several positive results, including lowered rates of infant mortality, higher rates of continued breast-feeding, and reduced rates of second pregnancies.[70]

- In the **United States**, a study was made of a comprehensive program for pregnant women under 18 years of age at a medical university that used nurses, social workers, a nutritionist, obstetricians, and a psychiatrist. Caseload management was done by nurse-midwives. Evaluators concluded that such an approach can result in a significantly lower incidence of low-birth-weight babies even among a population of socioeconomically high-risk adolescents.[71]

Prenatal nutrition intervention programs

- In **Nigeria**, an experimental program provided pregnant adolescents with antimalarial drugs as well as iron and folic acid supplements in the second half of pregnancy. A survey of birth outcomes showed a reduced incidence of cephalopelvic disproportion among participating adolescents compared with nonparticipating adolescents.[72]

- In the **United States**, a group of pregnant adolescents received calorie, protein, vitamin, and mineral supplements. The experimental group gave birth to infants with a significantly higher mean weight than a group that received no supplements; larger effects were observed among girls under 16 years of age.[73]

Postpartum and postabortion programs

- In a hospital-based program in **Brazil** for postpartum and postabortion adolescents, outpatient services were offered at specific hours and included counseling, education, and provision of contraception. Evaluation results showed that 50% of the young women hospital patients who received services or educational talks returned to the out-patient clinic for follow-up. Furthermore, the ratio of abortions to births in one participating hospital declined from 18% to 13% after 5 years of project operation.[74]

- In **Kenya**, the High Risk Clinic (HRC) was established to address the urgent RH needs of young women (under 25 years of age) admitted to Kenyatta National Hospital with complications related to incomplete or septic abortion. The target audience has been expanded to include postpartum young women and, to a lesser extent, nonpregnant young women. This separate, specialized clinic provides counseling and contraceptive services for young women in "an atmosphere free from the fear of being seen by relatives and other older persons." A telephone hot line is available for those seeking even greater anonymity. An evaluation of HRC services showed an increase in contraceptive acceptance following a clinic visit; 54% of clients who made a first visit accepted a family planning method

compared with the ever-use prevalence of 44% reported among clients before the visit. Those clients who experienced a pregnancy or an abortion were significantly more likely to accept a contraceptive method than those who had not conceived.[30]

- In **Ghana**, Ipas, a U.S.-based organization working in reproductive health and abortion service provision, sponsored a program that trained Ghanaian midwives in postabortion care. These midwives lived and worked in the community where they practiced primarily in private maternity homes or community health centers. An important feature of midwives within the community is how familiar women, of all ages, are with them and their work. Decentralizing postabortion services with trained midwives in the community can reduce delays in seeking, accessing, and receiving appropriate health care, especially for young women whose lack of money and of comfort with a bureaucratic medical system greatly contribute to this delay. Although an operations research project did not look specifically at adolescent access, information learned informally through the project suggests that access to high-quality postabortion care was improved for young women. Case stories taken from midwives include several examples of their providing confidential and sensitive services to vulnerable women, especially adolescents.[75]

- In **Brazil,** Ipas has worked with an NGO, ECOS, to better meet adolescent needs in treatment of abortion complications. ECOS developed a curriculum module for health care providers to sensitize them to the developmental, sexuality, and contraceptive needs of adolescents. This curriculum has been made available for sites that serve as postabortion care training centers in 12 states in Brazil. The specialized training is currently under way or planned; therefore, information on how postabortion care for adolescents may have changed is not yet available. A complementary study is being conducted of adolescent needs at sites treating this group for abortion complications. This study has been designed so the results will help providers better understand the circumstances leading to unsafe abortion and what modifications or improvements in services adolescents would like.[76]

B. Prevention and health promotion services in clinical settings

These services typically target young people before they face pregnancies and STDs, and they tend to stress prevention of undesirable consequences. Because this target group does not perceive as immediate a need for services as those young people already facing a pregnancy, the task of attracting such a clientele is more challenging. Adaptations of existing programs to achieve the goal of serving more youth vary considerably from an emphasis on training staff members to be more sensitive to youth needs to a complete program design that involves training of staff members, changes in clinic policies, and alterations in the institutional setting.

Some youth service projects have evolved over time in response to an increased demand from existing and potential youth clients. Other service projects have been set up as models or demonstrations, with evaluations of various kinds, to assess the effects of instituting changes considered more youth friendly. The model summaries that follow are grouped according to design and evaluation. The summaries begin with models developed as experimental designs with rigorous evaluations and outcome results, followed by models with process evaluations, and then descriptions of unevaluated or not yet evaluated projects. Some U.S. studies have tried to assess the effects of instituting specialized youth services on improved contraceptive use and delayed pregnancy with mixed conclusions. Programs in developing countries have recently increased, and most have not yet completed their evaluations.

Prevention and RH promotion programs

- In a **U.S.** study, a special adolescent protocol that stressed psychological and social concerns was implemented in six nonmetropolitan family planning clinics. The design included the following elements: one-to-one counseling, delay of pelvic examination, special staff training, trained teen counselors, involvement of male partners, encouragement of parental involvement, additional time for discussion, more frequent follow-up visits, and other refinements. This intervention resulted in greater contraceptive continuation and lower pregnancy rates (within 1 year) among clients in the experimental group compared with the control group.[77]

- An ambitious **U.S.** study in Philadelphia looked at the effect of expanded teenage-directed family planning services on its surrounding area. Among the added strategies were expanded afternoon and evening hours, walk-in hours, decreased waiting time, and outreach efforts directed at teens and their parents. The project was found to have no measurable effects on reproductive behavior, attitudes, and knowledge on its target population. These findings imply that, while the clients who come to a clinic may be well served, improving and increasing the availability of services will not necessarily increase the demand for services or affect the RH of the larger population living nearby.[78]

