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Intersections between Youth and Reproductive Health Supplies

A Report to the Reproductive Health Supplies Coalition

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SUPPLIES COALITION

This report was researched and lead-authored by consultant Sarah Castle, with substantial content and editorial contributions from the RHSC Secretariat.

Preface

In 2014, the Reproductive Health Supplies Coalition celebrated its 10th anniversary. As all such celebrations tend to be, this was truly a watershed event. On the one hand, it reaffirmed the many successes we had achieved in advancing the cause of commodity security. But on the other, it opened our eyes to many new opportunities that still lay before us. One of these was confronting the many barriers that impede young people's access to quality and affordable reproductive health services.

The issue of youth access has long been on the minds of many Coalition members. Young people make up the vast majority of new contraceptive users worldwide and youth-focused organizations have long made up a significant proportion of the Coalition's overall membership.

What opened the door to this new optimism, however, was the advent of our new Strategy 2015-2025, intended to guide our work in the coming decade. Built around four key pillars—availability, quality, choice, and equity—the strategy offers a framework for identifying activities that fall within our manageable interest—activities that make effective use of our key “levers of change” and that yield outcomes for which we can justifiably claim some attribution.

Within the new strategy, young people figure prominently, especially under the pillar of equity, because age bears such a powerful influence on both economic well-being and product needs, two of the key strategic drivers undermining equitable access to reproductive health supplies.

In 2015, the Coalition received a grant from the David and Lucile Packard Foundation that provided us for the first time with the means to launch new youth-focused initiatives in line with the principles and logic of our new strategy. Recognizing, however, that a supplies focus is very much underrepresented in the existing discourse on youth-focused issues, we commissioned this report to help get people thinking in new ways. By consulting past research and interviewing key stakeholders the author, Sarah Castle, dug deeper into the issues and identified new opportunities for highlighting the central role supplies play in ensuring the reproductive health of young people. Through this work, she has planted the seeds of exciting new initiatives which we hope will see come to fruition in the years ahead.

During our annual membership meeting in October 2015, a group of young members called upon the Coalition to strengthen young people's engagement and participation. In the six months since then, we have begun to do that. We have set up a Youth Discussion Group to share knowledge, solve problems and exchange best practices. Under the group, two consultations have already taken place, one in Kampala in December 2015, the other in Bali in January 2016.

Together, this report and the ongoing youth discussions hold out great promise for leveraging the strengths of our global partnership to truly broaden young people's access to the safe, effective and affordable reproductive health supplies and services they want and need.

John P Skibiak

Director, Reproductive Health Supplies Coalition

Executive Summary

Commissioned by the Reproductive Health Supplies Coalition (RHSC), this report aims to help its members better understand young people's needs for reproductive health supplies with a view towards framing future actions to ensure optimal and equitable access. It explores the supply-related barriers that impede access to the contraceptive services young people desire and need. The evidence presented here makes it possible to identify these barriers, understand better the variables that contribute to them, and target future youth-focused initiatives.

As key components of its Strategy 2015-2025, the RHSC emphasises the importance of four key pillars: availability, equity, quality and choice. In this report, specific emphasis is placed upon the pillar of equity, and in particular on the financial and product barriers that impede access to reproductive health supplies. The findings in this report lay out a comprehensive set of interventions which are themselves derived from best practices in the field. These hold out the potential to help young people demand and monitor the services and supplies that meet their needs.

Young people's access to commodities is hampered by a number of factors including restrictive policies, provider attitudes, cultural barriers, and/or social and financial vulnerability, the relative importance of which often depends on the local or national context. In some cases, the key obstacles may be enshrined in law. In others, the greatest obstacles may be the way laws are interpreted.

Common wisdom holds that young people's sexual activity is largely sporadic and unplanned. They often prefer short term methods (pills, injectables, condoms) which can be cheaper. Nevertheless, Long-Acting Reversible Contraception (LARCs) can be appropriate for this group and yield cost savings through fewer visits and follow-up. If used routinely over time, short terms methods work out to be more expensive as evidenced in the higher cost per Couple Years of Protection.¹

¹ CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure (<https://www.usaid.gov/what-we-do/global-health/family-planning/couple-years-protection-cyp>)

Although many programmes focus upon unmarried youth, young married women may also benefit from increased use of LARCs to postpone their first birth and space their second and subsequent births. Family disapproval, however, may make it hard for them to access services; so integrating family planning with postpartum care or childhood immunisation services may serve as effective strategies to increase access.

