

Thinking outside the separate space:

A decision-making tool for designing youth-friendly services



USAID
FROM THE AMERICAN PEOPLE

E2A EVIDENCE TO ACTION
for Strengthened Reproductive Health

About E2A

The Evidence to Action Project (E2A) is the US Agency for International Development's (USAID) global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, Intrahealth International, Management Sciences for Health, and PATH.

Contact Information

1201 Connecticut Avenue, NW, Suite 700
Washington, D.C. 20036

Tel. 202-775-1977
Fax 202-775-1988
info@e2aproject.org
www.e2aproject.org

This publication was made possible through support provided by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development, under the terms of Award No. AID-OAA-A-11-00024. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

Acknowledgements

The E2A Project gratefully acknowledges the generous support of USAID for the creation of this tool.

Suggested citation:

Callie Simon, Regina Benevides, Gwyn Hainsworth, Gwendolyn Morgan, and Katie Chau, *Thinking outside the separate space: A decision-making tool for designing youth-friendly services* (Washington, DC: Evidence to Action Project/Pathfinder International, March 2015).

The authors also would like to thank the following individuals for their valuable inputs into drafts of this tool: Anjala Kanesathasan, E2A and Intrahealth International; Cate Lane, USAID; and Shannon Taylor, USAID. Rena Greifinger of Population Services International and Claire Tebbets of the Planned Parenthood Federation of America were instrumental in the early conceptualization of the tool and provided examples of youth-friendly services referenced. Sarah Eckhoff of Pathfinder International provided support to developing the content and annexes for this tool.

This tool was field tested during the Workshop for the Prioritization and Dissemination of AYSRH Best Practices in Niger. The authors are grateful to the Ministry of Health and partners for their input and suggested revisions.

February 2015

Table of Contents

Acronyms.....	2
Background.....	3
What is this tool and why is it needed?.....	6
Section 1: What are the different models of YFS?.....	8
Section 2: Choosing a YFS model(s).....	14
Step 1: Determine desired health/behavioral outcomes and which sub-population of adolescents and youth the services should reach.....	15
Step 2: Conduct an SRH landscape analysis.....	16
Step 3: Determine what package of SRH services will be offered	16
Step 4: Determine available resources	17
Step 5: Determine desired level of coverage	19
Step 6: Select one or more models for delivering YFS.....	19
Model 1: Standalone clinic.....	20
Model 2: Separate space for YFS.....	22
Model 3: Mainstreamed YFS.....	24
Model 4: Mobile outreach services.....	26
Model 5: Community-based services	28
Model 6: Drug shops and pharmacies	30
Table 1: Summary of considerations and implication of different models of YFS.....	32
Step 7: Plan for scale-up of the selected YFS Model(s).....	35
Section 3: Supportive elements of YFS	36
Section 4: Additional recommendations to reach sub-populations of young people.....	40
Conclusion	44
References.....	45
Annex 1: Guides, tools, and resources for the implementation of YFS	48
Annex 2: Guiding questions to operationalize each step.....	54

Acronyms

FLW	Front line worker
FTP	First-time parent
HMIS	Health management information system
IDU	Injecting drug user
IEC	Information, education, and communication
LARC	Long-acting reversible contraception
LGBTQ	Lesbian, gay, bisexual, transgender, queer
LMIC	Low- and middle-income countries
MCH	Maternal and child health
MSM	Men who have sex with men
NGO	Nongovernmental organization
PGB	Programa Geração Biz
PPFP	Postpartum family planning
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
VYA	Very young adolescent
WHO	World Health Organization
YFS	Youth-friendly services
YPLHIV	Young people living with HIV



Background

Adolescents and youth (10-24 years)ⁱ have the right to live healthy sexual and reproductive lives. However, many adolescents and youth—particularly those in low- and middle-income countries (LMIC) —lack the information, skills, agency, and access to services that enable them to fulfill that right. Data from LMIC reflect this situation. For example, 46% and 49% of unmarried adolescent girls in West and Central Africa and East and Southern Africa, respectively, have an unmet need for contraception,¹ and few married and unmarried adolescent girls across least developed countries are currently using a modern contraceptive method (20% of 15-19 year olds and 29% of 20-24 year olds).² Low use of contraception, as well as early marriage, and societal pressure to bear children soon after marriage often leads to early childbearing and increased risk of unsafe abortion and maternal and infant mortality.³ Youth (15-24) continue to have a disproportionately high rate of HIV incidence, representing one-third of new HIV infections.⁴ Further, there is a growing cohort of young people living with HIV (YPLHIV) who have a unique set of sexual and reproductive health (SRH) needs. All too often, early childbearing, HIV, and other SRH outcomes have negative impacts well beyond the health of young people, including limiting educational or employment opportunities and preventing young people from fulfilling their full potential.

Use of high-quality and comprehensive SRH services could prevent or mitigate many of these poor health outcomes, but a wide range of barriers prevent young people from accessing these services.^{5,6} These include:

- Structural barriers, such as laws and policies requiring parental or partner consent, distance from facilities, costs of services and/or transportation, long wait times for services, inconvenient hours, lack of necessary commodities at health facilities, and lack of privacy and confidentiality.

ⁱThe WHO and other international organizations define youth as 15-24, adolescents as 10-19, and young people as 10-24. For the purposes of this tool, the terms will be used according to these definitions, with the terms “adolescents and youth” and “young people” being used interchangeably.



Addressing gender, age and life-stage barriers to SRH

Individuals are socialized from birth on the roles, responsibilities, and behaviors expected of them based on their age, sex and life stage. These inter-related norms shape perceptions of what it means to be a young man or young woman, including expectations for sexual activity and reproduction. For many young people, gender- and age-related norms restrict their ability to understand their SRH options, make informed SRH decisions, access SRH information and services, and sustain positive SRH behaviors. When choosing YFS model(s), it is important to address the gender and age norms that are barriers to youth SRH. Some examples include norms related to:

- **Masculinity and femininity** (e.g., expectations of how men and women should act, interact or treat each other);
- **Sexual activity** (e.g., promoting sexual experience for young men, while restricting pre-marital sex for women);
- **Fertility** (e.g., norms that place value on demonstrating fertility or on the desired number of children);
- **Mobility** (e.g., norms that restrict autonomous movement, particularly for women and girls);
- **Couple interaction** (e.g., communication between men and women or decision-making within marriage);
- **Access to or control of finances and other assets** (e.g., norms that restrict young women from earning or controlling their own income; inheritance laws or practices).
- Sociocultural barriers, such as restrictive norms and stigma around adolescent and youth sexuality; inequitable or harmful gender norms; and discrimination and judgment of adolescents by communities, families, partners, and providers.
- Individual barriers, such as young people's limited or incorrect knowledge of SRH, including myths and misconceptions around contraception; limited self-efficacy and individual agency; limited ability to navigate internalized social and gender norms; and limited information about what SRH services are available and where to seek services.

Youth-friendly services (YFS) (also called adolescent-friendly services) are designed to mitigate these barriers in order to attract and retain young people for services.⁷ According to the World Health Organization (WHO), to be considered youth-friendly, health services should be equitable, accessible, acceptable, appropriate, and effective (see Box 2).

YFS have been implemented for over two decades in LMIC. While studies of YFS are limited both in number and in their ability to assess the impact of YFS on health outcomes, sufficient evidence exists to suggest that YFS can increase young people's use of SRH services when they include three major components: (1) training for health care providers (on youth-friendly service provision and core competencies for delivering adolescent health services);⁴⁰ (2) improvements in facilities to increase access and quality of services for young people (e.g., lowering user fees, organizing services to improve client flow, and increasing privacy), (3) and community-based activities to cultivate an enabling environment and increase demand.^{5,8,9,10} Furthermore, young people themselves consistently prioritize privacy, confidentiality, and respectful treatment by providers as the most important attributes of quality health services.^{7,11,12}

Characteristics of youth-friendly services

The World Health Organization has established five characteristics for adolescent-friendly services:³⁹

Equitable: All adolescents, not just certain groups, are able to obtain the health services they need.

Accessible: Adolescents are able to obtain the services that are provided.

Acceptable: Health services are provided in ways that meet the expectations of adolescent clients.

Appropriate: The health services that adolescents need are provided.

Effective: The right health services are provided in the right way and make a positive contribution to the health of adolescents.

What does this mean when applied to health providers, health facilities, SRH services and programs?⁴⁰

Health provider and other staff characteristics and competencies:⁴¹

- All health providers are trained in YFS, including: basic concepts in adolescent health and development, including protective and risk factors; young people's evolving capacities; effective communication with adolescents; how to raise and discuss sensitive issues; local attitudes, beliefs, and practices related to youth SRH; how gender and life-stage-related norms influence young people's SRH; reflection on how providers' beliefs and values influence the delivery of youth SRH, in addition to the delivery of clinical SRH services tailored to young people.
- All staff are oriented on providing confidential YFS, including health providers, receptionists, security guards, cleaners, laboratory technicians, etc.
- All staff treat male and female young people with respect and demonstrate non-judgmental attitudes toward all young people.

- All health providers are aware of and apply laws and policies related to youth SRH access and choice, including those that allow young clients to receive services without the consent of their parents or spouses.
- Providers provide adolescents with time to understand their options and make decisions.

Health facility characteristics:

- Hours are convenient for males and female youth.
- Services are conveniently located so that both male and female youth can access them.
- SRH services, including contraceptives, are offered for free or at an affordable fee for young people.
- There are short waiting times for services.
- Counseling and treatment rooms guarantee privacy (auditory and visual).
- Possibly specific times, days or spaces are set aside for young people, so that they can avoid being seen by people they know.

Program design characteristics:

- All young people, regardless of sex, age, marital status or parity, are able to access and choose from a wide range of integrated SRH, family planning, sexually transmitted infection, HIV, and gender-based violence services in the health facility or through referrals.
- Information, education, and communication materials are available for young people.
- Community health workers/peer educators are available onsite and/or in the community and are able to provide or link young people to health services.
- Male and female youth are involved in the design and monitoring of quality services.
- Written guidelines exist and are well-known by all staff providing services to young people.
- Drop-in clients are welcomed and/or appointments can be quickly arranged.
- Publicity of YFS informs young people of the YFS.

What is this tool and why is it needed?

What is this tool?

This is a decision-making tool to guide program designers in selecting and adapting appropriate youth-friendly service delivery model(s) based on the country context, target population, desired behavioral and health outcomes, SRH services to be offered, and needs and objectives for scalability and sustainability. The tool outlines seven different YFS models and seven steps for selecting and planning the scale-up of appropriate YFS models. This tool is primarily focused on supply-side interventions. It is not designed to help program designers plan and implement demand-generation activities or interventions for fostering an enabling environment. However, users are encouraged to keep demand-side and broader enabling environment interventions in mind when working through the steps of this guide.

Why is this tool needed?

Taking into consideration the essential features of YFS described above, there are many channels, modalities, structures, or ways (i.e., different models) through which friendly services can be provided to young people. Yet, the most common approach—using a separate space or clinic to ensure privacy coupled with recreational and other programs to attract young people—has been implemented across a range of LMIC contexts. This model may not always be the most appropriate to the local context, it might not meet the needs of the specific young women and men that the program is aiming to serve, it may be more costly than other alternatives, and it has not been shown to be consistently scalable or sustainable. There is growing recognition, most notably in the WHO's 2014 report, *Health for the world's adolescents*, that it is time to shift from small-scale YFS initiatives to adolescent-responsive health systems.¹³ To move in this direction requires a shift in the way YFS are conceptualized and designed by donors, governments, and NGOs; from a one-size-fits-all YFS model to a highly adapted and contextualized model of YFS that is appropriate to the systems of a country and the needs of its diverse adolescent and youth population. Currently, there is no global

tool to guide program designers through the decision-making process that is required to develop such an adapted YFS model. This tool has been developed to fill this gap. There are several guides and other implementation tools, such as YFS facility assessments, training curricula, supervision checklists, and job aids, which can support implementation of YFS once a model has been determined. These are listed in Annex I.

Who is this tool for?

This tool is developed for program designers, including government officials, NGO staff, donors, among others, interested in improving the SRH and fulfilling the rights of young people by increasing access to and use of SRH services.ⁱⁱ

How is this tool organized?

This tool is organized in four sections:

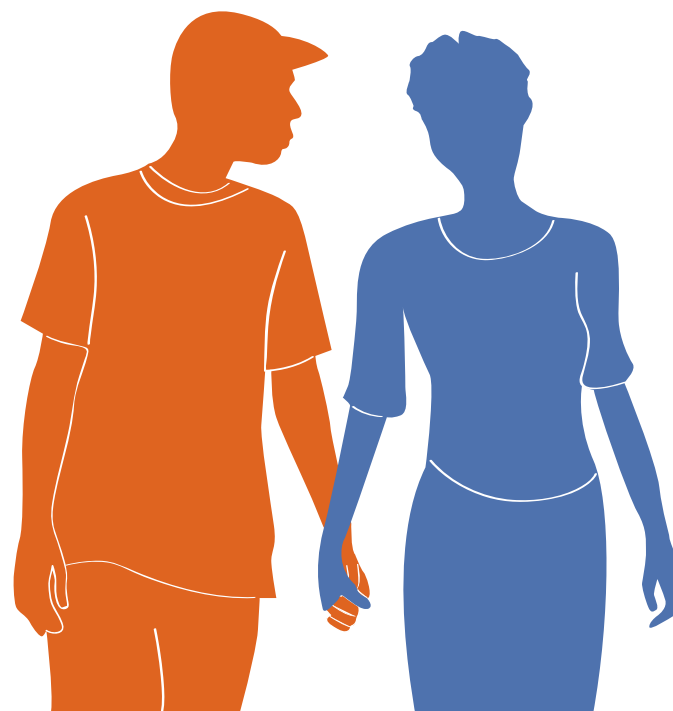
Section 1 lists the different choices for YFS models.

Section 2 walks through the seven steps that program designers should take in choosing YFS model(s). Steps 1 through 5 should be used in an iterative manner, so as to generate important information for steps 6 and 7.

Section 3 highlights the support elements, such as generating youth demand and fostering an enabling environment, that are important to consider when developing and implementing any approach to YFS.

Section 4 offers additional recommendations on adapting services to reach specific vulnerable sub-populations of young people.

ⁱⁱ This tool is designed for decision making about YFS in a relatively stable environment. In the case of humanitarian emergencies, conflicts, and/or other destabilizing conditions, additional considerations should be made for adolescent and youth SRH. A toolkit for these situations is included in Annex I.