- A model in the **United States**, the Peer Providers of Reproductive Health Services, was implemented to improve strategies for meeting the RH needs of adolescents. Peer providers were trained and certified as fully functioning, family planning clinic staff who delivered services to adolescent clients during Teen Clinic hours, as well as during regular adult clinic hours. Other features of this model include a strong outreach component that provided individual and group health education in schools and community settings, a teen phone line, a quarterly follow-up telephone call, an emphasis on male services, and a Teen Advisory Committee that provided input into program operations. An evaluation found increased contraceptive compliance by teen clients (27% increase in the percentage of female clients who always use birth control and a 17% increase in the percentage of female clients who used birth control at last intercourse), increased use of an effective contraceptive method at last intercourse (81%), decreased interval between sexual debut and adoption of

contraception, increased number of presexually active teenagers enrolled in the clinics, and an indication that the longer clients were exposed to the peer provider clinic the greater likelihood of decreased pregnancy and STD rates. Also, outreach at schools and in the community appeared to be a key referral source and was especially effective at increasing the number of male clients.[38]

- In **Zambia**, a John Snow, Inc. Service Expansion and Technical Support (JSI/SEATS) project, the Lusaka Urban Youth-Friendly Health Services project, collaborates with the Lusaka District Health Management Team to improve and to promote access to and use of quality RH services for youth ages 10 to 24 years. Before establishing the program, a participatory learning and action exercise was undertaken to create awareness and to identify needs. An important finding from this exercise was that parents are too shy to discuss RH issues with their children, a task formerly carried out by grandparents and aunties. Thus the project was conceptualized to the community as placing the health facilities in the role of grandparents—with parents kept informed. A key design element to attract and to serve youth is providing peer educators in two clinics; the peer educators also perform community outreach. Contraceptive education and prenatal care are available daily at seven health centers. Condoms and foaming tablets are provided free; referrals are made for other services. Assessment of youth utilization indicates that the number of users has doubled from baseline figures, including a significant increase in participation by nonpregnant teens seeking counseling and prevention services.[79,80]

- The Promotion of Youth Responsibility Project undertaken by the **Zimbabwe** National Family Planning Council, with technical assistance from Johns Hopkins University, Center for Communication Programs, sought to increase use of service facilities by young people. To achieve this goal, two major strategies were employed: a multimedia campaign to educate young people and encourage them to seek RH care and the training for providers on interpersonal communication. According to the follow-up survey, 28% of the young people in campaign sites reported visiting a health center compared with only 10% in the noncampaign sites. The greatest program effects were on groups thought to be least likely to seek services: males, single people, and those who lacked sexual experience. More intense exposure to campaign activities resulted in greater effects; for example, 40% with intense program exposure visited a health center compared with 14% with limited exposure.[81]

- In a major **U.S.** city, a public health facility established the Teen Clinic to serve a low-income community at high risk for teenage pregnancy. Program features included free services, expanded hours of operation, group discussions, and outreach activities to publicize the special services. An evaluation showed that new patient registration increased 82% compared with enrollment before the program began. This increase also compared favorably with two neighboring public health department facilities without specialized teen programs that experienced either a small increase (4%) or modest decrease (17%) during the same time periods. Importantly, the increased use of services was achieved at basically no financial cost to the clinic management, primarily owing to a staggering of staff time.[38]

- The Planned Parenthood Association of **South Africa** set up the Youth Information Centre Pilot Project to provide clinic RH services exclusively for adolescents and to create a replicable model for widespread adoption. A key planning strategy was the involvement of young people in the program's design; they are also involved in monitoring and management. The seven pilot centers are run by young professionals and offer contraceptive services, STD treatment, counseling, and pregnancy tests in a youth-friendly environment. Part of the "friendliness" was defined as not using the term "clinic" and not furnishing the centers in a medical mode. The centers also offer some form of entertainment, such as recreational and educational videos, and health literature. Privacy is assured. Referrals are made to handle health and social services not provided by the centers. Although full-fledged evaluations have not yet occurred following the initial baseline studies, attendance information shows that clients have been increasing since the program began. Staff members report improved attitudes toward condom use.[35]

- In **Brazil**, a public sector project to strengthen adolescent RH policy, training, and services was designed to establish an effective linkage between schools and health clinics. On the basis of some earlier efforts on incorporating sexuality education into secondary school curricula and on the consequent increased use of clinics by adolescents for family planning services, the project emphasized preparing health providers to work with adolescents. In addition, project components included a coordinated approach to policy revision, the training of student educators, and the establishment of cross-referral systems. The purpose of this pilot demonstration project was to identify a replicable model for referral between health clinics and nearby secondary schools that would improve the RH of adolescents attending those schools. A multimethod evaluation (including baseline and follow-up surveys) showed that significantly more students cited health center staff as potential sources of RH and sexuality information after an academic year of intervention and that significantly more students also used the health post to obtain information about how to avoid a pregnancy at follow-up compared to baseline.[82,83,84]

- In **Nigeria**, the ARFH observed that too few youth clients were attending the clinic situated in ARFH's main office because this location was not convenient, lacked accessible transportation, and had operating hours that conflicted with clients' daily routine. In response, and consistent with identified youth location preferences, ARFH established three satellite clinics in strategic locations accessible to larger populations of young people either living or working nearby. One site is next to a school involved in the project and sharing premises with an automobile mechanic workshop, another site is in an automobile spare parts dealers' community, and the third site is within a large shopping complex that is also close to workplaces of significant numbers of young people. Services at these satellite clinics depend in part on individual site needs, but generally they include counseling services by specially trained professionals, information dissemination by trained peer educators, and, in two sites, provision of nonprescriptive contraceptives. The shopping complex site also includes games, entertainment, and group health talks. Privacy and comfort are assured, and the clinics have educational posters that the young people find useful and attractive.