Other underserved groups include marginalized and vulnerable youth who are often difficult to reach. Young people living with HIV, for example, often experience discrimination at health centres because of their HIV status. And youth in emergency or humanitarian crisis situations must often deal with the effects of uncertain supply chains. Even if young people manage to access services, societal disapproval, provider bias or supply chain disruptions prevent them from getting the method they need or want. Stockouts may have an especially pernicious effect on young people as they often do not have the time, cash or autonomy to seek alternative supply sources and therefore quickly become discouraged.

Policymakers, providers, and both community and religious leaders have expressed reservations about the suitability of Emergency Contraception (EC) for youth. EC is not widely available in many settings and is not on the National Essential Medicines List of most developing countries; and yet it holds out unique benefits for young victims of sexual assault and can decrease unsafe abortion and reproductive morbidity and mortality. It is, therefore, crucial that EC be included in political agendas that address both commodities and reproductive rights.

With regard to service provision and delivery channels, many

young people seem to prefer to access their family planning methods via the private sector. They perceive it to be more discreet and to provide a better quality of care. A Total Market Approach (TMA) can support private sector provision whilst building up a public sector that is youth friendly. Voucher systems and social marketing can make commodities more affordable via franchises and other outlets where quality is assured. In addition, peer education and community outreach can bring supplies to specific groups who may be marginal or vulnerable. All of that, coupled with rights-based life-skills training could increase uptake.

Young people's needs and preferences should be considered in the design and implementation of their services and the development of new technologies. Making sure these services include life skills training can also enhance the likelihood young people will apply the reproductive health information they acquire even when society disapproves.

Evidence-based advocacy, carried out collectively by engaging multiple partners, is the best tool for mobilising the resources needed to improve contraceptive availability and service provision.

The interface between youth and reproductive supplies is complex. It encompasses a list of barriers ranging from policies, service delivery protocols, to cultural and legal obstacles. Enhancing young people's access to commodities should be a priority within countries' health and development agendas. In addition, youth involvement in the design, implementation and evaluation of relevant policies and services will be crucial in ensuring ownership and optimal impact.

Specific recommendations on the way forward are given at the end of this report. They include the need for task-shifting and the inclusion of emergency contraception in national Essential Medicines Lists. They also include recommendations for national policies to provide youth-friendly services, including to those under the age of 16. They recommend that young people actively participate in the design of service provision programmes at all levels (through family planning associations, health facilities, and community organizations) to ensure their needs are represented. And lastly, this report highlights the need for appropriate pre- and in-service training to overcome provider biases, and to ensure that providers have the necessary skill sets to adequate stocks of a broad range of contraceptive commodities.

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1. Background

The World Health Organization's report "Health for the World's Adolescents: A second chance in the second decade" (WHO 2014) provides compelling global evidence of the need to include youth in reproductive health programming. Efforts to delay the age at first birth, improve birth spacing and address Gender Based Violence (GBV) stand to improve health outcomes among young people. Effective access to and use of reproductive health commodities enable girls to remain in school, improve workforce participation and ensure opportunities for civic engagement. Making commodities more available to young people is key to increasing access to family planning and therefore critical to improve their lives and the development of the countries in which they live.

This report aims to understand young people's² access to reproductive health supplies. It explores the many barriers that impede their ability to acquire in a timely manner the contraceptive commodities they need and want.

The Reproductive Health Supplies Coalition (RHSC) envisages that 'All people are able to access and use affordable and quality supplies, including a broad choice of contraceptive methods needed to ensure their better sexual and reproductive health' (RHSC Strategy 2015-2025:2). In order to achieve this, the Coalition emphasises the importance of four key pillars: availability, equity, quality and choice. In this report, specific emphasis is placed upon the pillar of equity as it underpins the socio-cultural and economic determinants of family planning use as well as political and policy decisions that may hamper young people's potential access to commodities.