Section 1

This section briefly describes some of the YFS models that are implemented in LMIC today. Many variations on these models exist, and there are other less common models of SRH service provision for young people not mentioned here. In addition, more than one model could be employed in an adolescent-responsive health system to increase the number of delivery channels through which services are offered to young people and thus respond to the needs of distinct sub-populations of male and female adolescents and youth.

What are the different models of YFS?



First, a note on youth centers

In this guide, “youth centers” refer to recreational centers which may also offer some SRH services. Youth centers are most often separate buildings, which house spaces for recreation and/or vocational training, and have a space/room staffed by a health provider offering basic, preventive clinical SRH services or counseling and referral to services. Sometimes, a youth center (a space offering games, computers, recreational equipment) is located on the property of a health facility. Though the youth center model has been widely used in LMIC, **youth centers have been shown to be an ineffective way of increasing use of SRH services among adolescents and youth.**¹⁴ A systematic review of the evidence suggests that youth centers attract primarily males, usually older than the target youth population, for recreation, but visitors to youth centers rarely use the SRH services available.¹⁴ While the review found that some young women use the SRH services at youth centers, the review notes that these are rarely vulnerable youth or within the target age group. As such, youth centers are a costly and less effective way of increasing use of SRH services and have limited scalability. However, youth centers may remain appropriate for addressing the broader development needs of young people, including access to education, technology, and livelihood opportunities. As youth centers are not an effective modality of service delivery for adolescents and youth, they have not been included in this guide as an option for program designers to consider when trying to increase young people’s access to and use of SRH services.

Social franchising for adolescents and youth

A social franchise is a network of health providers/facilities linked through contractual agreements to provide services under a common brand. The providers/facilities may be supported by the private sector, public sector, or a combination of both. In a social franchise, providers/facilities agree to offer a set of services and maintain a certain standard of quality in order to be affiliated with a brand. The lead of the social franchise (often an INGO) provides training and support to start up and/or maintain their business; ongoing supportive supervision and capacity building; a common brand and centralized marketing strategy; a quality assurance system; a clear franchise fee structure; and a learning culture that fosters openness and innovation. Social franchises are sometimes linked with social marketed products such that a particular social franchise offers a specific brand of products (and the demand generation for one reinforces the other). Social franchising can be one way of developing and marketing YFS. In this case all the providers/facilities in the network would need to uphold YFS quality standards and the brand/marketing for the network would be focused on young people. Social franchise YFS could be composed of standalone youth clinics (model 1), separate space YFS (model 2), and/or mainstreamed YFS (model 3). While it will not be treated as a separate model in this tool, it is an important option for YFS designers as it provides a way to attract young clients and a mechanism to ensure quality services for young people across a network of facilities.



Model 1 Standalone clinic

Standalone clinic for adolescents and youth through public or private sector

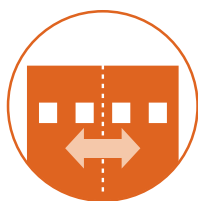
This model of YFS refers to a completely separate health center/clinic dedicated to serving adolescents and youth with a range of clinical services, including SRH services. This model is often implemented by the private sector, including NGOs or other private providers, but some countries have implemented this model through the public sector. Standalone youth clinics are often located in cities since they require a high volume of young clients to make them more cost effective and sustainable over time. This model may also include peer educators or counselors available for onsite counseling, as well as measures to promote the services among young people in the catchment area.



Model 2 Separate space for YFS

YFS offered through separate spaces co-located in public or private health facilities

In this model, SRH services for young people are provided in a separate room or separate building (by specifically trained providers) and/or on specific days within a public or private facility. This model can be implemented at all levels of health care facilities, but is most common in larger primary health centers or hospitals that have sufficient space for a separate YFS area, rather than at the lowest level of health facilities (e.g., health post or dispensary). Typically there is a dedicated YFS provider (i.e., a health provider whose only job is to provide services to young clients) who offers a wide range of integrated SRH services (i.e., contraception counseling and provision; HIV testing, treatment, and care; sexually transmitted infection (STI) testing and treatment; maternal health services; among others) in the YFS space. This model may also include a separate YFS waiting area with information, education, and communication (IEC) and audiovisual materials and/or separate reception and triage points for young clients. If the clinic/health system has fees for SRH services, this model may include subsidized pricing for young clients. As with standalone clinics, peer educators may be available onsite for counseling and this model should include demand-side measures to promote the services among young people in the facility catchment area.



Model 3

Mainstreamed YFS

YFS integrated/mainstreamed within existing services through a range of service delivery points in a public or private health facility (not separate space)

Rather than offering YFS in a separate room or building as described in the model above, this model requires that all (or most) health providers and support staff in the health facility offer high-quality services to young people as part of their routine service delivery. In this “whole facility” model, any provider, whether they offer contraceptive services, STI services, HIV treatment and care, maternity services, other SRH services, primary care services, or any other type of health service are non-judgmental to all young clients, ensure privacy and confidentiality, and offer quality counseling and referrals to other services if needed (e.g., the contraception provider would offer a full range of contraceptive methods to the client and refer him/her to other services within the facility or outside the facility, as needed). Special hours for adolescent and youth consultations can also be offered through this model. This mainstreamed model of YFS can be offered at any level of health facility, including primary health care facilities. Like the separate space YFS model, mainstreamed YFS should include additional demand-generation strategies to attract and retain young clients such as peer educators onsite and in the community, tailored IEC materials, publicity of special hours for youth consultations, promotion of the services among young people in the facility catchment area, and engagement with gatekeepers to reduce social barriers to service seeking.



Model 4

Mobile outreach services

YFS offered through mobile outreach services

Mobile outreach services, defined here as services offered in strategic locations closer to the people that most need them, can be an effective model to bring SRH services to young people. There are a range of different types of mobile outreach mechanisms, including mobile clinics (i.e., a full range of services offered in a specially equipped van/bus); satellite clinics (i.e., a full range of services offered in an existing non-health space/tent on a routine basis); services offered by a mobile team of health providers at lower level health facilities that don't routinely offer those services (e.g., provider trained in providing IUDs visits a lower-level health facility where providers don't have this capacity); and other non-routine outreach events (e.g., immunization days in communities, MCH days).¹⁵ These outreach services, which always include provision of services by health care providers (as opposed to lay front line workers [FLWs]), can be made youth-friendly by: ensuring that providers are trained in YFS and offer quality and non-judgmental services; maintaining privacy and confidentiality; and planning mobile outreach services in locations and at times that are accessible to young people. Mobile outreach services can be offered in non-health settings to reach targeted groups of young people. This could include: schools, workplaces, prisons, military facilities, sports clubs, or shelters for street youth, among other places. Demand-side strategies should be implemented in conjunction with mobile services, especially to raise awareness about the types of services that will be offered, as well as when, where, and for whom they will be offered.



Model 5 Community-based services

YFS offered through community-based outreach services by peers or other FLWsⁱⁱⁱ

Some YFS can be offered outside of the static health facility by peers or by FLWs. In this model, peers may be called peer educators or youth peer providers and are adolescents and youth with similar characteristics as the target population. Peer educators/peer providers can be trained and supported to offer a range of SRH services, including counseling, select contraceptive methods (e.g., condoms, combined oral contraceptives), HIV counseling and treatment adherence support, and referrals and vouchers for services in schools, youth clubs/groups, homes, and other youth-gathering places. FLWs are lay health workers, usually adults, who are trained to provide a range of services at the community level. Increasingly, FLWs are an official part of the national public health system, but in some contexts may be working for a NGO. FLWs, though often supported to provide services to older women with children, can be trained and supported to offer services that are friendly to adolescents and youth through home visits, mobile outreach, and other community-based channels.

ⁱⁱⁱ FLWs can also be referred to as “community health workers,” “community-based distributors,” “community health extension workers,” and “community health agents.”



Model 6 Drug shops and pharmacies

Drug shops and pharmacies

Drug shops and pharmacies, usually private sector but occasionally public sector, can be easily accessible to young people, and offer fast and (relatively) anonymous services.¹⁶ For these reasons young people often seek basic SRH commodities or services, including condoms, oral contraceptives, emergency contraception, injectables, and treatment for STIs/reproductive tract infections at pharmacies and drug shops. Pharmacies and drug shops can be considered a model of delivering youth-friendly services if pharmacists and pharmacy staff provide accurate, non-judgmental, and comprehensive counseling to adolescents and youth; provide IEC materials on SRH; maintain privacy and confidentiality; and refer young people to health facilities for any additional SRH needs.¹⁷ Social marketing, which uses commercial marketing techniques to make a product available and affordable through a range of channels, and links the product to a communications campaign which promotes brand recognition and demand, often targets young people and is an important tool in increasing demand for commodities and services at pharmacies and drug shops.



Model 7 SRH services in non-health settings

In order to reach young people where they are and reach some of the most vulnerable adolescents and youth, YFS can be offered in a range of different non-health settings where there is a large adolescent and youth population, including schools, workplaces, prisons, military facilities, areas where young injecting drug users (IDUs) gather, or areas where young sex workers live or work. In these cases, the YFS model will necessarily vary from place to place to accommodate the conditions of the non-health setting and the population to be reached in this setting. Besides the mobile clinics and satellite clinics described above, a static service delivery site which provides either a separate space or integrated YFS could also be considered. Given the high degree of variability of ways in which YFS can be delivered in non-health settings, this decision-making tool will not include this as a model in the remaining sections; though it remains an important option for program designers to consider.

The diversity of adolescents and youth

Adolescents and youth are a complex and heterogeneous population with different characteristics that influence their needs and vulnerabilities, including:

- age (e.g., 10-14, 15-19, 20-24);
- sex;
- life stage (e.g., unmarried, married, parenting);
- type of relationship (e.g., casual serial partnerships, multiple concurrent partnerships, monogamous marriage, polygamous marriage);
- sexual orientation (e.g., lesbian, gay, bisexual, transgender, queer);
- behaviors that might make them a key population for HIV (e.g., young men who have sex with men, young injecting drug users);
- health status (e.g., young people living with HIV);
- education level, schooling status (in or out of school);
- employment status;
- vulnerability status (e.g., living with a disability, street-based/homeless, refugee, illiterate);
- access and control over financial resources;
- household composition (e.g., living with both parents, single-parent household, orphans, adolescent-headed household);
- geographic local (urban, rural, slums, peri-urban).

The same service delivery model is rarely able to serve all cohorts and sub-populations of adolescents and youth, so program designers should identify and prioritize the sub-population(s) of young people that they wish to serve.

Section 2

Choosing a YFS model(s)

Each of the models described in Section 1 can address the SRH needs and rights of young people. So, how should you, as program designers, select a model or a combination of models to implement? The next section lays out the steps and considerations that can yield important information to help identify and select the most appropriate model(s) for your context. Each of these steps and decisions described below should be approached through a consultative, participatory, and iterative process with a range of key stakeholders, including adolescents and youth (especially representatives from the sub-populations that you aim to serve), Ministry of Health and other relevant ministries, NGO partners, and health providers.



STEP 1

Determine desired health/behavioral outcomes and which sub-population of adolescents and youth the services should reach

The first step in designing YFS is to ask: What are the **desired health outcomes** (e.g., HIV prevention, unintended or early pregnancy prevention, increase HIV treatment, care, and support) you aim to achieve and **which sub-population(s)** of adolescents and youth will the services aim to attract, serve, and retain? These two questions are critical and interrelated. In some cases, you may choose to first use data to identify the priority SRH issues for young people in the intervention areas and then, based on that, identify the sub-population of young people to target (e.g., if the desired health outcome is to reduce early pregnancy, the program may choose to target adolescent girls 12-17). In other cases, you may choose to begin by determining which sub-population to target, and then identify the key health and behavioral outcomes desired (e.g., if you want to focus on very young adolescents [VYAs], then the health and behavioral outcomes may be focused on life skills, body literacy, healthy and safe passage through puberty, and reducing adolescent pregnancies).

In both scenarios, you should conduct a thorough assessment of the health needs of young people in your country or selected catchment area using population-based data (e.g., the Demographic and Health Survey), census data, data collected by the Ministry of Health and Ministry of Youth, qualitative research examining vulnerabilities, service delivery data, and extensive stakeholder consultations, including with adolescents and youth (see Annex 1 for tools to support an adolescent and youth assessment). Using this data, you can identify priority health outcomes and priority sub-population(s) of young people. For example, in the context of low HIV prevalence, but high early marriage and childbearing, you may wish to prioritize the

reproductive health needs of unmarried and married adolescent girls. Alternatively, in the context of a generalized HIV epidemic and high incidence among adolescents and youth, you may choose to prioritize integrated services for adolescents living with HIV, or in a concentrated epidemic, you may choose to tailor services to young key populations. In this step, it is important to recognize the diversity of young people and consider how different combinations of characteristics shape the realities of young people in diverse ways (e.g., married adolescents with no children compared to those with several children; young people living with HIV who are married, unmarried, parents, and have no children, etc.) Prioritizing key sub-populations does not mean that the YFS model cannot address a wider set of SRH needs and a broader target group, but it will ensure that whatever approach is developed meets the specific needs of those most vulnerable to poor SRH outcomes, given the specific context.

Once you have identified desired health outcomes and sub-populations, it is important to conduct an in-depth formative assessment to inform the selection and adaptation of the appropriate YFS model(s). This includes developing a deeper understanding of the health needs of the sub-population(s); the unique barriers the sub-population(s) face in accessing services; the preferences, patterns, and behaviors of the sub-population(s) (e.g., when do they have time to seek services, where and with whom do they spend time); and who the key adult and peer influencers are that may facilitate or restrict young women's or men's SRH choices and access to services. See Annex 2 for questions to guide a formative assessment.

STEP 2

Conduct an SRH landscape analysis

After considering the desired health outcomes and specific sub-populations in Step 1, it is important to conduct a landscape analysis to understand the types of SRH services, health workforce and service delivery channels that currently exist for your priority sub-populations of young people, young people's perceptions and current use of SRH services, key actors currently involved or who can potentially contribute to youth SRH service delivery, and environmental factors that influence young people's access to and use of SRH services. Please see Annex 2 for a list of detailed questions to guide the landscape analysis.

Decisions about which YFS model(s) to introduce or scale-up should be informed by the results of the landscape analysis and aligned with national standards. An advocacy strategy may need to be included in the YFS implementation plan to ensure that a supportive policy environment is in place for the development of comprehensive adolescent-responsive systems. Similarly, a plan to address the identified sociocultural barriers to young people's access to SRH services within the service delivery environment and catchment community should be developed and included in the YFS implementation plan.