Operating hours are set to fit with client convenience. Drugs, especially for STD treatment, are dispensed at a subsidized rate, on credit, or both. According to ARFH, a significant increase in youth attendance and a higher distribution of condoms and vaginal foaming tablets have been recorded with the establishment of the satellite clinics. Anecdotally, there is evidence of increased awareness of the hazards of unprotected sex in the community and among adolescents. Principals from participating schools report a lowered incidence of unwanted pregnancy and drop-outs among girls.[85]

- In **Peru**, Instituto Peruano de Paternidad Responsable (INPPARES) set up the interactive, computer-based, instruction program "Isabel: Your Electronic Counselor." Johns Hopkins University, Population Communications Services (JHU/PCS) designed the CD-ROM to increase knowledge about sex, sexuality, unplanned pregnancy, contraception, and gender to encourage adoption of a family planning method and avoidance of risky behaviors among adolescents and young adults. The information, presented by means of videos, animated cartoons, text, and audio, is provided anonymously to the computer user, a great asset when sensitive material is being communicated. The touch-screen computer is set up in the clinic waiting room; a clinic "hostess" invites and directs young people and couples to try it out. The evaluation, conducted by the Population Council in Peru, along with INPPARES and JHU/PCS, found the typical user to be a woman (67%) between the ages of 13 and 24 (42.9%). Topics most frequently consulted were benefits of family planning, first sexual relation, machismo, hygiene, and abortion prevention. In a survey of users, clients liked the program and mentioned that it helped them avoid the embarrassment of having to ask strangers about issues of sex and sexuality.[86]

- In **Peru**, the FOCUS on Young Adults Project provided training in support of the Ministry of Health's School and Adolescent Health Program. That program offers integrated health care services that focuses on physical, reproductive, and mental health, with an emphasis on counseling. The strategy included piloting the FOCUS materials, training of trainers (TOT) workshops, and conducting regional workshops. Trainees at the regional workshops were mainly midwives and nurses, with a smaller proportion of doctors. Early evaluation results—of the TOT workshop—show an increase in knowledge of 162%, with a replicated workshop showing an increase of 73%. The broader evaluation, now under way, is designed to learn the effects of the training on improving quality and coverage of public health care to adolescents in three regions of the country, including how adolescents perceive services delivered by specially trained providers.[87]

- In the **Philippines**, in response to a Department of Health initiative, the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) supported an effort to improve RH services in collaboration with the Association for Philippine Schools of Midwifery, the Association of Deans of Philippine Colleges of Nursing, and the Foundation for Adolescent Development. The project aimed to strengthen adolescent RH services in 27 RH training network clinics and to improve adolescent RH training for faculty members in the schools of midwifery and colleges of nursing. Actions included training

needs assessments, development of training materials (especially focused on improved counseling), development of action plans to strengthen peer counseling and referral systems at the colleges and universities, and follow-up visits to the clinic sites to assess the quality of services to adolescents. According to the training posttests, attitudes were positively changed among faculty members and project staff members. Furthermore, site reports and follow-up visits showed adjustments at several clinic sites that improved service delivery for adolescents. These adjustments included the addition or improvement of counseling for adolescents, the arrangement of separate space for counseling adolescents, the setting aside of special times for adolescents, the establishment of outreach and referral systems, and the training of peer counselors.[88,89,90]

- The **Mexican** Institute of Social Security (IMSS), through its Adolescents Program, is responsible for providing health and social services, including sexuality information and RH care, to young people. With the recognition that young people have increased demands for education and services but are reluctant to attend IMSS clinics or other medical services when they were feeling well, IMSS launched a strategy to better serve adolescents in Mexico. On the basis of research and observation visits and in collaboration with JHU/PCS, IMSS established an institutional model to serve adolescents, integrating its medical, sports, and cultural centers as a more user-friendly approach. They defined a training curriculum and strategy to sensitize providers on the needs and realities of adolescents, and they developed an information, education, and communication plan for adolescents, their parents, and teachers. To help adolescents understand what to expect in clinics and to feel comfortable when attending a clinic, youth promoters, physicians, and paramedics visit schools and encourage guided tours of nearby facilities. As a result of pilot projects in three cities, IMSS has established a permanent nationwide program to serve adolescents in collaboration with several other government and NGOs. Because of the strong political will of its leaders and service providers, IMSS met the difficult challenge of providing youth-friendly services within the context of a medical environment.[3]

- In **Mali**, in response to a study on pregnancy among unmarried teenage girls, the Hamdallaye Maternity Hospital in Bamako redesigned its messages and services to meet the needs of adolescents. Emphasis was placed on communicating practical information to clients about the fertile period, contraception, and protection against STDs and HIV, as well as on providing contraception. Overall, the way clients were received was improved and adapted to reassure young people and to encourage them to come more often. Specifically, clinic hours were extended into the evening, clinic staff members tried to create a nonjudgmental atmosphere (particularly regarding the provision of contraceptives), and fee schedules were adjusted to allow free services when necessary.[91]

- In **Ghana**, the Program for International Training in Health (PRIME)/ International Training in Health (INTRAH) is working with the Ghana Registered Midwives Association to enhance positive provider behavior toward adolescents and to assess the potential of adolescent clients as a market niche. Given the entrepreneurial nature of private-sector

midwifery practice, the project is emphasizing the identification of factors that enable adolescents to become a viable market segment. This activity is based on a self-directed learning approach to improving the quality and access of RH services and is one module of a broader project to improve client-provider interaction.[92]

- Also in **Ghana**, PRIME partners, the Program for Appropriate Technology in Health (PATH) and INTRAH, in collaboration with the Youth Development Foundation and Planned Parenthood Association of Ghana, are planning a project to work with service providers from six clinics in Kumasi to expand adolescent access to youth-friendly RH information and services. This plan will be achieved by improving providers' understanding of and response to adolescent RH issues and needs and by building their skills and competency to address these needs—while advocating for improved adolescent RH services. Training and educational materials will be adapted for use, and youth-friendly services will be implemented, including a referral system. An evaluation, in collaboration with FOCUS, will be conducted that looks, in part, at the dynamic interface of youth groups with the medical system.[92]

- In **Colombia**, the IPPF affiliate, *Profamilia*, provides youth-friendly services in 36 clinics, with three different approaches. First, dedicated youth centers were established in three large cities in response to a heavy demand for services by young people. Given the high cost and the difficulty in sustaining such centers, other approaches needed to be implemented. These two other approaches included physical spaces set aside exclusively for young people in existing clinics with personnel exclusively attending to young people, and "Adolescent Services" provided to young people in regular clinics. Profamilia emphasized deployment of young professionals who were capable of empathy and had positive attitudes toward their young clients. Other youth-friendly features include convenient hours, group talks on sexuality issues, and audiovisual materials available for use by young people in the clinic.[45]

C. Outreach and community-based approaches

Given the challenge of attracting young people to clinics, new efforts have emerged to assist in client recruitment or as outreach activities to deliver services to locations where young people spend time. Some of these, such as hotlines and peer promotion programs, can be a component of the basic clinical program, providing information, and counseling, and referral to the clinic's services if needed. Others, including workplace and school-based programs, have recreated small versions of the clinic—usually with more limited services—in locations with significant numbers of young people.