The purpose of the report is to enable the RHSC and its partners to better understand the inter-face between young people and reproductive health supplies with a view to framing future actions to ensure optimal and equitable access. The evidence presented below will enable the Coalition to identify where inequities lay and what strategies fall within its manageable interest. Many supply-related barriers, stockouts for example, affect all age groups. But the evidence presented here highlights many of the ways young people find themselves particularly disadvantaged when it comes to dealing with stockouts. These connections are not

just pertinent to the Coalition, they comprise a strategic part of the FP2020's Youth Engagement Framework (www.familyplanning2020.org) and will be pivotal to the new SDGs, which many have argued must involve young people in their design³. The discussion presented below is pertinent to global thinking which benefits from information-sharing around best practices. New and emerging initiatives such as Passages (<http://irh.org/projects/passages/>) and Adolescent 360 (<https://ciff.org/news/adolescents-360/>), funded by the Bill & Melinda Foundation, must also recognize and address the interface between young people and commodities. This report, therefore, contributes new information to global and local debates and facilitates priority-setting.

It should be noted that there is an enormous amount of literature on, for example, the socio-cultural barriers that impede young people's access to services, such as stigma, and prevailing beliefs about pre-marital sexual activity (Mugisha and Reynolds 2008, Tumlinson 2013). This report does not pretend to address the full spectrum of youth-related issues, but rather those where better access to a more affordable and appropriate range of reproductive health supplies can make the critical difference.

2 The terms "youth" and "young people" are used interchangeably in this report to refer to individuals aged 25 and under (WHO 1999)

3 The youth-led development agency 'Restless Development' notes that if youth are not meaningfully involved in all stages of the SDGs' development, including accountability and review, they risk being left behind with policies that do not cater to their unique needs and experiences (<http://restlessdevelopment.org/>).

2. Methodology

A consultant, Sarah Castle, worked with the RHSC to identify a preliminary list of member organisations with substantive experience in young people's sexual and reproductive health, specifically at advocacy, policy and programmatic levels. Representatives of these organizations were sent a questionnaire devised by the consultant with input from RHSC

staff. A number of respondents were subsequently interviewed by telephone or Skype. Furthermore, an extensive literature review was carried out, which included unpublished reports from international NGOs and local organisations intervening in the field. A complete list of those who provided input for the report is included in Annex 1.

3. The context of young people's sexual behaviour

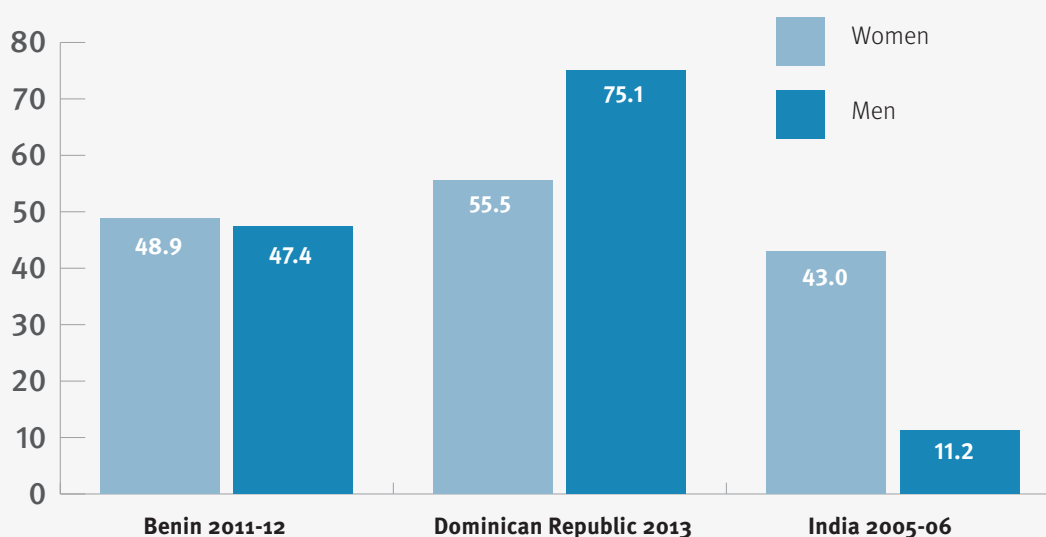
Every year more than 7 million births occur to young women under age 18; complications during pregnancy and childbirth are the second cause of death for 15-19-year-old girls. Globally, around three million girls aged 15-19 undergo unsafe abortions annually; and babies born to young mothers face a substantially higher risk of dying than those born to women aged 20 to 24 (WHO 2014). An analysis of Demographic and Health Surveys (DHS) data sets from 61 countries

estimate that 33 million young women have an unmet need for family planning (MacQuarrie, 2014).⁴ While nearly two-thirds of these reside in South and Southeast Asia, rates of unmet need for family planning are highest in Africa⁵. In a

⁴ Unmet need here refers to 'the %age of women who do not want to become pregnant, but are not using contraception' (MacQuarrie 2014).