STEP 3

Determine what package of SRH service will be offered

Rights-based comprehensive YFS offer an integrated package of SRH services, including as many onsite SRH services as possible with referrals to all other services that an adolescent or young person might need (see Box 5). The selected sub-population(s) of young people and their health needs/priorities (Step 1) and the national standards and guidelines governing which services can be offered at which service delivery level or channel (Step 2) will inform the decision of which services can be offered through YFS. In this step, it is important to identify priority services for the population and their partners to be sure that the YFS model selected will be able to offer the most essential services. For example, if the sub-population identified is a young key population and the desired health outcome is HIV prevention and treatment, then youth-friendly HIV counseling, testing, treatment, and care services are priority services and should be guaranteed. Other services, such as contraception services, as well as sexual and gender-based violence (SGBV) counseling and referrals, should be priorities for integration. Similarly, if the sub-population identified is first time parents (FTPs)—young women (under 25) who have a child or are pregnant for the first time and their partners—then services for female FTPs should include youth-friendly maternal health services, postpartum contraception, and linkages with child health services. When considering the package of essential services, it is important to reflect on how to make each service youth-friendly (see Box 1). The selection of priority services should inform the selection of a YFS model (Step 6). Once a model is selected, all efforts should be made to provide the widest range of services needed by the young people, including referrals to the other services mentioned in Box 5 as appropriate. Please see Annex 2 for a list of guiding questions for Step 3.

Determine available resources

SRH services which can be delivered through youth-friendly modalities

- Counseling on SRH, including puberty, relationships, and sexuality
- Human papillomavirus vaccine
- Gynecological exams
- Pregnancy testing
- Contraception counseling and full range of contraceptive methods, including long-acting methods
- Counseling and treatment of irregular or painful menstruation
- Reproductive and urinary tract infection testing and treatment
- Sexually transmitted infection counseling and treatment
- HIV counseling and testing
- HIV treatment, care, and support
- Postabortion care
- Antenatal care, delivery services, and postnatal care
- Prevention of mother to child transmission of HIV
- Sexual and gender-based violence counseling, services, and referrals to additional multisectoral response services

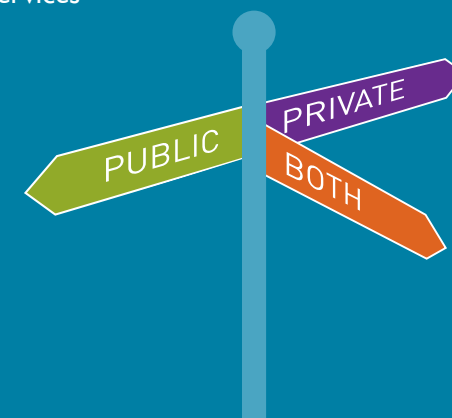
The next step in making a decision about which YFS model(s) to implement is to assess the resources available for YFS, including the financial resources and in-kind contributions available, and the strength of the health system (i.e., the health workforce, commodity logistics systems, health information systems, governance, financing, and service delivery infrastructure). Resources for demand-generation activities, youth participation and advocacy, and/or interventions to create a supportive environment should also be considered.

The assessment of available resources should be conducted through a participatory process, involving the Ministry of Health and other key ministries, civil society, United Nations agencies, donor agencies, and the private sector. Assessing the existing resources will give you a sense of what is possible and feasible prior to selecting a YFS model(s). For example, is there a strong public or private health system to build on? Or will the program need to invest in substantial health system strengthening prior to ensuring that the system is responsive to adolescents and youth? Please see Annex 2 for a list of guiding questions for Step 4.

Which sector for YFS: public, private, or both?

As you progress through the steps in this tool, including the next step of model selection, you will need to determine if efforts will focus on the public sector, the non-governmental sector (including NGOs and faith-based health care providers) and the for-profit sector, or a combination of these. There are many considerations when selecting with which sectors to work, including:

- Are the program designers affiliated with the Ministry of Health, NGOs or the private sector?
- Is the public-sector health system strong enough to include YFS (e.g., does it have capacity to participate in/conduct in-service training and refresher trainings, systems for monitoring and supervision of services, commodity logistics systems that limit stock-outs)?
- Is there a strong for-profit private sector? Does it extend beyond the capital and other major cities? Does it offer high-quality services? Is it monitored or regulated by the government to ensure quality and compliance with national laws and policies?
- Are there strong NGO or faith-based health networks or sites throughout the country? Are there religious or cultural issues that might limit their ability to offer YFS? Do they extend beyond the capital and other major cities? Do they offer high-quality services? Are they monitored or regulated by the government to ensure quality and compliance with national laws and policies?
- What perceptions do your target young people have of the private, non-governmental, and public sector providers and health facilities? Studies have revealed that young people's preferences for using public- or private-sector services are very context specific and vary by country.
- What are the benefits and challenges of each in the context? For example, private-sector and NGO services can be more flexible in terms of hours and locations, which could make them friendlier to adolescents and youth. However, YFS through the NGO and private sector may only reach a small subset of the adolescent and youth population who are able to pay for services (even if service fees are highly subsidized). In addition, most for-profit private-sector facilities are in urban or peri-urban areas where client flow is sufficient to sustain service delivery and profits, so young people in rural areas may not benefit from private-sector YFS. On the other hand, implementation of YFS in the public sector may be constrained by limited resources and common health system challenges like commodity stock-outs. YFS offered through faith-based health providers might be restricted based on religious beliefs.
- Is it feasible to work in multiple sectors to maximize access to services for young people? For example, the African Youth Alliance program in Ghana successfully implemented YFS through the public and private sectors. In this case, overall coordination and national standards and guidelines are critical to ensure the YFS through the two sectors meet common quality standards and are complementary (e.g., reaching different geographic areas or youth populations) with functional referral mechanism between them. Other examples of public-private partnerships for service delivery include private sector-supported mobile outreach, which complements public-sector facility-based services and simultaneously builds provider capacity.



STEP 5

Determine desired level of coverage

With the sub-population(s) of young people and the services to be delivered identified, and the resources available in mind, you must decide what level of coverage the services will aim to reach prior to selecting the YFS model(s). For example, will the achievement of your desired health outcome require national coverage to reach the general population of adolescents and young people? Or will it be sufficient to focus on specific geographic areas and/or smaller sub-populations of adolescents and young people? Will the available resources enable you to reach your desired level of coverage? When setting targets related to coverage of YFS, you should consider tradeoffs between selecting a lean YFS model that will be more easily expanded to reach a large number of young people and a more intensive YFS model that may be more likely to reach particularly vulnerable sub-populations, but may be more cumbersome to scale up to attain national coverage.

STEP 6

Select one or more models for delivering YFS

As program designers, you should take into consideration all the decisions and information from previous steps and determine which model(s) of YFS to implement or scale-up. The YFS models, described in Section 1, are outlined in the boxes below. The boxes include factors you should consider when examining the relevance of each service-delivery model to the context in which you are working, considering the targeted sub-population(s) of female and male adolescents and youth, available resources, SRH services prioritized, and objectives for scale-up. Following each box are some considerations for selecting and implementing the YFS model and the potential for scalability and sustainability (Step 7 examines scalability in more detail). Where relevant, specific examples of programs that have implemented the different YFS models are mentioned. These examples are drawn from three in-depth case studies: Programa Geração Biz (PGB) in Mozambique,²⁰ Top Réseau Social Franchise in Madagascar,²¹ and Youth Peer Providers in Ecuador.²² You should use information below to identify the most appropriate YFS model(s).



Model 1: Standalone clinic

Do you:

- STEP 1** ☐ Aim to reach young people in an urban area with a large and dense youth population?
- STEPS 1 & 2** ☐ Aim to reach a population of adolescents and youth with the resources to travel (even within a city) to a clinic and potentially pay for services?
- STEP 3** ☐ Want to offer a full range of SRH services in one place that offers high levels of privacy and confidentiality (low risk of being seen by adults in their communities)?
- STEP 4** ☐ Have sufficient resources, including budget and human resources, to build/run a full clinic dedicated to adolescents and youth (with the range of clinic staff, commodities, supplies needed) available?
- STEP 5** ☐ Aim to limit coverage to only dense urban areas?

If you answered “yes” to at least **three** of these questions, then you might consider implementing:

Standalone clinic for adolescents and youth

Considerations for the model

Resources required: The standalone clinic model is resource intensive as it requires sufficient funding and human resources to operate a full health facility dedicated to adolescents and youth, including infrastructure, staff, commodities and equipment, health management information systems, and laboratory facilities. It may be most appropriate in a dense urban area where the demand for the services will merit the resource investments. Also, due to the costs to operate the facility, this model of YFS may require charging fees for the services, which can limit access among young people in the lowest wealth quintiles (though it often includes a sliding scale or highly subsidized services). Investments should also be anticipated for provider training on YFS, youth-friendly counseling and IEC materials.

Privacy: Depending on how it is implemented, this model may offer young people the highest degree of privacy of any of the YFS models since only other young people will frequent the facility. However, if the facility is dedicated only to SRH (rather than all primary health care services for young people), young people may worry about being seen entering the facility.

SRH services: This model has the potential to offer a full range of comprehensive SRH services to young people all in one place. This will depend on resource constraints and whether the facility is in the private or public system. If it is not possible to offer a comprehensive package of SRH services, adolescent- and youth-friendly referral systems must be in place.

Population of young people served: Where it exists, the standalone clinic is most likely to attract unmarried young people without children, as young people who are married or have had children may not identify themselves as “youth” and may not choose to use the clinic. Due to the high levels of privacy and confidentiality that this model may offer, the standalone clinic may also attract marginalized youth who would be stigmatized in other circumstances. This includes lesbian, bisexual, transgender, and queer (LGBTQ) young people and young key populations such as men who sleep with men (MSM) and IDUs, among others.

Scalability and sustainability: Given the need for this model to be implemented in urban areas and by organizations/entities with significant resources, it is not likely to be scaled outside of densely populated urban areas. It is potentially highly sustainable if client load is sufficient to generate revenue to sustain service delivery over time as initial investment and program funds diminish.

Real life Example

Top Réseau Social Franchise, Madagascar

Leveraging a network of private providers

In 2000, PSI/Madagascar launched the Top Réseau branded network of private providers and clinics. The social franchise network was designed as a network of private providers dedicated to offering youth-friendly sexual and reproductive health (SRH) services. In 2005, the network expanded to include services for men who have sex with men and commercial sex workers, and in 2008 the network began gradual expansion to offer SRH for all women and men with the final change in branding occurring in 2011.

Private providers are able to join the network if they pay a small membership fee, agree to offer the core services specified for the network, uphold key attributes of the network (namely, confidential, affordable, high-quality reproductive health services for youth), and comply with PSI quality assurance and supervisory requirements. In exchange for network membership, providers benefit from training and coaching, allocation of certain equipment and materials, promotional materials and signage, and PSI's multi-level communication campaign that aims to create demand for services for the Top Réseau network.

In 2013, there were 250 providers from 213 clinics across urban towns in the country within the Top Réseau social franchise network. From January 2001 through June 2011, the Top Réseau network successfully met the health needs of 730,839 youth. The majority of clients seeking services between 2001 and 2010 were females in the 20-24 year old age cohort, but males 15-24 make up a significant minority.

Standalone clinics dedicated to YFS, such as those initially designed in Madagascar, are resource intensive and are unlikely to be feasible in a public sector context. Within the private sector, the Top Réseau example showed that they are possible, but unlikely to be sustained as a dedicated service. As the network grew so did the desire among providers to expand the target population and the range of services offered in order to both increase revenue and meet additional SRH needs felt by the communities. Results from the first few years of the expanded Top Réseau model are promising, suggesting that initial efforts to design and market dedicated YFS could maintain youth commitment to the services even after services are expanded to a broader client base.



Model 2: Separate space for YFS

Do you:

- STEP 1** ☐ Aim to reach a general population of adolescents and youth as opposed to a specific highly marginalized or vulnerable sub-population?
- STEP 1** ☐ Aim to reach young people who are sufficiently mobile (with financial resources if needed) to access a static facility?
- STEP 1** ☐ Aim to reach young people in both urban and rural areas (assuming the public or private clinics for intervention are located in both urban and rural areas)?
- STEP 3** ☐ Anticipate a large enough number of adolescents and youth clients to keep a dedicated provider busy with a full client load?
- STEP 3** ☐ Seek to offer a full range of SRH services for young people?
- STEP 3** ☐ Aim to implement YFS in an area where adolescents might be highly stigmatized for seeking SRH services, and therefore require high levels of privacy and confidentiality (through a separate space) to facilitate care-seeking behaviors?
- STEP 4** ☐ Have sufficient human resources to support a dedicated YFS provider to work in the YFS room all day or for the majority of the day in each facility?
- STEP 4** ☐ Have an extra consultation room or dedicated spaces available in most health facilities that could be repurposed for the provision of services to young people?
- STEP 4** ☐ Have resources to raise awareness about the YFS offered through separate spaces and to increase demand among the specific sub-populations of young people?
- STEP 5** ☐ Aim to increase the coverage to other facilities having similar conditions of implementation?

If you answered “yes” to at least **six** of these questions, then you might consider implementing:

Separate space YFS

Considerations for the model

Resources required: The separate space model requires fewer resources than a standalone clinic for adolescents and youth, but it still may require more resources than may be feasible. This model requires that a clean, private, well-equipped separate consultation area be available for YFS and usually includes a separate waiting area as well. The model also requires a full-time or at least part-time health provider dedicated to providing services solely to adolescents and youth. Investments should be anticipated for provider training on YFS, youth-friendly counseling, and IEC materials. Therefore, this model may be most appropriate for larger health facilities with multiple rooms and multiple providers. These health facilities are often found in more densely populated urban and peri-urban areas where the number of youth clients can justify the resources allocated to the YFS.

Privacy: This model has the advantage of offering high levels of privacy given the separate consultation and waiting space. However, if the separate space is highly visible from the waiting room, it can diminish privacy for young clients.

SRH services: This model has the potential to offer young people a comprehensive range of SRH services in one room. Efficient internal referrals to different services, including laboratory services, might also be necessary.

Population of young people served: In the urban and peri-urban context, this model may reach a wide range of sub-population(s). For example, if implemented in the public sector where services are typically free or low cost, the model can attract

young people in the lowest wealth quintiles. However, since this is a static facility-based model that usually offers services during regular working hours (e.g., 8 a.m.-2 p.m.), it may not reach highly transient populations (e.g., homeless or street youth), youth who are in school or working, or populations with restrictions on mobility (e.g., young married mothers and VYA).

Scalability: The scalability of any YFS model depends, to a large degree, on the ability for the model to be successfully embedded within a health system. Because this model is implemented within existing health facilities, with sufficient commitment from governments and/or private-sector actors, this model could be successfully scaled up. In fact, this model has been scaled up in a number of countries, including Mozambique, Ethiopia, Ghana, Viet Nam, and Uganda.²³ However, based on learnings from the scale-up experiences of these countries and others, there needs to be careful consideration of the resources required to sustain the model before deciding to scale-up.