These newer models hold significant promise for serving young people because they address the fundamental challenge of recruitment; instead of requiring clients to come to the services, these outreach programs take the services to the clients. Many of these outreach programs are relatively new and have not yet been evaluated. Furthermore, some are limited in design or

practice to providing information, counseling and referral and do not provide—or have not succeeded in providing—significant health services (such as contraceptive distribution or STD treatment). Following are several promising outreach or community-based models and examples of each.

Outreach to schools

Until recently, schools have been involved in facilitating adolescent reproductive health care primarily by allowing outside speakers to present information about RH issues and service locations; by the presence of peer educators who provide education, some counseling and referrals; and by direct referrals by teachers, guidance counselors or nurses. Although clinics, including RH services, within the school setting have become more common in the U.S.[93], this model is virtually non-existent in the developing world. The situation will undoubtedly change, as suggested by the appearance of new projects such as the clinic-school linkage begun in Brazil (see p. 24) and by the example below.

- In **Nigeria**, Action Health Incorporated (AHI) has begun conducting mobile clinics on the premises of interested schools within a local school district. Based on findings that many young people need adolescent-friendly services that are affordable and accessible, this approach is designed to: increase the number of young people who make informed choices about their sexuality, increase the number of young people who practice safe and responsible sex and provide general and pubertal health services to adolescents in their own environment. The mobile clinic provides, on a drop-in basis counseling, laboratory tests, treatment and referral for health matters. Consultation and counseling services are free, with tests conducted and drugs supplied at low prices. Although no contraceptives are provided to clients at the schools, students are referred for these (and other services not available at the mobile clinic) to the AHI Youth Centre which provides a broader array of services including those related to general health, sexual health, birth control, reproductive tract infections, sexual violence and drug abuse. Special youth-friendly characteristics are part of the clinic's approach, too, such as a warm welcome in the waiting room, films and print material available to use, drop-in visits, privacy, respect and confidentiality. Program administrators, judging from results on the exit questionnaires, conclude significant patient satisfaction as friends (likely prior users) were cited as the greatest source of referral.[94]

Workplace programs

The workplace is another location where significant numbers of young people can be reached, especially in particular industries and in certain countries, such as tea estates and clothing production in Asia. In Sri Lanka, for example, programs in the Free Trade Zone and on tea estates address ways to improve conditions for women workers, including family life education and health and family planning services.[8] While the advantages are clear to the employees, employers are increasingly recognizing the benefits of a healthy workforce, including the retention of employees who can avoid unintended pregnancies. Although programs are still

rare, it is likely that this approach will become more common. Some factories, as in Tanzania, have begun including RH services in their health rooms. More unusual is a multifaceted workplace program reaching beyond the immediate workforce into the community, as summarized below.

- In **India**, the Tata Iron and Steel Company, through its Centre for Family Initiatives (CFI), seeks to establish a model of corporate action to help young people become informed on sexual and reproductive health matters. It targets adolescents aged 14-18, single or newly married, living in nearby residential and slum areas, as well as those whose parents work in the company. Specific objectives for its education and health service program are preventing/minimizing child marriage, premarital sex, unwed pregnancies, and deaths of young mothers. Income is generated for the project through performances of the CFI Drama Troupe consisting of unemployed young people.[95]

Recreation and sports-related programs

The strategy of combining RH education and services with existing programs or other activities for youth has been tried in various ways in recent years. Youth centers, for example, developed in the late 1970's and 1980's in Latin America as a way to provide RH health within an environment meeting broader adolescent needs, such as tutoring, employment guidance, skills development, cultural activities, counseling and health services. Recreational activities were typically a key aspect of these centers.[5] While projects in Guatemala and Mexico showed some successes, evaluations also indicated that the multiservice approach was costly and did not attract as large a client base as planned.[96,97] The use of peer promoters, who provided information and referrals to the youth center in Guatemala did, however, significantly increase the center's distribution of condoms.[97] A recent evaluation in Kenya confirmed the ability of youth centers' to attract males, as the Latin American ones had done, but also reported low attendance and limited use of RH services.[98]

- In a Nairobi, **Kenya** slum, the Mathare Youth Sports Association was begun as an effort to promote sports and clean-up activities among boys in the neighborhood. It has expanded to include girls sports and reproductive health education, especially AIDS awareness. It has also become a model for empowering youth to run their own organization, as well as to develop self esteem and skills to benefit themselves and their community. Although the program stops short of offering RH services, it has provided awareness and information about the issues, as well as promoting greater skills for young people to manage their lives. No impact evaluation has been conducted but program data reveal that approximately 10,000 youth have been reached with AIDS education.[35]

Outreach to newlymarrieds

In countries with a high prevalence of early marriage, social traditions usually foster early childbearing as well. Many young brides in these countries, in spite of the legal age of marriage,

are young adolescents facing the same health risks from too early pregnancy and childbearing as their non-married counterparts. Thus programs that attempt to delay the first birth among newlyweds, while facing considerable challenges, can contribute significantly to improved health for mothers and their infants. The following program has pioneered a successful strategy.