⁵ Unmet need for family planning among young married women is highest in the West and Central Africa region (averaging 29.3%), followed by the East and Southern Africa region (25.5%) (MacQuarrie 2014)

Table 1 : Percentage of sexually active women and men, below the age of 18



Source: Demographic and Health Surveys

quantitative survey of sexually active young people in six countries (Uganda, Nigeria, Nepal, Vietnam, Pakistan and Bangladesh) carried out by Marie Stopes International, respondents were asked about their non-use of family planning (MSI 2014). The most common reason cited was ‘I don’t know how to get hold of it’. This reason was cited more frequently than ‘fear of side-effects’ or societal disapproval, indicating that access issues are a priority for improving uptake among youth.

It is recognised that young people constitute a very heterogeneous group with significant differences in both behaviours and demand for family planning. For example, Table 1 shows that in Benin, West Africa, around half of all girls and boys reported being sexually active by age 18.

In India, 43% of girls aged 15-19 were sexually active and most of these were likely to be married given the early age of marriage in this setting. In the Dominican Republic, 55% of girls are sexually active compared with three quarter of boys. These figures illustrate the diversity in young people’s sexual activity and the consequences this may have on their supply needs. Married youth, for example, may have very different priorities, obligations and ‘world views’ compared to those who are unmarried, especially in contexts where premarital pregnancies are frowned upon—an increasingly common scenario as the age of marriage rises due to increases in education and employment opportunities. In addition, the

‘biosocial gap’ is also increasing as age at menarche lowers while the age at marriage rises (Nalwadda , Mirembe, Byamugisha et al 2010). All these factors contribute to increasing demand for family planning among young people.

In many instances, sexual encounters of young people are unplanned, sporadic and often furtive, particularly in a climate of adult disapproval (Aluzimbi, Barker and King et al 2013). This often prompts them (especially girls) to favour short-term methods of contraception because longer-term methods might imply that they are planning for sex, which in turn could affect their reputation among peers. Young people’s preference for short-term methods is discussed in detail below together with its implications for supply chains and for the cost-effectiveness of provision. It is recognised that other factors may be extremely important in determining young people’s use of contraception.

“We meet so many friends especially when we go to beaches and attend sports—having sex here is unplanned and appears to be fun for everyone”

Farida, 22 years old, Uganda
(Aluzimbi, Barker and King et al 2013)

4. Policies and young people’s access to reproductive health supplies

This section reviews the range of policies that can affect, positively or negatively, young people’s access to reproductive health supplies. It also sets out pathways towards stronger policies that meet young people’s commodities needs.

In general, there are two types of policy and legal barriers that affect young people’s access to commodities, all of which are summarised in IPPF’s ‘Over-protected and under-served’ (IPPF 2014).

The first set of barriers include what might be referred to as direct barriers—namely, laws which explicitly and purposefully restrict the delivery of certain services. Illustrative of this are laws that prohibit abortion or, in Peru, that place legal restrictions on the provision of contraceptives you young people (Anabella Sanchez, JSI, 2015).

The second set are indirect barriers which do not directly restrict access to sexual and reproductive health services or products but nonetheless have that effect. For example,

statutes that establish minimum ages for sexual consent or majority are sometimes interpreted by providers as minimal ages for service provision. In Senegal, research revealed that the average minimum age for contraceptive provision was 18 despite norms and protocols that specifically prohibit age restrictions (Sidze et al 2014). These policies do not, however, include clear statements ensuring that young people have unrestricted access. As a result, many providers simply establish their own limits based on their own preconceptions about sexuality and cultural acceptability.