Sustainability: If institutionalization—the incorporation of YFS into national standards, guidelines, and service delivery processes, such as training and supervision—is prioritized, then there is potential for sustainability of this model. But, reliance on dedicated space and providers means that services may cease to be youth-friendly if the trained provider assigned to provide YFS leaves or funding for new provider training ends. In addition, if the YFS client load is not high, it may be challenging for facility management or district/regional management to justify the use of dedicated separate space and providers. As a result, other health concerns may take priority over YFS and providers and/or the dedicated space may end up being used to address other priorities. This may be particularly true in the private sector where profit motives may cause rapid reallocation of resources to more profitable services when external support for YFS ends.

Real life Example

Programa Geração Biz, Mozambique

Combining separate space and mainstreamed YFS

Programa Geração Biz (PGB) in Mozambique serves as an excellent example of the different implications of separate space and mainstreamed YFS within the public sector. PGB began in 1999 and is implemented by the Government of Mozambique Ministries of Health, Youth and Sports, and Education, with technical support from Pathfinder International (until 2012) and technical and financial support from United Nations Population Fund (UNFPA). Over the course of 10 years, PGB scaled up YFS to cover all 11 provinces in Mozambique. When PGB began and throughout most of the pilot and scale-up phases, the primary model of YFS used by PGB was a separate space model: YFS were offered by a dedicated provider in a separate building and/or room at public health facilities. After nearly a decade of implementation, the Ministry of Health changed its approach in order to reduce the resources needed to implement YFS and improve sustainability. The new strategy includes separate space YFS at referral hospitals, where there is sufficient client load to support use of dedicated providers and space, and mainstreamed YFS at primary health care facilities, where the population is less dense and less likely to provide sufficient volume to support dedicated resources. During the pilot phase, the youth client profile was predominantly female. Gender considerations were taken into account during the scale-up phase to ensure the models could reach both young men and young women.



Model 3: Mainstreamed YFS

Do you:

- STEP 1** ☐ Aim to reach a large number of the general population of adolescents and youth or a sub-population that experiences limited stigma associated with being seen at a health facility (e.g., FTPs)?
- STEP 2** ☐ Aim to include different perceptions and needs of youth in service delivery?
- STEP 3** ☐ Seek to offer a full range of SRH services to young people?
- STEP 4** ☐ Have no extra consultation rooms or space available in most intervention health facilities?
- STEP 4** ☐ Have a limited number or a shortage of health providers in most health facilities?
- STEP 4** ☐ Have resources now to invest in YFS (to train a large cohort of providers and facility staff), with potentially fewer resources in the future?
- STEP 4** ☐ Have the capacity to provide in-service training to all service providers and facility staff on YFS? (Note: Ideally, pre-service training would also be available.)?
- STEP 4** ☐ Have resources to raise awareness about the integrated services and increase demand among the specific sub-populations of young people?
- STEP 5** ☐ Aim to cover a large proportion of the country, including rural areas with smaller health facilities?

If you answered “yes” to at least **six** of these questions, then you might consider implementing:

Mainstreamed YFS

Considerations for the model

Resources required: This model may be less resource intensive than models 1 and 2 because it does not require a separate space, infrastructure improvements, or dedicated providers. However, as the model requires training all (or most) providers and staff in a facility, significant training resources are needed upfront. While these initial investments may be significant, over time less in-service training may be needed (compared to model 2) as a critical mass of trained providers will exist in the system. As part of implementing mainstreamed YFS, a special emphasis (and resources) should be allocated to ensure that adolescent and youth sexual and reproductive health (AYSRH) is integrated within pre-service training to ensure future providers are prepared to offer mainstreamed YFS.

Privacy: The mainstreamed YFS model is less private for young people compared with models 1 and 2 since young people may be seen by adults when seeking services (given there is no separate space or waiting area). Young people, who often prioritize privacy, may find this model less appealing and may be less likely to seek services. However, some programs using this model have found creative ways to make mainstreamed YFS more private and attractive to clients. These include:

- Curtains or wall board to partition waiting areas so services are offered in the same room as adult services, but the waiting area is private. This can help assuage young people’s fears of being seen by an adult relative or friend while waiting.
- Designate certain days or certain hours of the day for young people and encourage them to come during that time.
- Within larger facilities, rather than separate rooms, have a desk available in the lobby or waiting area that is staffed by trained young people who can provide information and counseling,

referrals to community support groups, and help with navigating service delivery (e.g., direct them to the appropriate room or expedite service delivery through a fast-track mechanism).

- Work with lay counselors and/or young people to offer counseling and information to young people, including what to expect when they see the provider, while they wait to see a provider. This can reduce the time spent with the provider and reduce client wait times as well as the burden on providers. While this can be done in any of the facility-based models, it may be particularly important in the integrated YFS model where young people may have more concerns about judgment and stigma that counselors can help alleviate.

SRH services: This model has the advantage of ensuring that the full range of SRH services available at a given health facility are offered to young people in a youth-friendly manner. However, not all services will be offered in the same room (such as in models 1 and 2). Clients have to move between consultation rooms at the facility, which compromises their privacy.

Population of young people served: This model can be implemented across a range of health facility types and in both rural and urban areas and may attract and serve a wide range of young people because it allows access to YFS across a range of service delivery entry points. For example, young mothers can receive youth-friendly maternity services, young people living with HIV (YPLHIV) can receive youth-friendly HIV services, and even young fathers who might bring in children to child health services can be counseled in a youth-friendly way on their SRH needs. As this model is a static facility-based model and it is one with less privacy for young clients, it may not serve sub-populations with limited mobility and sub-populations who are highly stigmatized, such as young LGBTQ people or unmarried pregnant women in socially conservative environments.

Scalability: As this model of YFS can be implemented within an existing health system—either private or public sector—the model has scale-up potential. Furthermore, as this model can be implemented at any level of the health system (in a range of different types of facilities) and doesn't require dedicated space or providers, it may require less resources over time and be more scalable than the separate space model. However, this model has not been widely implemented and its scalability has not been well tested, so this reflects an important area for future learning.

Sustainability: The integrated YFS model has high potential for sustainability as the need for financial investments lessens over time. In addition, as noted above, the turnover of providers, which often negatively affects the sustainability of separate space YFS will have less impact on this model since a critical mass of trained providers will exist in the system. Like scalability, the integrated YFS model's potential for sustainability has yet to be tested and there needs to be more learning in this area.



Model 4: Mobile outreach services

Do you:

- STEP 1** ☐ Aim to reach specific vulnerable, marginalized, or otherwise hard-to-reach or rural young people with comprehensive SRH services?
- STEPS 2 & 3** ☐ Have a limited range of SRH services available at the lowest level of the health system (e.g., no long-acting reversible contraceptives available at the health post/dispensary level)?
- STEP 4** ☐ Have sufficient resources to fund mobile outreach services, including resources for vehicles, fuel, commodities and equipment; counseling job aids; and payments to providers?
- STEP 4** ☐ Have the supervision and monitoring systems to monitor quality of mobile outreach services?
- STEP 4** ☐ Have the ability to establish youth-friendly referral mechanisms and follow-up mechanisms for clients requiring follow-up visits?
- STEP 4** ☐ Have community workers who can generate demand for mobile outreach services?
- STEP 4** ☐ Have the ability to build a supportive community environment so youth can freely access mobile outreach (and related demand-generation and referral) services?
- STEP 5** ☐ Have sufficient resources in place that are built into the existing health system; or are they private-sector resources, and are some costs able to be recouped to ensure increase of the level of coverage?

If you answered “yes” to at least **five** of these questions, then you might consider implementing:

Mobile outreach services

Considerations for the model

Resources required: In general, mobile outreach services are resource intensive. However, the level of resources required varies by type of mobile outreach. For example, mobile clinics (or clinics on wheels) can require significant upfront investments and ongoing costs such as fuel, staffing, commodities, and more to operate. Teams of mobile providers who go from higher-level facilities to lower-level facilities (or who rotate among lower-level facilities) to provide a comprehensive set of services require transportation and provider payments, but because lower-level facility infrastructure is used, the overall resource requirements can be less than the clinics on wheels model. Other kinds of mobile outreach, including satellite clinics where services are routinely offered in an existing community building (e.g., schools, church, or under a tent near a market), require resources for transport, provider payments, commodities and equipment, and tents or other equipment to ensure privacy, but may be less costly than a clinic on wheels model. For all of these approaches to be youth-friendly, investments in provider training on YFS, youth-friendly counseling and IEC materials, equipment to guarantee privacy, and demand generation activities to ensure young people know about the mobile services will be required.

Privacy: Most of the different mobile outreach strategies allow for private consultation and service provision. However, the waiting area may not be private for young people since mobile outreach is generally offered in public places close to the community. Building community support for YFS is an important part of this model to ensure that young people can openly access mobile outreach and related services.

SRH services: The purpose of mobile outreach services is to expand the types of services available to clients, including the full range of contraceptive methods, HIV treatment services, and other SRH services (depending on the focus of the mobile services). With this in mind, this model has the potential to offer young people a full set of SRH services in a location that is more accessible to them. It is important to establish clear and effective referral mechanisms for services that are not offered through mobile outreach.

Population of young people served: Mobile outreach services are designed to fill gaps in the access people have to health services. With this in mind, youth-friendly mobile outreach services are likely to provide access to hard-to-reach populations, including those who live in rural places or may be more socially isolated, and young mothers and FTPs. Some programs have had success in targeting mobile outreach services to location where large numbers of young people live or work (e.g., tea plantations, factories, universities) in order to reach the sub-populations of young people who are often unable to access facility services when they are open.

Scalability: The ability to scale up mobile outreach services depends on the resources available to pay the ongoing operational costs of this service delivery model. The geographic characteristics and transport infrastructure in target communities also influence the scalability. In most cases, funds limit the ability to scale this model. However, there are some examples of government investments in this approach or donor funding being used to leverage public-private partnerships that contribute to the scale-up of mobile outreach services.

Sustainability: Mobile outreach services could be intended as a stopgap measure—to fill a gap in services available at lower level facilities, to fill a gap in the access remote communities have to health facilities or to strengthen referrals to static clinics. Mobile outreach services could also be intended as a long-term part of the health system. If the latter is the intention, then the mobile outreach services will need to be systematically integrated with the health system in order to be sustainable, this includes ensuring that there is an ongoing source of funding or cost-recovery mechanism to cover the costs of the mobile outreach services.





Model 5: Community-based services

Do you:

STEP 1

- ☐ Aim to reach specific vulnerable, marginalized, or otherwise hard-to-reach or rural young people with select SRH services?

STEP 1

- ☐ Aim to address specific high-burden SRH issues among distinct sub-populations, such as early and closely spaced pregnancies among young married adolescents or HIV testing among young IDUs?

STEP 1

- ☐ Aim to engage male partners in support of family planning/SRH actions or as direct clients?

STEP 2

- ☐ Have the policy frameworks to allow FLWs and peer educators to offer SRH services, such as distributing contraceptives at community level and community-based HIV testing?

STEP 3

- ☐ Aim to include perceptions of the different health providers and FLWs in the design of the intervention?

STEPS 2 & 4

- ☐ Have the ability to establish youth-friendly referral mechanisms back to static facilities for comprehensive, quality services?

STEPS 3 & 4

- ☐ Have the resources and capacity to build a supportive community environment so youth can interact with FLWs or peer educators and access services?

STEP 4

- ☐ Have an existing and sustainable system of FLWs or peer educators or have the systems to develop and sustainably support a cadre of outreach workers (including supervision systems and mechanisms for recruitment and retention)?

STEP 4

- ☐ Have the systems and resources to ensure sustainable access to SRH commodities (such as condoms, HIV tests, oral contraceptives, and emergency contraception) for FLWs or peer educators?

STEP 4

- ☐ Have the resources to provide FLWs and peers with an adequate supply of IEC materials and job aids?

STEP 4

- ☐ Have the supervision systems and resources for ongoing training to maintain quality of care?

STEP 5

- ☐ Have donor or NGO support, and commitment of the government to increase the coverage?

If you answered “yes” to at least **six** of these questions, then you might consider implementing:

Community-based services

Considerations for the model

Resources required: Community-based services through FLWs and peer educators require sufficient resources to continuously support recruitment, training, supervision and quality assurance, and retention. Furthermore, FLWs and peer providers require a constant supply of commodities. These can be supplied through the public sector, which means they are usually free or low cost but may have periods of stock-out, or through the private sector, which may make them more costly. Though community-based services can be quite resource intensive, they are made less so if the program is able to build on an existing system of FLWs or peer educators to make them more youth-friendly.

Privacy: As community-based services by FLWs or peer educators can be provided anywhere, it is possible to find a private space for services, including in a home, in a private area outside, in a building nearby, etc. Building community support for YFS is an important part of this model to ensure that young people can openly access mobile outreach and related services.

SRH services: While this model offers a critical channel through which to reach marginalized young people, it only allows for provision of a select set of services that can be offered outside of a facility. This is dependent on national policies, but it often includes SRH counseling, HIV prevention counseling, and provision of select

contraceptive methods (usually condoms, oral contraceptive pills, and sometimes emergency contraception and injectables). With this in mind, this model is best if implemented in the context of a supportive policy environment that allows FLWs and peer providers to offer a wide range of contraceptive methods and other SRH services, and with a strong referral system to comprehensive facility-based YFS.

Population of young people served: Community-based service delivery through FLWs or peer providers is an important model for reaching vulnerable or marginalized young people who are unlikely or unable to access facility-based services,²⁴ including young people with limited mobility such as FTPs, young married women, VYAs, adolescents and youth in the lowest wealth quintile, and young people in very rural areas. This model can also allow for interactions with male partners to support family planning/SRH and address their needs.

Scalability: A community-based model of YFS is more scalable if the program engages with an existing cadre of FLWs or peer educators (e.g., a FLW cadre that is part of the public health system). In this way, existing systems can be built on and used to reach young people and this approach can be scaled to wherever the FLWs or peers are operating. Without an existing system for recruiting, training, supervising, and supporting the FLWs and peer educators, this type of service delivery for YFS may be too resource intensive to scale up.

Sustainability: Even within the context of a system of FLWs or peer educators that is supported in an ongoing way by the public or private/NGO health system, recruitment and retention of FLWs and peer educators can be a major challenge to sustainability. This is particularly true for peer educators who age out.