- In **Bangladesh**, Pathfinder International has worked with NGOs for over a decade to reach younger, low parity couples with RH information and services before they begin childbearing. In most couples, the newlywed wife is under 19 years old. All newly married couples are registered by a Family Welfare Assistant field worker during a home visit, which establishes a relationship with the couple and their in-laws, while providing information on family planning. The field worker, when appropriate, provides family planning services and referrals for maternal and child health care. Orientation meetings are also held. Given recent changes in the contraceptive delivery system in Bangladesh, women now get their contraceptive services (along with other reproductive and general health services) at health clinics. Some home visits are still made, however, by the newly created "contraceptive depot holders" who sell contraceptives for a small commission on the sale. A major advantage of the program is the confidence that young women have in the depot holders, who are women from the community well known to them. Program findings indicate that overall contraceptive use has increased: the contraceptive prevalence rate of newlywed adolescents (aged 15-19) in the targeted areas increased from 19% in 1993 to 39% in 1997.[99]

Peer outreach programs

Peer outreach programs have often been instituted as an educational and referral component for "youth-friendly" clinics and youth centers. Increasingly, however, these activities are more independent, offering some services (typically provision of condoms and foaming tablets) and referring to a variety of community-based agencies for needs they cannot meet. Trained young people tend to be effective educators, accessible to their peers and able to relate to their cultural and age-specific concerns. From available evaluations, however, peer promoters seem more effective in providing information than in counseling; they appear even less effective in distributing contraceptives.[5] While more evaluations are needed to help guide program planners on issues such as training, compensation, support and retention of peer promoters, some promising programs have been documented, such as the one summarized below.

- The West Africa Youth Initiative (WAYI), operating in **Nigeria** and **Ghana**, is a collaboration of U.S. based NGOs and a Nigerian NGO working with small groups in both countries to develop project approaches as the basis for replication and expansion. Most approaches center on peer promotion activities. An evaluation of WAYI showed an increase in knowledge and use of modern contraceptive methods among the target population. The target population also scored significantly higher, compared to the control group, on a self-efficacy scale surveying feelings of confidence around saying "no" to sex, asking a partner to use condoms, and buying condoms.[100]

Social marketing

Social marketing campaigns have great potential for reaching a young target group because these activities combine the use of mass media, a strategy well suited to reaching youth, with placement of products in youth-friendly settings. Concerns of HIV/AIDS have made this strategy particularly appealing, because evidence shows that condoms are able to be marketed successfully with this approach—although the experience has primarily been with adults to date. There is also evidence that young people prefer to obtain condoms from the private, compared to the public, sector even if the cost is somewhat higher.[101] Activities that target young adults, although modest in number and primarily directed at HIV prevention, are underway in Jamaica and Kenya, as well as the program carried out and evaluated in Botswana, as summarized below.

- In **Botswana**, the Tsa Banana ("for youth") Program was designed to help persuade young people that RH services are meant for adolescents as well as adults. Activities included a communications campaign; youth-oriented social marketing of condoms; community outreach, including peer sales educators; and development of youth-friendly outlets. Retail outlets participating in the program agreed to display a Tsa Banana sign (identifying them as youth friendly) and representatives from these outlets attended a workshop on RH counseling to better offer advice to adolescents and to recommend a visit to a Tsa Banana Clinic. An evaluation of intervention and control groups found that although more desired changes occurred in the intervention site, there were mixed results as well as differences among males and females. A positive result unique to the intervention site was an increased belief that people use condoms to avoid sexual risks. On the other hand, females were more likely to feel shy about purchasing condoms after the intervention.[102] Focus groups showed that both males and females are shy about obtaining condoms in public, although males obtain condoms from friends.[101]

Telephone hotlines

Hotlines, while not providing direct health services, can assist young people to clarify their needs and can identify appropriate service sites. Very often, hotlines are part of a larger education, counseling and service program. For example, in the Philippines, a multimedia campaign for young people developed by the Population Center Foundation, in collaboration with JHU/PCS, featured popular songs that encouraged young people to delay sexual activity. Young people were encouraged to call Dial-a-Friend, a hotline staffed by trained counselors.[103] More typically, hotlines are used by clinics to provide an anonymous counseling opportunity, which can refer clients to the clinic for services, if needed. The two successful hotlines, reviewed below, are both operated by family planning associations.

- The **Japan** Family Planning Association began its hotline, in conjunction with clinical services, for adolescents in 1982. During the first seven years of operation, calls to the hotline outnumbered visits to the clinic by 9-1.[104] The **Lebanon** Family Planning

Association also runs a telephone counseling service especially geared to youth. Its purpose is to disseminate accurate information on sexual and reproductive health, provide counseling, and assist in finding appropriate solutions to sexual problems.[105]

IV. STRATEGIES AND ACTIONS TO MAKE SERVICES YOUTH FRIENDLY

As interest and activity in the area of youth-friendly services increases, a corresponding body of experience and practical tools can help program planners. Three practical areas of assistance for planning and enhancing youth-friendly services include suggestions of ways to overcome barriers and resistance; suggestions for assessment and planning tools; and information about training materials.

A. Ways to overcome barriers to establishing youth-friendly services

As indicated earlier, young people tend to avoid seeking RH services, especially at clinics and health centers. Some professionals cite this reality as a reason not to establish specialized services; in other words, why bother to do so if such services will not be used? This circular reasoning results in keeping matters as they are—no youth-friendly services and few young people attending clinics. At the same time, an assessment must be made regarding how best to deliver RH services—within a fixed site or as an outreach or partnership involving other activities.

Realistically, however, whatever model is selected, some clear challenges and barriers exist to providing youth-friendly services that should be recognized and addressed. Many of these barriers can be met or overcome by adjustments in operations, by staff selection and preparation, and, most importantly, by a commitment to the new approach. But costs—financial and otherwise—are involved that program managers should be aware of and should consider in making their plans. Some of the primary barriers, with some strategies to overcome them, are described below.

Providing RH services to young people is a sensitive public issue

In addition to being a new area of service, providing RH care to young people is often considered sensitive or controversial. This view derives from a traditional discomfort in many societies to publicly addressing sexual issues, and particularly when those issues involve young, unmarried people. Although unproven by evidence, a common concern focuses on the fear that providing services will encourage sexual activity.[106] Such concerns affected decision making in Indonesia, where political and cultural circumstances were deemed too inhospitable to serving youth. Thus, when staff members of an affiliate of a family planning association wanted to allow "mainstream" youth to receive contraceptive and STD services (which sex workers were receiving), the board rejected the idea as too controversial.[107]

In spite of this strong challenge, service providers increasingly recognize some obligation to provide sexually active people, although they may be young, unmarried, or both, with preventive and curative RH care. Where successful program initiatives have been developed, they required careful planning and concerted efforts to work with, and to gain the support of, the community. A fundamental starting place is the collection of statistics and research findings to establish a case for why such services are needed. Evidence can be accumulated on how other programs have developed services, and, where possible, such experiences can be used to demonstrate benefits of services and the lack of negative consequences. Finally, good research and preparation involve identifying probable criticism in advance and preparing strong responses, if necessary.