It should be noted that widely divergent definitions of ‘youth’ also have an impact on young people’s access to reproductive health supplies. In Zambia’s Adolescent Health Strategic Plan 2011-2015, the definition of ‘youth’ is drawn from the country’s National Population Policy (2007), which includes people between the ages of 10 and 35 years. The plan states that the young people meeting these criteria are eligible to join youth friendly centres or to access standard health facilities where they can obtain family planning. But given that such an age-spread is not widely recognised as constituting the definition of ‘youth’, the failure to cite it repeatedly in relevant laws could deprive ‘older’ users, between the ages of 26 and 35 from receiving services, which in turn would undermine the goals of the Strategic Plan itself.

Laws and policies can also, however, facilitate young people’s access to services and supplies. Senegal’s 2005 Reproductive Health Law, for example, seeks to ensure young people’s access to reproductive health services. In 2006 the Adolescent National Health Strategy followed. The strategy drew on wider initiatives to support civil society involvement and government accountability and to mobilise donor support for family planning provision, including for young people (Population Reference Bureau 2012).

Facilitative laws can also improve supply chains. In 2014, Zambia approved their first-ever budget line for reproductive health supplies—a significant move made possible thanks to effective targeted advocacy by the Planned Parenthood Association of Zambia (<http://pai.org/blog/edford-interview/>). From that point on, supplies were funded through donor and domestic support, with government covering about one third of the cost. Together, donors and the government leverage resources through thematic partnerships. One of them is the ‘Adolescents and Youth Cluster’ that invests in 1) providing comprehensive sexuality education 2) integrating HIV and sexual and reproductive health services 3) reaching marginalised girls and 4) encouraging youth leadership and participation

Clearly, the link between facilitative policies, adequate supply chains and accurate and appropriate information is key to improving young people’s access to family planning.



Editorial from Zambia Daily Mail

“There has been an increase in the number of children aged between 10 and 15 years seeking family planning services at health institutions. This is a serious matter that requires a multi-pronged approach to effectively deal with.

Firstly, it must be collectively agreed that Zambia has a problem because it is not logically and morally and possibly legally right to have such young children on contraceptives”.

September 16th 2014

5. Access barriers and youth sub-groups

Young people constitute a diverse group, and many sub-groups require different targeting strategies. Based on a review of the literature and current programming efforts along with responses from RHSC partners, the following groups were identified:

Sexually active youth under the age of 15

Despite the wide variability in definitions of youth, there is widespread consensus that inadequate attention has been paid to the contraceptive needs of the very young. USAID's Office of Population and Reproductive Health at USAID, which is committed to targeting young people from the age of 10, recognises that those under the age of 15 face a unique set of barriers when accessing reproductive supplies—provider bias being a notable one (USAID 2012). Additionally, since very little data exist on this age group⁶, suppliers, programmers, and implementers often lack relevant information to support their efforts. Key barriers include the requirements for parental consent for those under the age of 18 who wish to access family planning. According to Cottingham, Germain and Hunt (2012), accessing care and commodities by the very young calls for a rights-based approach.⁷ This approach has also been put forth by Nigeria's 'Action Health Inc.', which has a Charter of Rights that binds providers and clients to making sure that even the very young have access to commodities (Dr. Uwemedimo Esiet – personal communication).

⁶ Data collection is often hindered by a requirement for parental consent to interview those under 18 or by child protection and ethical considerations that do not permit the enrolment of such groups in studies.

⁷ Cottingham, Germain and Hunt (2012) note how human rights can be used to identify, reduce, and eliminate barriers to accessing contraception; A rights-based approach can enhance laws and policies; and governments' legal obligations in relation to contraceptive information and services. It can also serve to eliminate stigma, discrimination and gender based violence, promote free and fair choice and integrate reproductive health services in way that enhances young people's broader life chances with regard to education and employment.

Young people in lower wealth quintiles

The costs of health consultations and the often significant distances to health facilities are barriers for young people in the lower wealth quintiles. Innovative service delivery approaches may be needed to deliver access to such groups, for example by mobile outreach or by workplace provision. In Ghana, 58% of women access their family planning via the private sector (www.track20.org 2015).

Unmarried young people

Data on the use of contraceptives by unmarried women are less available than comparable data among married women, in large part because Demographic and Health Surveys have historically measured only the latter. Where data are available however, they tend to show that unmarried women use family planning more often than their married counterparts (Blanc, Tsui, and Croft et al 2009).