Real life Example

Peer Provider Program, Ecuador

Peer providers and affordable health services

In 1998, Family Planning and Health Care Centers (CEMOPLAF) in Ecuador with support from Planned Parenthood Federation Global, a division of Planned Parenthood Federation of America, began implementation of a Youth Peer Provider model in which youth provide SRH information and contraceptive services to fellow young people at the community level.

The Youth Peer Providers offer SRH counseling and provide male condoms and oral contraceptive pills; some Youth Peer Providers also provide injectables and emergency contraceptive pills. For all other services, young people are referred to the CEMOPLAF health center where they receive friendly SRH services from trained nurses and doctors. Commodities from the Youth Peer Providers and from the CEMOPLAF health center are offered at a subsidized fee, but no young person is turned away if they cannot pay.

In 2011, there were 231 Youth Peer Providers across 21 sites. Between 2007 and 2011, 98% of the 27,418 young people accessing contraceptive services from the Youth Peer Providers were from urban areas; 98% were 10-19 years old and 2% were 20-24; 93% were in-school adolescents; 64% were male; and 93% were not living with a partner.



Model 6: Drug shops and pharmacies

Do you:

STEP 1

- ☐ Aim to reach young people with sufficient resources to pay for SRH commodities?

STEP 1

- ☐ Aim to reach young people with sufficient mobility to travel to pharmacies and drug shops?

STEPS 2 & 3

- ☐ Have formative evidence suggesting young people use pharmacies and drug shops for basic SRH commodities and needs?

STEP 2

- ☐ Have national policies supporting pharmacy and/or drug shop provision of key SRH commodities and counseling to young people?

STEPS 2 & 4

- ☐ Have a wide network of private or public sector pharmacies and drug shops willing to work on youth-friendly delivery of commodities and basic services?

STEPS 2 & 4

- ☐ Have a fairly stable pharmacy and drug shop system (rather than a pharmacy system with constant turnover and informal pharmacies)?

STEPS 2 & 4

- ☐ Have the ability to develop and maintain clear and consistent referral systems between pharmacies/drug shops and comprehensive SRH services that are youth-friendly?

STEP 4

- ☐ Have sufficient resources and systems in place to monitor and assure quality of pharmacy and/or drug shop services?

If you answered yes to at least **five** of these questions, then you could consider implementing:

Youth-friendly drug shops and pharmacies

Considerations for the model

Resources required: Working with pharmacies and drug shops to make them more youth-friendly requires resources for training, supervision/quality improvement, and routine monitoring. These resources may be well spent within the context of a stable pharmacy and drug shop sector; however, if the pharmacy sector has high variability and is constantly changing, then the needed retraining and quality improvement processes may be too resource intensive.

Privacy: This model has the advantage of offering young people select SRH commodities and services in a place which young people often feel most comfortable and which offers them easy access. Privacy and confidentiality of the pharmacy and drug shop services depend on the location and lay out of the pharmacy or drug shop, but given that the process of buying a commodity and receiving counseling at a shop is relatively quick, young people have a great chance of entering and leaving without being seen. Overall, this model can be conducive to privacy.

SRH services: Like community-based services, pharmacies are only able to offer a narrow set of services, including counseling and provision of select contraceptives and STI/reproductive tract infection treatments, so it is essential to pair this model of YFS with a facility-based model of YFS and ensure effective referral systems are in place so that young people have access to the full range of SRH services that they need.

Population of young people served: Pharmacies and drug shops are well suited to reach young people who live in urban and peri-urban areas (where more pharmacies and drug shops are located) and attract young people who have the ability to purchase commodities like condoms or other forms of contraception. Young people who may be unlikely to seek facility-based service due to stigma, such as young MSM or young women who are unmarried and seeking contraception, may be more likely to use a pharmacy for these services.

Scalability: The scalability of the pharmacy and drug shop model depends significantly on the strength and stability of the pharmacy and drug shop sector. If there is a solid network of pharmacies that is well regulated, the youth-friendly approach may be scalable within the network. If all pharmacies and drug shops in a country or a context are operating completely independently with no network or linkages, it may be too resource intensive to scale-up this approach. Umbrella professional associations that have strong membership and service platforms (for training, supervision, accreditation, etc.) can be important partners for this model of YFS and allow for scale and sustainability.

Sustainability: Similarly, the sustainability of this model depends on the stability of the pharmacy and drug shop sector. High turnover will reduce sustainability while consistency in the pharmacies and the pharmacists would be conducive to sustainability. Youth-friendly pharmacies and drug shops have been implemented in a number of countries, but scale-up and sustainability of this model has not been well documented, and there needs to be further learning.



Table 1: Summary of considerations and implication of different models of YFS

YFS Model	 Model 1: Standalone clinic	 Model 2: Separate space for YFS
Which sub-population is best reach?		
Age cohort	Most often young men and women 15-24	Most often young women and men over age 15
Marital and childbearing status	Most often unmarried with no children (unless it is a specific clinic for young mothers)	Varies, but rarely reaches young mothers and parents who are no longer thought of as adolescents or youth
Marginalized or highly vulnerable populations	Potential to reach vulnerable sub-populations, but usually only those with high mobility and based in urban areas	Marginalized populations may find increased privacy a draw; though the perception of the YFS as focused on family planning may prevent young men from seeking services
Consideration for WHO YFS criteria: acceptable, appropriate, effective, accessible, and equitable	• High level of privacy and confidentiality, making it highly acceptable • Able to offer wide range of services with high quality (appropriate and effective) • Very limited accessibility given need to locate in urban area • May not be equitable for young people who can't afford services or travel to reach services	• High level of privacy and confidentiality, making it highly acceptable • Able to offer wide range of services with high quality (appropriate and effective) • Accessible to urban and peri-urban areas • Equitable for range of socio-economic levels, perhaps less equitable for particularly vulnerable groups (e.g., LGBTQ)
Scalability (low, medium, high)	Low: Highly resource intensive and usually only successful in densely populated urban areas	Medium: Relies on existing health infrastructure which can be scaled, but is resource intensive (requires space and dedicated human resources)
Sustainability (low, medium, high)	Medium: If the standalone clinic generates resources through fees (as many do) and they are located in urban areas with high demand, they can be self-sustaining	Medium: When institutionalized within the health system and there is sufficient human resources to maintain dedicated providers; Reliance on available space and dedicated providers means that YFS stop when trained providers leave or projects end

	 Model 3: Mainstreamed YFS	 Model 4: Mobile outreach services
Which sub-population is best reach?		
Age cohort	Potential to reach young men and women from a wide age cohort given multiple service entry points (10-24)	Varies based on type of mobile outreach and who is targeted
Marital and childbearing status	Potential to reach both married and unmarried	MCH mobile services often reach young married women who have children; HIV, SRH and family planning mobile services can reach both married and unmarried young people
Marginalized or highly vulnerable populations	Generally not designed to attract marginalized or highly vulnerable populations	If conducted at places where marginalized or highly vulnerable young people live or work
Consideration for WHO YFS criteria: acceptable, appropriate, effective, accessible, and equitable	• May lack privacy and confidentiality making it less acceptable for young people • Able to offer wide range of SRH services, but not able to offer them all in one room; young people would be referred to other consultation rooms in the facility • Able to be offered at lowest level of health facility making it accessible to urban and rural areas • May be highly equitable for range of socio-economic levels and rural/urban, may not be equitable for particularly vulnerable groups	• Offers privacy and confidentiality and services in a convenient location making it acceptable • Able to offer a wide range of needed SRH services, making it appropriate and effective • Can be highly accessible if offered in locations close to where young people live or work • Improves equitable access to health services by reaching poor, rural, or otherwise marginalized populations
Scalability (low, medium, high)	Potential high (yet to be demonstrated): Increased scalability because it relies on existing health system; but, requires initial resources for training for all providers in facility; however, there are economies of scale once critical mass of providers and facilities reached	Medium: Scalable only if sufficient resources are in place and it is built into the existing health system; or it is done by the private sector and able to recoup some costs
Sustainability (low, medium, high)	Potential high (yet to be demonstrated): Improves scalability by reducing reliance on separate space and on one provider; has high likelihood of sustainability by reducing costs needed overtime	Low: Given the need for significant and ongoing resources to sustain the mobile outreach services, the potential for sustainability is low

	 Model 5: Community-based services	 Model 6: Drug shops and pharmacies
Which sub-population is best reach?		
Age cohort	Varies based on targeting, can reach full range of ages, including VYAs 10-14	Older male and female youth (potentially more males than females)
Marital and childbearing status	Varies depending on objectives and provider training; Potential to reach married and unmarried and those with and without children	Potential to reach married and unmarried and those with and without children
Marginalized or highly vulnerable populations	If targeted specifically to reach marginalized or highly vulnerable young people	Potential to reach marginalized or vulnerable if they live in urban/peri-urban area and have some financial resources to buy commodities
Consideration for WHO YFS criteria: acceptable, appropriate, effective, accessible, and equitable	• Peer providers may be highly acceptable and appropriate, while adult FLWs may be less acceptable (more fear of judgment and lack of confidentiality) • Not able to offer full range of SRH services and high variability in the quality of services making it less effective • Community-based nature of services is highly accessible, but also requires effective referral systems • With targeted outreach strategies may reach most marginalized and vulnerable, making it equitable	• Young people may prefer the pharmacy for privacy and confidentiality (acceptable) • Services offered at pharmacy are limited and quality is highly variable limiting effectiveness and appropriateness • Highly accessible in most urban and peri-urban contexts; less so in remote rural areas where there are not pharmacies and drug shops • Available to young people who can afford services, but may attract marginalized populations (equitable)
Scalability (low, medium, high)	Low: Rarely scalable without donor or NGO support, with few exceptions of scaled-up public sector FLW systems; high turnover of outreach workers limits scale	Medium: Ability to scale depends on coverage and strength of existing network of pharmacies and resources to provide consistent quality assurance and support to large network of pharmacies
Sustainability (low, medium, high)	Low: Sustainable only if fully institutionalized within health system, rather than reliant on project-based funding for implementation; in cases where it is institutionalized, potential for sustainability is much higher	Low: Most countries experience high turnover and mobility/informality in the pharmacy sector making sustainability difficult as pharmacies open and close and pharmacists move

Plan for scale-up of the selected YFS model(s)

Once you have selected the YFS model(s) that are most appropriate for your desired health outcomes and specific context, it is important to reflect on the scalability of the model and take early steps to plan for future scale-up. This tool draws on an understanding of scale and scale-up as articulated in the WHO/ExpandNet literature.^{18,19} ExpandNet suggests that there are different types of scaling up including:

- Horizontal scale-up: expansion of YFS to new places or populations
- Vertical scale-up: institutionalization of YFS in systems, policies, and procedures

The ExpandNet framework suggests that sustainable scale-up is achieved through a combination of vertical and horizontal scale. When assessing scalability of your selected YFS model(s), you should consider scale-up objectives related to both horizontal scale (i.e., the number of service delivery points/coverage you aim to introduce or sustain) and vertical scale (i.e., the degree to which the national system has incorporated YFS in national strategies, guidelines, tools, budgets, and work plans).

It is highly recommended to work with diverse stakeholders to set scale-up targets, focusing on gradual expansion to ensure quality, and including emphasis on the policy and advocacy work that is critical for sustainable scale-up and an adolescent-responsive system.

When planning for scale-up it is important to identify which institution(s) or organization(s) will be responsible for adopting and implementing the selected model(s) of YFS, sometimes referred to as

the “user organization(s).”¹⁸ In many cases, the Ministry of Health will be the main user organization for YFS delivery models. It is important to clarify which departments and divisions within the Ministry of Health will lead the installation, implementation, monitoring and evaluation of the YFS model. There may also be situations where non-governmental entities, including NGOs or private-sector institutions, are user organizations. It is therefore important to clarify each actor’s roles and responsibilities, as well as to assess their capacity and credibility to introduce, implement, or scale up particular YFS models with quality and fidelity.

Similarly, an assessment of the resource team, which supports the promotion and wider use of the YFS model(s), is important at this stage. The resource team can be composed of government entities, civil society organizations, research institutes, private-sector actors, and groups of young people. You should begin by clarifying which actors have been involved in developing or piloting YFS delivery models in your country. Then, assess their level of interest and capacity to support the process of developing new models or scaling up effective models.

It is also important to consider the different contexts in which the YFS model(s) will be scaled up and how to ensure sufficient flexibility in the model(s) to adapt to diverse settings.

See Annex 2 for guiding questions related to step 7. Refer to Annex 1 for more detailed publications related to the systematic scale-up of health interventions.

Section 3

Supportive elements of YFS

Regardless of which model you may choose for YFS, there are important elements beyond supply-side interventions that should be considered when designing the YFS and working towards adolescent-responsive health systems. These include demand generation and building SRH competencies among youth, as well as fostering an enabling environment for youth to access and use the SRH information and services they need. These are described in this section.



How will young people be involved in the design and implementation of the program?

For services to be truly responsive to young people, they must be involved in the design of services, and young men and women can also be an important partner in implementing and monitoring YFS. The first step is for you, as program designers, to clearly articulate the purpose and desired outcomes of youth participation. For example, does youth participation seek to help ensure the relevance and appropriateness of YFS interventions? Does it aim to build young people's capacity as leaders? Does it attempt to promote young people's right to participation? Does it seek to amplify the voices of young people in advocacy and governance? Does it aim to bring youth perspectives to monitoring the quality of YFS delivery? Perhaps it is for several or all of these reasons. Clearly establishing the purpose of youth involvement in a program will help to guide the selection of the appropriate model(s) for participation.

There are many different models of meaningful youth participation in the design and implementation of programs²⁵, including:

- Training and involving young people in formative research, both as researchers and participants;²⁶
- Training and supporting young people as advocates to promote youth SRH and rights (SRHR), specific models of YFS delivery and/or to influence changes in the legal and judicial environment to promote young people's access to SRHR services and information;^{27,28}
- Supporting young people to take on governance roles in program management, including participating in co-management committees;²⁹
- Training and supporting young people to play active roles in program implementation, including as peer service providers,³⁰ peer educators, youth program managers, etc.;
- Training and supporting young people to monitor and evaluate program quality (e.g., through exit interviews, mystery client studies, and regular review meetings with providers, youth clients, and peer educators).

It is important to consider which young people the YFS are meant to serve and be sure that young people who are representative of these groups are involved in the program design and/or implementation. For example, if your target population includes young adolescent girls, it would be important to make sure that there are adolescent girls involved in program design, even if they might be more difficult to identify and include than other groups of young people. This would apply for other sub-populations of young people as well.

How will demand for services be generated among young people?