Programs can help foster support by diligently identifying community leaders who support provision of RH services to adolescents. These allies should have the respect of the community and should represent key stakeholder groups, such as the religious sector, schools, youth organizations, and the health sector. When information and explanation of proposed services are presented to the community, these leaders can help make the case.

The rationale for the clinic must make sense to the community by meshing with its values and by connecting to its practices and traditions. Thus, as cited above, a Zambian project positioned its health facility staff to be regarded as "grandparents," the group traditionally tasked with discussing sex and reproduction with youth.[79]

Staff attitudes can be negative or ambivalent about serving young people with RH care

Negative staff attitudes are often given as the main reason young people avoid seeking clinical services. Thus, even if management decides to provide services to young people, staff members can resist such efforts—or perform unresponsively if assigned to adolescent RH services. When considering how to address this challenge, it is important to note that service providers are products of their cultures and that, in most societies, sex between unmarried people is taboo. This deeply ingrained attitude can translate into disapproval or hostility.[108] In Antigua, for example, nurses assigned to work with young people indicated that when they became aware that young clients were sexually active, they encouraged them to change their ways and pursue sports or hobbies instead.[15] A study of a Botswana social marketing program revealed that young people—especially girls—feared provider attitudes regarding condom acquisition in clinics, pharmacies and stores.[101]

To help overcome such resistance or inappropriate performance, projects need both to select staff members who are supportive of providing RH to young people and to ensure their training. In new efforts, staff members can be selected according to attitude, interest, and willingness to be trained. In ongoing efforts, however, care must be taken to select among existing staff members those who are most suited to the task. In addition, all clinic staff members—from receptionist to cleaner—should be oriented to the needs and sensitivities of young people with

whom they will, or might, interact. In some instances, doctors can provide a special challenge as they are often the most powerful among clinic staff and cannot be replaced easily by alternate staff. If they hold negative attitudes, implementation can be stalled—or they may not serve young clients. The Lentera project (part of the Indonesian Planned Parenthood Association) partially addressed this problem by engaging young resident physicians who were seeking STD-related medical experience with female patients (because most STD patients in hospitals are men).[109] Similar placements of young physicians or student counselors can help solve the problem of reluctant staff; young staff members also have the benefit of being closer in age to their clients. Such arrangements will be more effective if the experience or practice needs of the new professionals are met. In Peru, for example, the IPPF affiliate, INPPARES, had less turnover among peer counselors than most programs because INPPARES engaged university students in psychology or social work who valued the relevant experience for their careers.[110]

Making RH services youth friendly requires additional training, staff time, and costs

Some additional resources will be necessary to institute or make services youth friendly. Staff selection and training are undoubtedly the most important and perhaps the most costly action. Programming more staff time per client results in higher operating costs.

Adjustments in facility characteristics, depending on how extensive, can require financial outlays, particularly if separate space or improved privacy must be created. Subsidizing client fees will require that additional resources be applied to the youth program.

These challenges may be substantial for most programs, whether they depend on public support, donor support, or client fees. Some programs have found that a youth component has so many benefits—especially far into the future—that attracting funds is somewhat easier than for other programs. Furthermore, at least a couple of programs have been able to make youth-friendly adjustments for minimal costs. In Chile, specialized centers with comprehensive care are part of the Adolescent Health Program. Though some additional funds have been provided by the Ministry of Health, the program is based primarily on a reallocation of resources previously used for traditional programs, including infrastructure, equipment, and personnel.[58] In the United States, a Teen Clinic reported an 82% increase in registrants for teen family planning that followed the implementation of special services of which most were included with little or no financial costs. This increase was achieved primarily by careful selection of appropriate staff members, by staggering schedules to accommodate adolescent-preferred hours, and by other actions with low direct costs, such as outreach, recruitment, development of networks, and establishment of referral arrangements.[38]

Laws and policies are often unclear or ambiguous on providing young people with RH services

Provision of RH services to young people must be within the relevant country's legal framework, but sometimes laws are not clear as to what services can be provided, under what circumstances, and to whom. When ambiguities exist, service providers can find themselves uncertain about particular actions, such as providing contraceptives to young, unmarried clients.

While clinics cannot necessarily have an effect on the laws, managers can explain existing laws as clearly as possible and, most importantly, can develop policies that enable them to serve young people to the fullest extent of the law. In this way, protocols can be defined clearly for staff, eliminating the need for personal interpretation that can be restrictive and in conflict with other clinic activities. For example, in Kenya, providers without clear mandates for serving this group tended to interpret ambiguous government policy narrowly.[8]

B. Assessment and planning tools

Tools are becoming available to assist program planners and managers to assess the "youth friendliness" of existing services and to identify what policies and operational characteristics need to be established. These tools can also be used by planners as a guide in setting up new services. A quick checklist, summarizing youth-friendly characteristics described in this document, appears on p. 42. The tools described below are available as indicated.

Assessment tools place a major emphasis on youth responses so that services will best meet their needs. No matter what approach is taken to plan improvements or to establish services for young people, part of the process should include finding out what young people need and want and how best to deliver these services. This gathering of information can be done through one of the following approaches or by another kind of needs assessment of the identified target audience.