The YFS will only be successful if young people know about the YFS and are motivated to seek services. Therefore, you should develop an appropriate demand-generation strategy to complement the YFS. Decisions on which strategies should be used to create demand among young people are highly context specific and should address the multiple barriers that limit access to and understanding of SRH information and related positive behaviors. In places with high mobile phone penetration, mHealth (e.g., an SMS program) might be an appropriate choice.³¹ In

Real life Example

Youth Peer Provider Program, Ecuador

The distinguishing characteristic of the Youth Peer Provider model is that young people are the actual service providers. Youth clients report that they found the Youth Peer Providers to be approachable since they had seen them as classmates or at sporting and other community events.

places with high radio listenership, services could be advertised through the radio. Engaging peer educators to conduct one-on-one or small group sessions has been a common strategy. In addition, supporting school-based comprehensive sexuality education with referrals to YFS,^{iv} and creating linkages between schools and other community activities (e.g., sports events) and YFS have been noted as effective in program case studies.^{20,22} Vouchers for services or transportation are promising and testing is underway to see if they increase use of services among adolescents.³² Building on existing community engagement strategies, existing community groups, and existing platforms (e.g., radio or schools) enhances scalability of the community engagement and demand generation component of YFS.

How will an enabling environment be fostered?

As emphasized in the introduction to this decision-making tool, the evidence is clear that significant community engagement is needed to reduce the sociocultural barriers young people face in seeking SRH services. Any YFS program design—no matter which model is selected—must ensure that activities are planned to foster an enabling environment. In order to address the most significant barriers young people face in their environment, it is important to do a participatory assessment with young people and consider the range of community pathways that influence AYSRH.³³ Once key context-specific barriers are identified, you can tailor strategies accordingly. For example, if fear of parents or in-laws finding out that a young person is going to YFS is identified as a major barrier, then the program may choose to have the YFS provider hold meetings with parents in the community to explain the purpose of the services offered and ease their concerns or deploy respected FLWs/change agents or women's group leaders to talk with parents and in-laws to catalyze reflection and help shift

their perspectives. Similarly, if community elders or religious leaders are creating an environment that stigmatizes AYSRH, then working with these leaders through community leader committees, public dialogue and reflection, and peer-to-peer engagement with well-respected champions will be essential.

How will the YFS approach be linked with other sectors to promote positive youth development?

As they grow up, young people need education, livelihood skills and opportunities, healthy relationships, and platforms for civic engagement, in addition to access to high-quality health services. There is growing recognition of the importance of engaging various sectors in programming for young people in order to support adolescents and youth to grow into healthy and productive adults.

Opportunities to do this within the implementation of YFS might include partnering with livelihood programs to offer YFS in workplaces or conduct service outreaches to livelihood training facilities, and working with schools to offer onsite services or refer to nearby YFS. These strategies can help increase awareness of and access to YFS. Conversely other sector programs benefit when young people are healthy and able to participate without leaving the program.

Beyond linkages during implementation, when designing YFS, it is important to collaborate with diverse ministries and stakeholders working on youth development to identify opportunities for linkages, increasing coverage and achieving a collective impact. Multi-ministry initiatives can also be a facilitating factor for scale and sustainability as they contribute to increasing political investment in a program that includes YFS (see Box on Programa Geração Biz).

^{iv} Pathfinder International's *Pathway to Change* tool has been successfully used with young people for this purpose.

How will YFS be monitored and evaluated?

It is essential to routinely monitor the use of services by young people and the quality of the services offered. To do this, it is important to collect data that allows for analysis of service visits by age cohort (10-14; 15-19; 20-24), by sex, and by type of service (see Annex I for M&E resources). If the program is aiming to target a specific sub-population, data should also allow for analysis to understand if that population is being reached (e.g., if you are targeting FTPs, then it is important to collect information on parity). This is particularly challenging when working within the public sector where service delivery data is collected through the national HMIS, which often doesn't disaggregate by age cohorts in the way that would be most useful to YFS managers. Many YFS initiatives rely on a two-pronged strategy to address this: programs introduce temporary separate data collection forms to collect age-disaggregated data, while at the same time conducting advocacy to revise the national HMIS. For some YFS programs, it might be equally important to routinely assess which young people are NOT accessing services and adjust as needed. It is easy to underestimate the resources required to collect, analyze, and use age- and sex-disaggregated data, and it is important to be sure to budget appropriately for this aspect of YFS in order to ensure quality services through analysis and use of data for quality improvement.

Real life Example

Multisectoral Collaboration under Programa Geração Biz (PGB)

PGB was designed to improve SRH outcomes through collaboration and linkages between the health sector, education sector, and the community. Multisectoral coordination was institutionalized through the national PGB Multisectoral Coordination Committee, made up of national and provincial-level representatives from the ministries of health, education, and youth and sports as well as young members of civil society. Leadership of the committee rotated annually between the three ministries.

The success of this program, particularly its ability to be scaled and sustained over more than a decade speaks to the importance of this multi-ministry approach and the engagement of civil society.

Section 4

Additional recommendations to reach sub-populations of young people

As described in Step 1, it is essential for program designers to identify desired health outcomes and behaviors as well as the specific sub-population of adolescents and youth that the YFS are aiming to serve. The selection of YFS model(s) must be made with this population in mind, and as described above, some YFS models or combinations of models may be more appropriate for reaching vulnerable sub-populations of adolescents and youth. This section provides some additional recommendations and considerations for specific sub-populations of adolescents and youth. The following recommendations stem from the literature and the authors' experiences, but evidence and programmatic examples of reaching these populations are sparse.



First-time parents

It is important to address the needs of young people across the life cycle, from early adolescence to later adolescence to marriage and childbearing. Analyzing existing adolescent and youth programs and service delivery models, it is evident that FTPs—or young women who are pregnant or mothers for the first time and their partners—are often overlooked.³⁴ Yet, FTPs have important SRH needs, particularly for maternal health services and for contraceptive services to help space or limit subsequent pregnancies. FTPs face social and gender barriers in accessing facility-based services, including high opportunity costs (i.e., their household responsibilities may prevent them from seeking services), limitations on their mobility, and inability to negotiate with partners and/or in-laws to allow them the time and resources to seek health services. To make health services more “friendly” to FTPs several service delivery models could be considered:

- **Community-based service delivery models:** Services brought to the community level through FLWs and community-based distribution of contraception may be more accessible to FTPs given limitations on the mobility of young mothers, and also allow for engagement with couples and fathers on their new parenting roles and responsibilities.
- **Integrated YFS model to increase contraception counseling during antenatal care and postpartum contraception counseling and provision for young mothers:** While postpartum contraception is recommended for all mothers, anecdotal evidence suggests that providers are less likely to counsel young women in the postpartum period because they assume that young women should have another child again soon. These providers often have misconceptions around the appropriateness of certain contraceptive methods for young women and believe that women should have as many children as they can while they are young. An integrated YFS model that ensures all services (including maternal health services) in a facility are friendly and responsive to young people, including FTPs, can help increase non-judgmental and comprehensive counseling

to young mothers. This is also an opportunity to involve fathers who attend or visit the facility upon the birth of their child in postpartum family planning, ongoing SRH issues, and childcare.

- **Integrate SRH and child health services and make them friendly to adolescents and youth, particularly FTPs:** FTPs may be more likely to seek services for their children than for themselves, and men who might otherwise not interact with the health system may do so when involving the health of a child. A child health visit could be an important opportunity to screen young women or couples for SRH needs. In fact, the Family Planning High Impact Practice (HIP) initiative has named the integration of contraception and immunization services a promising high-impact practice. The HIP brief recommends that deliberate efforts to integrate immunization and family planning services, either through combined service provision (both services provided on the same day and location) or through single service provision plus referral (one service offered along with education, screening, or referrals for the other service) is a promising practice, which the advisory group recommends be promoted widely, provided that it is implemented within the context of research and carefully evaluated in terms of both impact and process.³⁵



- Complement YFS for FTPs with community-level engagement with young mothers (e.g., through small groups or home visits), and their male partners, co-wives, in-laws, and other key gatekeepers to foster dialogue on health and fertility and engender reflection and transformation of inequitable gender norms.

Young people living with HIV

With increasing access to treatment, a generation of children born with HIV is now entering adolescence. In addition, adolescents and youth continue to bear a high incidence of new HIV infections. With the population of perinatally and more recently infected adolescents and youth is growing, there is an urgent need to address the comprehensive SRH and psychosocial needs of YPLHIV, including counseling on contraception and healthy pregnancy so that YPLHIV can choose when and if to have a child, and have a healthy pregnancy and a healthy baby. In addition, YPLHIV must contend with sociocultural factors, including stigma, which can limit options. There are a growing number of resources that support the delivery of HIV and AIDS treatment and care services for young people, including supporting treatment adherence, and the transition of young people from pediatric to adult HIV treatment settings (see Annex 1). Fewer resources exist to support programs and providers to meet the broader SRH and psychosocial needs of YPLHIV. When considering services for YPLHIV, the separate space YFS model may be appropriate as it allows young people to receive comprehensive and integrated services, including HIV treatment, care, and support as well as other SRH services, in one private and confidential space. In addition to comprehensive service provision, programs for YPLHIV have successfully employed support groups that link adolescents and youth with a social support networks, education on HIV and SRH-related topics, life skills, livelihood opportunities, and mentorship from adults, depending on the support group model.

Lesbian, Gay, Bisexual, Transgender, and Queer young people

Young LGBTQ individuals are among the most underserved groups in many countries across Asia, Latin American and the Caribbean, and Africa. National laws and policies continue to deny the human rights of these young people, and nearly all SRH services remain entirely focused on serving heterosexual populations of adolescents and youth. Globally there is growing recognition of the importance of ensuring services address the needs and rights of these populations. In the 2012 Bali Declaration, young people themselves called on the world to uphold the sexual and reproductive rights of LGBTQ young people.³⁶ Efforts to ensure that services are respectful and meet the needs of LGBTQ must carefully consider: any legal implications of working with this population and how to protect providers who uphold the rights of these individuals; where to offer services that will be most accessible to young LGBTQ populations; how to work with providers and other staff to ensure respectful and comprehensive care (e.g., going beyond training in clinical service delivery to include significant reflection around stigma, norms, and values); how to make sure it is explicit to all clients and staff that LGBTQ people are welcome; what package of services is needed (e.g., for young gay men, providers should feel comfortable counseling on safe anal sex practices, SGBV services, and referrals should be available); how to ensure that counseling and service delivery is done with inclusive language (e.g., that does not assume the client has a heterosexual partner); and how to engage young LGBTQ in designing the services and delivering services (e.g., serving as peer providers).^{37,38} Psycho-social support is also a critical concern among these populations as they often face significant discrimination, bullying, and abuse. Making services friendly to this population should include efforts to respect sexual rights, establish linkages with support groups, and work with parents and communities to create an enabling environment. If specific mental health needs are detected, adolescents and youth should immediately receive clinical support either at the primary health facility or be referred to specialized services. Any of the YFS models may be appropriate for these

populations if these key factors are taken into consideration, but models which provide greater privacy and confidentiality may be preferable, including community-based peer provider models, standalone youth clinics, social marketing, and pharmacies.

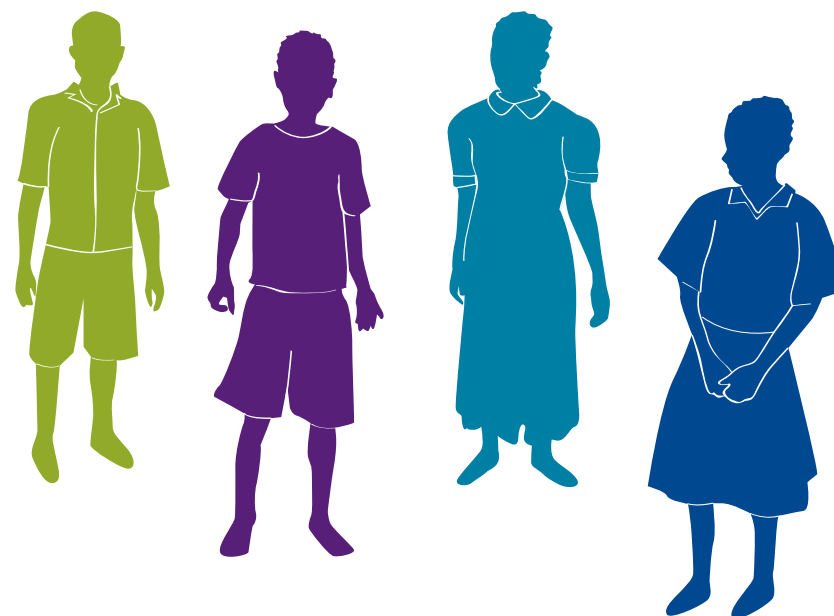
Very young adolescents

There is growing recognition that the period of early adolescence (ages 10-14) offers a window of opportunity to form more equitable gender norms before inequitable norms are cemented, prevent early and forced marriages, and improve health information and linkages with services before girls and boys have their first sexual experiences or at the age when they are having initial sexual experiences.

To support healthy growth and development, all VYAs, both those who have experienced sex and those who have not, need comprehensive and age-appropriate sexuality education, including information on their bodies and puberty. Some VYAs also need SRH services ranging from counseling and treatment for girls with irregular or painful menstruations to a full range of contraceptive and maternal health services for those at risk of unintended pregnancy or who are pregnant and at risk of maternal morbidities and mortality. However, program data suggests that VYAs are not currently accessing services through most YFS models. VYAs may face additional barriers to seeking services that current YFS models are not addressing, including an inability to travel alone to a clinic, challenges with providers or policies related to the VYA's ability to consent to services and/or policies that require parental or spousal consent, laws and policies around age of consent for sex, and additional fear and stigma surrounding sexual activity at an early age.

It is important to consider the needs of VYA when determining the health outcomes and target population for the YFS. If the context suggests that services must reach VYAs (e.g., there is a high rate of early and forced marriage), then the YFS model will need to be developed with strategies to reach VYAs. This may include:

- Community-based service delivery for newly married girls.
- Linking services with existing programs for VYAs, such as girls' groups/ safe spaces programs, literacy programs, or other recreational programs for VYAs.
- Service delivery at schools or close referral systems with accompaniment for the VYA to services.
- Supporting a routine health visit for young girls (e.g., the 12-year-old checkup) to address a range of health issues, including vaccinations, menstrual health and hygiene.
- Engaging with male parents and other influencers who shape VYAs health and development.



Conclusion

This decision-making tool suggests a process and provides guidance that you, as program designers, can use to design YFS that are responsive to desired health and behavioral outcomes, specific sub-population(s) of adolescents and youth, the country context, and the objectives for scale. After using this tool to select the model or combination of service delivery models that are most appropriate to needs and realities, you should proceed with developing a program implementation plan, set measureable objectives, and use the tools and resources in Annex I to fully develop and implement YFS.



References

1. Macquarrie KLD, *Unmet Need for Family Planning Among Young Women: Levels and Trends. DHS Comparative Reports No. 34* (Rockville, MD: 2014).
2. Population Reference Bureau, *The World's Youth 2013 Data Sheet* (Washington, DC: 2013).
3. Post M., HTSP 101: *Everything You Want to Know About Healthy Timing and Spacing of Pregnancy* (Washington, DC: Extending Service Delivery Project, 2005).
4. UNICEF, *Towards an AIDS-Free Generation - Children and AIDS: Sixth Stocktaking Report* (New York; 2013).
5. Tylee A, Haller DM, Graham T, Churchill R, Sanci L, "Youth-friendly primary-care services: how are we doing and what more needs to be done?," *Lancet* (2007) 369(9572):1565–73.
6. Williamson LM, Parkes A, Wight D, Petticrew M, Hart GJ, "Limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research," *Reprod. Health* (2009) 6:3. Available at: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2652437&tool=pmcentrez&rendertype=abstract>. Accessed February 15, 2014.
7. Senderowitz J, *Making Reproductive Health Services Youth Friendly* (Washington, DC: Focus on Young Adults Pathfinder International, 1999).
8. Mavdezenge SN, Luecke E, Ross DA, *Effectiveness of HIV Prevention, Treatment and Care Interventions Among Adolescents: A Systematic Review of Systematic Reviews* (New York, NY: 2013).
9. Napierala Mavedzenge SM, Doyle AM, Ross D, "HIV prevention in young people in sub-Saharan Africa: a systematic review," *J. Adolesc. Health* (2011) 49(6):568–86. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22098767>. Accessed November 7, 2013.
10. Dick B, Ferguson J, Chandra-Mouli V, Brabi L, Chatterjee S, Ross D, "Review of the evidence for interventions to increase young people's use of health services in developing countries," in *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries*, eds. Ross D, Dick B, Ferguson J (Geneva: UNAIDS Intragency Task Team on HIV and Young People,)2006.
11. Erulkar AS, Onoka CJ, Phiri A, "What is youth-friendly? Adolescents' preferences for reproductive health services in Kenya and Zimbabwe," *Afr. J. Reprod. Health* (2005) 9(3):51–8.
12. Ambresin A, D M, Bennett K, et al, "Assessment of Youth-Friendly Health Care :A Systematic Review of Indicators Drawn From Young People ' s Perspectives," *J. Adolesc. Health* (2013) 52(6):670–681. Available at: <http://dx.doi.org/10.1016/j.jadohealth.2012.12.014>.
13. World Health Organization, *Health for the world's adolescents: A second chance in the second decade*, (Geneva: 2014). Available at: <http://apps.who.int/adolescent/second-decade/>.
14. Zuurmond M a, Geary RS, Ross D, "The effectiveness of youth centers in increasing use of sexual and reproductive health services: a systematic review," *Stud. Fam. Plann.* (2012) 43(4):239–54. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23239245>.



15. High Impact Practices in Family Planning (HIP), *Mobile Outreach Services: expanding access to a full range of modern contraceptives* (Washington, DC: USAID, 2014).
16. High Impact Practices in Family Planning (HIP), *Drug Shops and Pharmacies: Sources for family planning commodities and information* (Washington, DC: USAID, 2013).
17. PATH, "Increasing Access to Reproductive Health Through Pharmacists," *Outlook* (2004) 21(2).
18. World Health Organization, ExpandNet, *Practical guidance for scaling up health service innovations* (Geneva: World Health Organization, 2009).
19. World Health Organization, ExpandNet, *Nine steps for developing a scaling-up strategy* (2010).
20. Hainsworth G, Zilhao I, Badiani R, et al, *From Inception to Large Scale: The Geração Biz Programme in Mozambique Analytic Case Study* (Geneva: World Health Organization, 2009).
21. McBride J, *Social Franchise Case Study: Madagascar's Top Reseau Network* (Washington, DC: Population Services International, 2011).
22. Tebbets C, Redwine D, "Beyond the clinic walls: empowering young people through Youth Peer Provider programmes in Ecuador and Nicaragua," *Reprod. Health Matters* (2013) 21(41):143–53. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23684197>. Accessed December 2, 2013.
23. Hainsworth G, Engel DMC, Simon C, Rahimtoola M, Ghiron LJ, "Scale-up of Adolescent Contraceptive Services : Lessons From a 5-Country Comparative Analysis," *JAIDS* (2014) 66:200–208.
24. Denno DM, Chandra-Mouli V, Osman M, "Reaching youth with out-of-facility HIV and reproductive health services: a systematic review," *J. Adolesc. Health* (2012) 51(2):106–21. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22824440>. Accessed December 3, 2013.
25. DFID-CSO Youth Working Group, *Youth Participation in Development: A Guide for Development Agencies and Policy Makers*, (London; 2010).
26. Rutgers WPF and IPPF, *Explore: Toolkit for involving young people as researchers in sexual and reproductive health programmes* (London, 2013).
27. IPPF, *Want to change the world? Here's how.. Young people as advocates: Your action for change toolkit* (2011).
28. Restless Development. *ACT 2015! Advocacy Strategy Toolkit* (2014).
29. Walker D, Pereznieto P, Walker D, Pereznieto P, Smith K, *Partners for change: Young people and governance in a post-2015 world* (London: Overseas Development Institute, Plan, Restless Development, 2014).
30. Planned Parenthood Global, *Youth Peer Provider Program Replication Manual* (New York: Planned Parenthood Global).
31. The Health Communication Capacity Collaborative HC3, *Utilizing ICT in Demand Generation for Reproductive, Maternal, Newborn, and Child Health: Three Case Studies and Recommendations for Future Programming* (Baltimore, 2014).

32. Austrian K, Jackson Hachonda N, Hewett P, *The Adolescent Girls Empowerment Program: Lessons Learned from the pilot test program* (Lusaka: Population Council, 2013).
33. Inter-Agency Working Group (IAWG) on the Role of Community Involvement in ASRH, *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators* (Washington, DC and New York: IAWG, 2007).
34. Greene ME, Gay J, Morgan G, Benevides R, Fikree F, *Reaching Young First-Time Parents for Healthy Spacing of Second and Subsequent Pregnancies* (Washington, DC: Evidence to Action Project, 2014).
35. High Impact Practices in Family Planning (HIP), *Family Planning and Immunization Integration: Reaching postpartum women with family planning services* (Washington, DC: USAID, 2013).
36. Bali Global Youth Forum Declaration (2012). Available at: http://icpdbeyond2014.org/uploads/browser/files/bali_global_youth_forum_declaration.pdf.
37. The Joint Commission, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*, (Oakbrook Terrace, Illinois: 2011).
38. YAPA, Nepean Access Project Reference Group for the Nepean Better Futures Strategy, *Opening the doors: A "Do it Yourself" Access and Equity Manual for Working with Young People* (Australia, 2006).
39. World Health Organization, "Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services" (Geneva: WHO, 2012).
40. Senderowitz, J., Solter, C, Hainsworth, G., Module 16: Reproductive Health Services for Adolescents (Pathfinder international, 2004). Available at: http://www.pathfinder.org/publications-tools/pdfs/Module-16-Reproductive-Health-Services-for-Adolescents-Training-Guide_pdf.pdf?x=114&y=25.
41. World Health Organization, "Core Competencies in Adolescent Health and Development for Primary Care Providers: Including a Tool to Assess the Adolescent Health and Development Component in Pre-Service Education of Health-Care Providers" (Geneva: WHO, 2014).

Annex I:

Guides, tools, and resources for the implementation of YFS

Title	Author(s)	Year	Summary
Adolescent HIV Care and Treatment, Module 2: The Nature of Adolescence and the Provision of Youth-Friendly Services	ICAP	2011	While this training guide was written for adolescents living with HIV, the training session could be easily broadened to youth-friendly services more generally. The guide provides step-by-step instructions for leading a group dialogue about how to assess for and develop youth-friendly services.
Adolescent Data Guides	UNFPA	Multiple	This series of Adolescent Data Guides, which draws principally on data from the Demographic and Health Surveys, aims to provide decision makers at all levels — from governments, nongovernmental organizations, and advocacy groups — with data on the situation of adolescent girls and boys and young women. The age range covered is 10-24. The data are presented in graphs, tables, and maps (wherever possible), providing multiple formats to make the information accessible to a range of audiences. The guides clearly define the gap between investment and need, and illustrate how the most vulnerable youth populations may be excluded from the very programs intended to help them.
Adolescent HIV testing, counseling, and care: Implementation guidance for health providers and planners	WHO	2014	This new interactive tool is designed as a companion to "HIV and adolescents: guidance for testing and counseling and care for adolescents living with HIV." It illustrates, animates, and amplifies the recommendations and key messages of the guidelines with practical guidance and engaging, multi-format resources for reaching adolescents and providing more appropriate, appealing, and effective HIV testing and counseling, treatment and care services specifically for them.
Adolescent Job Aid	WHO	2010	This job aid is a useful desk reference, which provides health care workers with recommendations for working with adolescent clients. The job aid focuses on the clinical interaction between patient and provider with suggestions for: a) greeting an adolescent client; b) taking a history of the presenting problem; c) going beyond the presenting problem; d) doing a physical exam; e) communicating about treatment options; and f) dealing with laws and policies that affect young people.

Title	Author(s)	Year	Summary
Adolescents Sexual and Reproductive Health Toolkit for Humanitarian Settings	UNFPA, Save the Children, USA	2009	This toolkit is intended to guide humanitarian program managers and health care providers to ensure that sexual and reproductive health interventions put into place both during and after a crisis are responsive to the unique needs of adolescents. It provides user-friendly tools for assessing the impact of a crisis on adolescents, implementing an adolescent-friendly Minimum Initial Service Package, and ensuring that adolescents can participate in the development and implementation of humanitarian programs.
Assessment of Youth-Friendly Postabortion Care Services: A Global Tool for Assessing Postabortion Care for Youth	Pathfinder International	2008	This tool is designed to help assessment teams, project managers, supervisors, and providers collect detailed information on the quality of postabortion care services provided to adolescents at a given facility in order to make services more youth-friendly.
Certification Tool for Youth-Friendly Services	Pathfinder International	2004	This certification tool is a means to quantify the status of youth-friendly services in a facility setting in order to issue a certification or a provisional certification for youth-friendly services when repeated by comparing the score at follow-up to that baseline.
Clinic Assessment of Youth-Friendly Services: A Tool for Improving Reproductive Health Services for Youth	Pathfinder International	2003	This tool helps program managers and clinicians determine the extent to which current reproductive health services are youth-friendly. Results from the tool can be used to tailor services to better meet the needs and preferences of young people.
The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence	AIDSTAR-One	2013	This document should be used as a guide to help medical providers better address and respond to the unique needs and rights of children who have experienced sexual violence and exploitation. The focus is on the delivery of clinical post-rape care services and includes information on establishing services tailored to the needs of children.
Core Competencies in Adolescent Health and Development for Primary Care Providers: Including a Tool to Assess the Adolescent Health and Development Component in Pre-Service Education of Health-Care Providers	WHO	2014	This document aims to help countries develop competency-based educational programs in adolescent health and development in both pre-service and in-service education. In addition, it provides guidance on how to assess and improve the structure, content and quality of the adolescent health component of pre-service curricula.
Cue Cards for Counseling Adolescents on Contraception (Multiple Languages)	Pathfinder International	2013	The set of cue cards is designed to help a range of community- and facility-based providers counsel adolescents and young people on their contraceptive options. The cue cards address: combined oral contraceptives, progestin-only pills, emergency contraception, male and female condoms, injectables, implants, intrauterine devices, and the lactational amenorrhea method. The provider can use the front side of the cards to offer information to adolescents about all available options, and after the adolescent chooses a method, they can turn to the back for specific instructions on use.

Title	Author(s)	Year	Summary
Demystifying Data: A Guide to Using Evidence to Improve Young People's Sexual and Rights	Guttmacher Institute, IPPF	2014	This guide aims to help health care providers, educators and advocates in the field of sexual and reproductive health and rights to better understand and use evidence on adolescents' knowledge and behaviors. The guide provides demographic and socioeconomic information about adolescents, as well as measures of their access to, need for, and use of sexual and reproductive health information and services. It is ultimately designed to provide professionals in the field with information they can use to argue effectively for and design policies and programs to meet young people's sexual and reproductive health and rights. It is useful for conducting initial assessments of the conditions of adolescents and youth, as suggested in Step 1 of this tool.
Engaging Men and Boys in Gender Equality and Health	Promundo, MenEngage, UNFPA	2010	This toolkit addresses strategies and lessons learned for engaging men and boys in diverse themes such as sexual and reproductive health; maternal, newborn and child health; fatherhood; HIV and AIDS; gender-based violence; advocacy and policy; as well as addressing issues around monitoring and evaluation. It includes tools and activities from organizations and programs from around the world which can be adapted and utilized by other organizations.
Evidence-based guidelines for youth peer education	FHI360	2010	This tool offers recommendations on evidence-based, youth peer education practices and a framework for quality assurance of youth peer education programs. Developed with global experts, these guidelines offer specific tips for each phase of program implementation, explanations of the available evidence on what works and real-world examples of how the guidelines are used in successful programs. A checklist, action planning tool, and comprehensive list of peer education tools and publications are also included.
FOCUS Tool Series 5 - A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs	Pathfinder International	2000	This is a comprehensive guide and accompanying toolkit for monitoring and evaluating adolescent and youth programs. This includes guidance for setting up monitoring and evaluation systems and a range of tools and resources for conducting monitoring, supervision, and program evaluation.
Girl-Centered Program Design: A Toolkit to Develop, Strengthen & Expand Adolescent Girls Programs	Population Council	2010	This toolkit is meant for those interested in working with adolescent girls ages 10–24. It can be used to design, run, or strengthen a program or to write a proposal to work with girls. The toolkit has three main sections: the first focuses on structure, the second on content, and the third on monitoring and evaluation. Within each chapter is an introduction to the topic, examples from existing programs for girls, and practical, user-friendly tools.
HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV	WHO	2013	The WHO, in collaboration with UNICEF, UNFPA, UNESCO, and the Global Network of People Living with HIV (GNP+), has developed these guidelines to provide specific recommendations and expert suggestions—for national policy-makers and program managers and their partners and stakeholders—on prioritizing, planning, and providing HIV testing, counseling, treatment, and care services for adolescents.