1. Self-Assessment Module: Sexual and RH Programs for Youth

International Planned Parenthood Federation/Western Hemisphere Region, New York, 1998

This assessment tool is designed to help agencies improve the planning, the implementation, and the evaluation of youth programs. It focuses on activity components most commonly part of NGO youth programs in developing countries or which most lack a body of practical, programmatic information. Areas covered include general institutional capacity, sexuality education, and clinical services or community-based distribution. While designed for NGOs with ongoing youth programs, this assessment tool can be applied in government programs and in organizations planning a new program. The module has undergone field-testing with four IPPF affiliates and two NGOs in Latin America. Results show that the module is useful for identifying organizational weaknesses and areas of needed attention. For example, in the clinical services area, field tests showed a need to strengthen links between educational programs and clinical services, to strengthen protocols for clinical services for youth, and to strengthen strategies to serve youth in "mainstream" clinics.[111]

The self-assessment methodology used in this tool is a participatory process that consists of responding to provided questions and then discussing selected questions in an analysis workshop in which participants identify problems and find solutions. The final product is an action plan. The entire process can be completed during a one-week period. The module includes clear instructions for conducting the assessment, as well as questionnaires and forms for tabulation and development of the action plan. It also includes a good review of key elements and strategies for delivering services to youth and a section on supplemental resources.

Ordering information:

IPPF/WHR, Inc.
Sharda Kalloe, Evaluation Department
120 Wall Street, 9th Floor
New York, NY 10005-3902
212-248-6400 (phone) 212-248-4221 (fax)
e-mail: <skalloe@ippfwhr.org> or <info@ippfwhr.org>
Cost: US$8

2. Developing Youth Friendly Reproductive Health Clinic Services: A Protocol for Assessment and Planning

FOCUS on Young Adults, Washington, D.C. (Available April 1999)

This assessment tool, designed for RH clinic managers and young adult RH program planners and managers, will help users determine the level of access to RH services among young people in a given setting and the quality of those services. A major focus in assessing service quality will be placed on "youth friendliness."

The tool consists of key questions and different methodologies, presented in a logical order, to guide those conducting the assessment.

Ordering information:
FOCUS on Young Adults
Communications Coordinator
1201 Connecticut Avenue, NW, Suite 501
Washington, DC 20036
202-835-0818 (phone) 202-835-0282 (fax)
e-mail: <focus@pathfind.org>
URL: <www.pathfind.org/focus.htm>

Cost:
One copy free to those who request it while supplies last and able to be downloaded from FOCUS website

3. Improving Contraceptive Access for Teens *(Vol. IV of* Communities Responding to the Challenge of Adolescent Pregnancy Prevention*)*

Advocates for Youth, Washington, DC, 1998

Although based on conditions and experiences in the United States, this resource for program planners, service providers, community leaders, and youth advocates provides practical information and guidance that is applicable for many settings in developing countries. The document gives considerable background information on the importance of contraceptive access programs, the obstacles to access for teens, the factors contributing to adolescent contraceptive use (including a review of health behavior models), the strategies for teen-friendly family planning services, and a review of contraceptive options for teens. Included are relevant facts and programmatic examples.
The practical selections focus on planning for teen-friendly services. Included are questions for conducting a needs assessment; suggestions for getting started; and tips for working with teens, developing goals and objectives, considering staffing and training needs, developing a funding

strategy, dealing with controversy, and planning for evaluation.

Ordering information:

Advocates for Youth
1025 Vermont Avenue, NW, Suite 200
Washington, DC 20005
202-347-5700 (phone) 202-347-2263 (fax)
e-mail: <info@advocatesforyouth.org>
Cost:
US$25 per volume; US$115 for complete five-volume set*
(plus 15% of your total order for postage and handling)

C. Training materials

In response to the key variable in making clinics more youth friendly, international, national, and local agencies have increased efforts to train providers to better serve young people. This new emphasis has resulted in new, tested curricular materials and in increased program experiences.** The following materials are either available now or are in progress and will soon be available. Contact information is provided.

1. Zimbabwe Youth Reproductive Health and Counseling: A Trainer's Manual.

Zimbabwe National Family Planning Council, Harare (under development; production scheduled for Spring 1999)

This manual was developed by the Zimbabwe National Family Planning Council and JHU/PCS to better prepare service providers to work with youth. It is divided into two modules: "Challenges Youth Face Today" and "Interpersonal Communication with Youth." The first module focuses on the young people themselves and contains sessions on physical development, sexuality and patterns of sexual behavior, STDs and contraception for young people, substance abuse, relationships, and self-esteem and stress. The second module has nine sessions that address the counselors' values, the communication and counseling process, how to talk about

* The complete five-volume series includes Volume I—Mobilizing for Action; Volume II—Building Strong Foundations, Ensuring the Future; Volume III—Designing Effective Family Life Education Programs; Volume IV—Improving Contraceptive Access for Teens; Volume V—Linking Pregnancy Prevention to Youth Development.

** FOCUS updates its "Annotated Bibliography of Training Curricula for Young Adult Reproductive Health Programs" semi-annually. To receive the most current information, access the bibliography on FOCUS's web site <www.pathfind.org/focus.htm> or contact FOCUS to receive a copy.

sexuality, helping youth solve problems and make decisions, use of group talks and visual aids, and challenging moments in counseling. Each session includes information for the trainer on preparation and materials needed and suggests both the content and methods to be used. Where needed, the manual includes newsprint, overhead samples, and handouts to copy and give to participants. The suggested duration of the counseling course is four weeks, but a two-week version is also outlined. Workshop evaluation forms are included.

Contacts:

Mr. Godfrey Tinarwo, Executive Director
Zimbabwe National Family Planning Council (ZNFPC)
Harare Hospital Grounds, P.O. Box ST 220
Harare, Zimbabwe
263-4-620-281/5 (phone) 263-4-620-280 (fax)
e-mail: <znfpc@harare.iafrica.com>
or
Peter W. Roberts/Jane Brown
Johns Hopkins Center for Communication Programs
111 Market Place, Suite 310
Baltimore, MD 21202
410-659-6300 (phone) 410-659-6266 (fax)
e-mail: <proberts@jhuccp.org> or <jbrown@jhuccp.org>

2. Orientation Programme on Adolescent Health for Health Care Providers

WHO/UNICEF/Commonwealth Medical Association (under development; production scheduled for late 1999)

An orientation program for health care providers serving adolescents is being jointly developed by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the Commonwealth Medical Association. The target audience consists of health care providers (doctors, nurses, and clinical officers) in Africa, Asia, Eastern and Central Europe, and South and Central America. The orientation focuses on tailoring clinical practices to meet the special needs of adolescents. A strategy to achieve this objective is for participants to better understand the perspective of adolescents.