Title	Author(s)	Year	Summary
How to Reach Young Adolescents: A toolkit for educating 10-14 year olds on sexual and reproductive health	DSW	2011	This toolkit was designed to be used by implementers, including NGOs, governments, or private industries who want to implement a sexual and reproductive health project for 10-14 year olds enrolled in primary school. The toolkit includes a range of different approaches, activities, and recommendations.
Improving the Health Sector Response to Gender-based Violence	IPPF	2010	This manual provides tools and guidelines that health care managers can use to improve the health care responses to gender-based violence in developing countries. It includes practical tools to determine provider attitudes to gender-based violence, legal definitions, the responsibilities of health care providers, and the quality of care.
Keys to Youth Friendly Services	IPPF	2011	These briefs explore key elements to ‘unlocking’ access to sexual and reproductive health services for young people. They include adopting a sex-positive approach, ensuring confidentiality, celebrating diversity, developing autonomy and decision making, and obtaining informed consent. Practical tips, case studies, and sexual rights literature are included to support health providers.
Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents	FOCUS on Young Adults Project	1999	This guide provides step-by-step information on designing a participatory appraisal with adolescents to analyze their sexual and reproductive health-related concerns, and on using participatory learning and action tools for this analysis. It also discusses the process of data analysis and documentation.
Making health services adolescent friendly: developing national quality standards for adolescent-friendly health services	WHO	2012	This guide provides step-by-step guidance for developing standards for health service provision to adolescents. The book is intended for national health program managers. While it is not directed toward individual clinics and services, it presents core values and guidelines that clinics can use in their own assessments and service development. It also provides valuable background information on youth-friendly service provision.
Making your health services youth-friendly: A guide for program planners and implementers	PSI	2014	This guide provides an overview of the global need for youth-friendly service provision and key recommendations for developing/strengthening sexual and reproductive health services so that providers are better able to engage and retain young people in care. The guide helps program planners and implementers assess the services, identify gaps, and develop action plans. It has a specific focus on private sector or franchise clinics, but can be applied across different service delivery models.
A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action. 2nd Edition	IGWG	2009	This is an updated and revised version of the 2003 reference manual prepared by IGWG's Gender Manual Task Force. It provides organizations with a current resource on how to integrate a gender-equity approach into the design and implementation of reproductive health programs and includes case studies and worksheets.

Title	Author(s)	Year	Summary
Module 16: Reproductive Health Services for Adolescents - Training Curriculum, Module 16: Reproductive Health Services for Adolescents - Participants Guide	Pathfinder International	2004	This is a training curriculum to prepare providers to offer youth-friendly services. Providers are sensitized to the needs of adolescents and are prepared to tailor sexual and reproductive health services so that they are youth-friendly. The module puts particular emphasis on dual protection, safer sex, counseling, providing care to the pregnant adolescent, and dealing with issues of gender, sexual abuse, and sexual orientation.
Orientation Programme on Adolescent Health for Health-Care Providers	WHO, Commonwealth Medical Association Trust, and UNICEF	2006	This comprehensive training program consists of handouts for participants and a facilitator's guide for the overall course and for all the modules. It provides detailed guidance on how to run each module. In addition it contains tips for the trainers, lecturing aids such as overhead slides in electronic form with accompanying talking points and study materials.
Provide: Strengthening youth friendly services	IPPF	2008	This guide is meant to support the strengthening of youth-friendly services through self-assessments and planning for improved quality. It includes a self-assessment tool and a sample client exit interview tool.
Quality Assessment Guidebook: A guide to assessing health services for adolescent clients	WHO	2009	This guidebook provides instructions for assessing adolescent health services. The youth-friendly characteristics and definitions at the beginning of the guide are helpful for organizations and providers that are less familiar with youth-friendly service provision.
Toolkit for Transition of Care and Other Services for Adolescents Living with HIV	AIDSTAR-One	2014	This toolkit is a guide that assists both health care providers and community care providers to tailor a package of services for adolescents living with HIV. Health care providers and community care providers are the intended primary users of the toolkit, and they should use it and distribute content/tools as appropriate to the adolescent and the family/caregiver.
Using Data to See and Select the Most Vulnerable Adolescent Girls	Population Council	2012	This brief seeks to find and target vulnerable adolescent girls and shape policy context. It provides guidance on resources and tools that can reveal the internal diversity of adolescents, identify the onset and extensiveness of vulnerability, demonstrate where there are high concentrations of vulnerable girls, assess girls' share of youth resources, and identify communities and vulnerable girls for program participation. The brief concludes with field applications for making dynamic use of data.
What Works for Women and Girls: Prevention for young people	Futures Group, Health Policy Project, What Works Association, Inc.	2012	This is an online resource that compiles and summarizes the base of evidence to support successful HIV programming for women and girls.

Title	Author(s)	Year	Summary
Youth-Friendly Services Supervision Checklist (Available upon request)	Pathfinder International	2014	This checklist can be used to assess youth-friendly services during supervision visits to clinics and facilities. The checklist includes a series of questions that can be used to guide the supervision of youth-friendly services ranging from gender, sexual and reproductive health services, and contraception, to STIs and HIV and AIDS care and treatment services.
Youth-friendly services for married youth: A curriculum for trainers	EngenderHealth	2008	This curriculum seeks to enhance health care providers' understanding of young married men's and women's reproductive health needs and enables them to provide appropriate information, support and services.
Youth-Friendly Pharmacy Program Implementation Kit: Guidelines and Tools for Implementing a Youth-friendly Reproductive Health Pharmacy Program	PATH	2003	This kit is intended to guide the development of a sustainable, pharmacy-based initiative. Organizations can adapt the model and the materials as needed to suit a variety of environments.
Youth-Friendly Postabortion Care Supplemental Training Module – Youth-Friendly PAC Task Force, PAC Consortium	PAC Consortium	2012	This is a supplemental training to be added to a comprehensive postabortion care (PAC) health provider training or used as a refresher training for practicing PAC providers. The goal is to improve providers' ability to provide high-quality PAC services to adolescent clients aged 10-19. The training module is organized around the five essential elements of PAC: community and service provider partnerships, counseling, treatment of incomplete and unsafe abortion, contraceptive and family planning services, and reproductive and other health services. The training module includes a trainer's manual, trainer's tools, participant handouts, and PowerPoint slides.
Youth Participation Guide: Assessment, Planning, and Implementation	Family Health International/ YouthNet	2005	This guide seeks to increase the level of meaningful youth participation in reproductive health and HIV and AIDS programming at an institutional and programmatic level. The target audience includes senior and middle management, program managers, staff involved in implementing activities, and youth who may be engaged at all levels of an organization's work.

Annex 2:

Guiding questions to operationalize each step

The following guiding questions can be used to work through each step with key stakeholders. They can be used during workshops and other technical working sessions to help plan and evaluate the introduction, modification, or scale-up of youth-friendly services (YFS) model(s).

STEP 1 GUIDING QUESTIONS

Determine desired health/behavioral outcomes and which sub-population of adolescents and youth the services should reach.

1.1. What are the major sexual and reproductive health (SRH) issues among male and female adolescents and youth in the country or catchment area where you will work?

What data do you have to support this?

What is the magnitude of the problem?

1.2. What sub-groups of male and female young people are most affected by these priority SRH issues? For example:

- ☐ Young men and women of different age groups (e.g., 10-14 yrs, 15-19 yrs, 20-24 yrs)
- ☐ Unmarried or married (monogamous or polygamous) young people
- ☐ Young parents or young people without children
- ☐ Young men, young women or both
- ☐ Young men and women with different levels of education (no education, primary, secondary, tertiary)
- ☐ Employed or unemployed young men and women. If employed, in which sector?
- ☐ Young men and women of different sexual orientations (heterosexual, homosexual, bisexual, transsexual, intersex)
- ☐ Key populations for HIV, including young men who have sex with men, young sex workers, young people who inject drugs
- ☐ Young men and women in rural areas or young men and women in urban areas

1.3 Among the identified sub-populations above, which will you specifically aim to serve?

1.4 What data exists about these specific sub-population's SRH needs (including quantitative, qualitative, demographic, health, sociological, etc.)?

1.5 What additional formative research should be conducted to inform the selection and adaptation of the appropriate YFS model(s)?

**1.6 Which stakeholders should be consulted to analyze this data to help design your program?
How can you meaningfully involve young people in this process?**

STEP 2 GUIDING QUESTIONS

Conduct landscape analysis

- 2.1 What SRH services currently exist for the sub-populations of adolescents and youth identified in step 1?
Which services do not currently exist?**

- 2.2 What are young people's perceptions of the existing SRH services?**

- 2.3 Which actors are involved in providing these YFS to the specific sub-populations of adolescents and youth?**

- 2.4 Where and how do adolescents and youth currently seek SRH services?**

Which sub-populations of young people are currently accessing YFS?

Which sub-populations of young people are not accessing YFS?

What barriers prevent young people from the priority sub-population from accessing the current YFS?

2.5 What are the existing national laws, policies, and service delivery guidelines that are relevant to service delivery for young people?

Does a national or sub-national policy on adolescent and youth health exist?
Does it support the implementation of youth-friendly SRH services?

Are there national or sub-national standards and guidelines for youth-friendly SRH services?

Is adolescent and youth sexual and reproductive health (AYSRH) covered in pre-service education for health care workers?

Is there a national in-service training curriculum on AYSRH for health providers?

What is the age of consent to sexual activity?

Are there any restrictive policies in place, such as those requiring parental or partner consent for SRH services, those that limit access to long-acting methods for adolescents, or those that make homosexuality or other identities or behaviors illegal?

What are the national laws and procedures related to gender-based violence?

2.6 Who are the champions of AYSRH and YFS in the Ministry of Health, local partners, and communities?

2.7 What is the social and cultural environment in which the YFS will be implemented?

What is the role of religious institutions in this environment?

Who are the thought leaders and influencers?

Who are the gatekeepers of the sub-population of young people you are interested in reaching?

What are the predominant norms around adolescent sexuality and gender?

2.8 What demand-creation interventions currently exist to increase demand amongst the specific sub-populations of young people?

STEP 3 GUIDING QUESTIONS

Determine what package of SRH service will be offered

- 3.1 Which SRH services are necessary to achieve the desired health outcomes for the specific sub-populations of adolescents and young people identified in step 1?**

What types of services are necessary for prevention?

What types of services are necessary for diagnosis, treatment and care?

What is the minimum essential package of services and what is a more comprehensive package of services?

- 3.2 Which of these services are currently offered to young people through the health facilities in your intervention catchment area?**

- 3.3 Which of these services are not offered to young people through the health facilities in your intervention catchment area? What are the reasons these services are not currently offered?**

STEP 4 GUIDING QUESTIONS

Determine available resources

4.1 What type of infrastructure currently exists in your intervention catchment area that can introduce or scale up YFS (in the public and private sector)?

Are there stand-alone adolescent and youth health facilities (public or private)?

Are there facilities that offer SRH services to young people in a separate room or space?

Are there facilities that offer SRH services to young people on specific days or at specific times?

Are there facilities where a youth-friendly approach is integrated into the delivery of all services?

Are fully-equipped mobile health units already available to provide YFS?

Does infrastructure exist to conduct youth-friendly community-based services?

What other structures exist to offer SRH information and services to young people and adolescents?

4.2 What human resources are available to introduce or scale up YFS in your intervention catchment area (in the public and private sector)?

To what extent are health providers trained on providing quality SRH services to young people?

What types of health providers are mandated and available to provide youth SRH services?

Are there existing Front Line Workers (FLWs) who can be trained in YFS provision? Will new FLWs need to be recruited?

Are there existing youth peer educators who could serve as peer providers?

4.3 To what extent does the current health management information system (HMIS) monitor data related to AYSRH? What changes might need to be implemented to the HMIS?

4.4 What financial resources are available to introduce or scale up the selected YFS model(s)?

STEP 5 GUIDING QUESTIONS

Determine desired level of coverage

- 5.1 What is the optimal level of coverage to achieve your desired health outcome (e.g., national coverage to reach the general population of young people, sub-national coverage to reach the general population of young people in select regions or districts, national coverage only for specific sub-populations, sub-national coverage for specific sub-populations in select regions or districts)?

- 5.2 What level of coverage is realistic given the available resources (infrastructure, human resources, and financial resources)?

STEP 6 GUIDING QUESTIONS

Select one or more models of delivering YFS

6.1 Based on the results from Steps 1 – 5, which YFS model(s) is the most appropriate?

- ☐ YFS model 1: Standalone clinic
 - ☐ YFS model 2: Separate space for YFS
 - ☐ YFS model 3: Mainstreamed YFS
 - ☐ YFS model 4: Mobile outreach services
 - ☐ YFS model 5: Community-based services
 - ☐ YFS model 6: Drug shops and pharmacies
-
-

6.2 Please consider the following factors as they apply to your situation and the proposed YFS model(s)

Resources required

Privacy

SRH services

Population of young people served

Sustainability

STEP 7 GUIDING QUESTIONS[▼]

7.1 Which institution(s) or organization(s) will be responsible for adopting and implementing the selected model(s) of YFS at scale (i.e., the “user organizations”)?

If there are several user organizations, what are their specific roles and responsibilities for implementing youth-friendly SRH services?

What is their capacity to implement the particular YFS model(s)?

7.2 What stakeholders will promote the introduction or scale-up of the selected YFS model(s) (i.e., the resource team members)?

How effective is the leadership of these stakeholders?

How well do these stakeholders understand the political, social, and cultural environments where the YFS models will be implemented or scaled up?

What is the capacity of these stakeholders to train the user organizations or other actors on the selected YFS model(s)?

What is the capacity of these stakeholders to advocate in favor of the selected model(s) of YFS?

7.3 What type of scale-up is anticipated to increase access to the selected YFS model(s) (e.g., vertical and/or horizontal)?

7.4 For horizontal scale-up:

How many sites are expected to adopt (or are already adopting) the YFS model(s)?
Where are they located (scope of expansion)?

Are there regional differences between sites (economic, cultural, political, and programmatic) that can affect scale-up?

What is the time period during which expansion will take place?

What methods/approaches/activities will be used (or are already being used) to expand the YFS model(s) to new sites or sub-population groups?

Who are the main stakeholders that should be involved in horizontal scale-up?

To what extent are the core aspects of the YFS model(s) packaged in a clear and concise way in order to facilitate horizontal scale-up?

7.5 For vertical scale-up:

What changes at the policy, legal, institutional, or political level will need to be made in order to facilitate the scale-up process?

Who will lead the necessary advocacy efforts to facilitate vertical scale-up?

Are resources for advocacy and related costs of vertical scaling up available or do they need to be mobilized?



Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project

www.e2aproject.org