The sessions will use a wide range of teaching and learning methods, provide new information, stimulate reflection in a "safe" environment, and encourage the sharing of experiences. The orientation will be flexibly structured so that it can stand alone or can be incorporated into other programs; it can also be undertaken in a one-time session or be staggered over a period of time. RH, as well as other health issues relevant to adolescents (such as nutritional disorders and substance use), can be selected for inclusion in the program.

A participatory development workshop was held in Uganda, resulting in a refined document that was then tested at a second workshop in Zambia and at a third workshop in Malaysia. A fourth, and final, participatory workshop is planned for the Caribbean, possibly in early 1999.[112]

Contact:

Department of Child and Adolescent Health and Development,
WHO, Geneva, Switzerland
791-33-69 (phone) 791-07-46 (fax)

3. Client Provider Interaction (CPI) Prototype Curriculum for Global Adaptation and Use

PRIME (under development)

In accordance with its mandate to increase the access to and the quality of family planning and RH services, PRIME (PATH and INTRAH) is developing a prototype CPI training curriculum on interpersonal communication and counseling. This prototype is in response to an identified gap in training resources that address client comprehension, adherence, and satisfaction with services. The curriculum will consist of a series of modules that target the most challenging areas of behavior change. One of these modules will be on adolescent RH, featuring effective work with adolescents both in personal counseling and outreach settings. PRIME will pretest the set of modules in developing countries in at least two continents. The prototype will be available by Spring 1999.[92]

Contacts:

Elaine Murphy (PATH) <emurphy@path-dc.org>
Sharon Rudy (INTRAH) <srudy@intrah.org>

CHECKLIST: CHARACTERISTICS OF YOUTH-FRIENDLY SERVICES

Provider Characteristics	
❑	Specially trained staff
❑	Respect for young people
❑	Privacy and confidentiality honored
❑	Adequate time for client and provider interaction
❑	Peer counselors available
Health Facility Characteristics	
❑	Separate space and special times set aside
❑	Convenient hours
❑	Convenient location
❑	Adequate space and sufficient privacy
❑	Comfortable surroundings
Program Design Characteristics	
❑	Youth involvement in design and continuing feedback
❑	Drop-in clients welcomed and appointments arranged rapidly
❑	No overcrowding and short waiting times
❑	Affordable fees
❑	Publicity and recruitment that inform and reassure youth
❑	Boys and young men welcomed and served
❑	Wide range of services available
❑	Necessary referrals available
Other Possible Characteristics	
❑	Educational material available on site and to take
❑	Group discussions available
❑	Delay of pelvic examination and blood tests possible

- Alternative ways to access information, counseling, and services

V. FUTURE NEEDS TO IMPROVE PROGRAMMING

Program planners and managers are increasingly aware of the need to serve young people with RH services. More recently, a limited number of efforts have been made to make services attractive, relevant, and friendly enough that young people will feel comfortable coming and returning for care. Increasingly, training programs better equip service providers to meet the needs of young clients. Resources and tools now exist both to assess whether existing services are youth friendly and how to adapt them (or begin new efforts) to include characteristics preferred by youth.

Yet challenges and obstacles remain. Foremost among them is the lack of compelling data and evaluation findings to guide planners in establishing youth-friendly services or to demonstrate to policy makers and the public that such efforts are advantageous. Some of these challenges can be addressed collectively by those pursuing activities in the adolescent RH field. Other actions must be conducted at the national and local levels and especially in the local communities where clinics and other programs will operate. Some key actions are described below that could foster more substantial gains in establishing effective services for youth.

Undertake evaluation and disseminate findings on youth-friendly services

As evidenced by this review, limited evaluation findings are available to assist program planners in designing effective programs. Programs that train providers to serve adolescents or to adjust service operations to better accommodate their needs should incorporate an evaluation component into their plan from the beginning. It is also important that greater efforts be made to look at specific adjustments or components within the new design. Among other factors, the field needs to know the following:

- How are staff best selected for work with adolescents? What criteria can be used?
- What are effective training components to prepare staff for the provision of adolescent RH care? Are there good materials for dealing with key issues of attitude, confidentiality, and respect?
- What facility elements tend to be most important for serving young adults—drop-in scheduling, operating hours, separate clinics, costs, physical setting, outreach components?
- What services should comprise a minimum package of RH services for adolescents depending on resources available or likely to be available?
- What services should be included in a referral system?

- How can services best be linked with schools, community groups, and other professional agencies? Can services be placed within school settings as part of their health offerings?

- How can counseling efforts (such as hotlines) be more effectively linked to services?

- How can services better reach underserved, non-affiliated youth (for example, out-of-school youth)?

- How important is youth involvement in planning, implementing, and evaluating youth-friendly services?

Foster policy support and networking to establish youth-friendly services

Given that policy constraints (or lack of clear policies) compromise efforts to establish and to provide services for young people, efforts to foster positive policies are often necessary. Success in this initiative will be based, in part, on evaluation findings that indicate the benefits of establishing youth-friendly services. Another facilitating factor is the collaboration of youth groups, health and other service organizations, and government agencies in pursuing a common agenda. Intersectoral cooperation among several ministries in Peru, for example, resulted in a key change in the law related to allowing pregnant young women to remain in school.[113] Efforts to forge nongovernmental networks will also affect policy outcomes and can help generate needed community support—and referrals—for clinic services that get established.

Conduct public education campaigns to gain support

Providing RH services to young people can be a sensitive issue, especially in communities where such programs represent a new idea and are not well understood. Helping the community to see a positive role for these services—as the Zambia project did, as described above—can help ensure success but requires an organized campaign of public education. The community, of course, is diverse, requiring tailored communications with various interests, such as religious leaders, social service providers, educators, and others. Parents and other adult family members are a key group whose support determines children's participation. Discussions and work with this group often requires more personal interchange and opportunities to become familiar with clinic objectives and operations. If handled well, parents can move from detractors to allies, sometimes requesting a program activity to help them become better informed—and equipped—to work more comfortably with their children.

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