It is widely believed that the sexual behaviour of unmarried youth is typically sporadic or infrequent and this has implications for their use of services and corresponding supplies. These patterns of sporadic sexual contact, perhaps with multiple partners, imply distinct sets of commodity requirements, such as favouring short-term methods such as pills and injectables as well as condoms for HIV and pregnancy protection.

"The pill is most suitable, because injections are not advised for girls or for young unmarried women, because when you are married, you can be left sterile. However, with Pilplan, after you marry, you stop using it and you can become pregnant".

Bamako, Mali female client, 19 years old, secondary schooling
(Castle, 2003)

Young people also make decisions about method choice with a view to their future fertility, which implies concerns over longer-term side-effects. For example, in Mali, Castle (2003) found that urban, unmarried young women were wary of using either the pill or injectable contraception because of fears the methods would leave them sterile. Contraceptive decision-making, therefore, was driven not just by the immediate desire to limit fertility, but also by the desire to get pregnant in the future.

Young married women

Unmet need for family planning among young married women is highest in the West and Central Africa region (averaging 29.3%), followed by the East and Southern Africa region (25.5%). The region with the lowest level of unmet need is the Middle East and North Africa (10.8%) (MacQuarrie 2014). In many settings, especially in rural Africa, the median age at marriage is very low (Marston, Slaymaker and Cremin et al 2009). In addition, newly married women often face familial and community pressure to conceive, despite the physiological risks of early childbearing. For example, in Burkina Faso, the social capital of young wives (particularly in polygamous marriages) and daughters-in-law often hinges on being able to prove their fertility as soon as possible after marriage (Bankole, Hussain and Sedgh et al 2014). Nevertheless, studies indicate that once new wives have proven their fertility, many do want to postpone their next birth for two or more years, meaning that unmet need among young women can still be substantial (Diallo 2015).

In many settings, young married women may not have the autonomy or mobility to access more urban-based, youth-friendly services. In such circumstances, mobile outreach that targets young married women in their villages of origin may be more effective (Eva and Ngo 2010). Sensitisation may include strategies to postpone first birth (to limit the risk of fistulae, obstructed labour and postpartum haemorrhage) as well as space subsequent births. This may require explaining to other marital family members, such as husbands and mothers-in-law, the benefits of family planning, including LARCs (Castle 2011). The antenatal care associated with a first pregnancy also represents an ideal opportunity to encourage the delay of a second birth. Expectant mothers can also be reached with family planning messages and services during child immunisation campaigns. Such neutral settings often provide an ideal opportunity for delivering services that might otherwise be opposed by family members (USAID/

Family Planning High Impact Practices 2013). Such an integration of services, however, would typically have supply chain implications, as contraceptives and vaccines often follow separate distribution channels.

Young people living with HIV (YPLHIV)

Young people living with HIV (YPLHIV) need sexual and reproductive health information, skills and services so that they can discuss their status with health professionals, get the correct medication and prevent transmission (UNFPA/WHO 2006). Around the world, the delivery of family planning services has been successfully incorporated into programmes that make ARVs available to people living with HIV, especially the key affected populations such as men who have sex with men, transgenders, intravenous drug users and sex workers (Spaulding et al 2009). These programmes need not only confront the discrimination associated with being HIV positive but also the stigma commonly associated with contraceptive use, especially by unmarried women (GBC Health 2012). With regard to commodities, barrier methods, including dual protection, are a priority.

Young people in humanitarian and emergency situations

Young people are often disproportionately disadvantaged in humanitarian and/or environmental crises. Evidence suggests that in many such settings, gender based violence (GBV) increases and with it, the need for emergency contraception (EC) and other contraceptive methods. (Humanitarian Practice Network 2014). Unfortunately, in all too many emergencies, contraception is an afterthought and contraceptive supplies do not figure among the commodities typically 'pre-positioned' before disasters strike. This disconnect underscores the need for a real integration of reproductive health needs (including supplies) into countries' Disaster Risk Reduction plans (United Nations/International Strategy for Disaster Reduction 2015). Initiatives such as SPRINT (www.ippf-sprint.org) run under the auspices of IPPF provide theoretical, technical and clinical guidelines on the Minimum Initial Service Package, which includes provisions for reproductive health services and commodities for young people.

6. Method preference

This section of the report explores some of the method choice considerations that typically set young people apart from older family planning users.

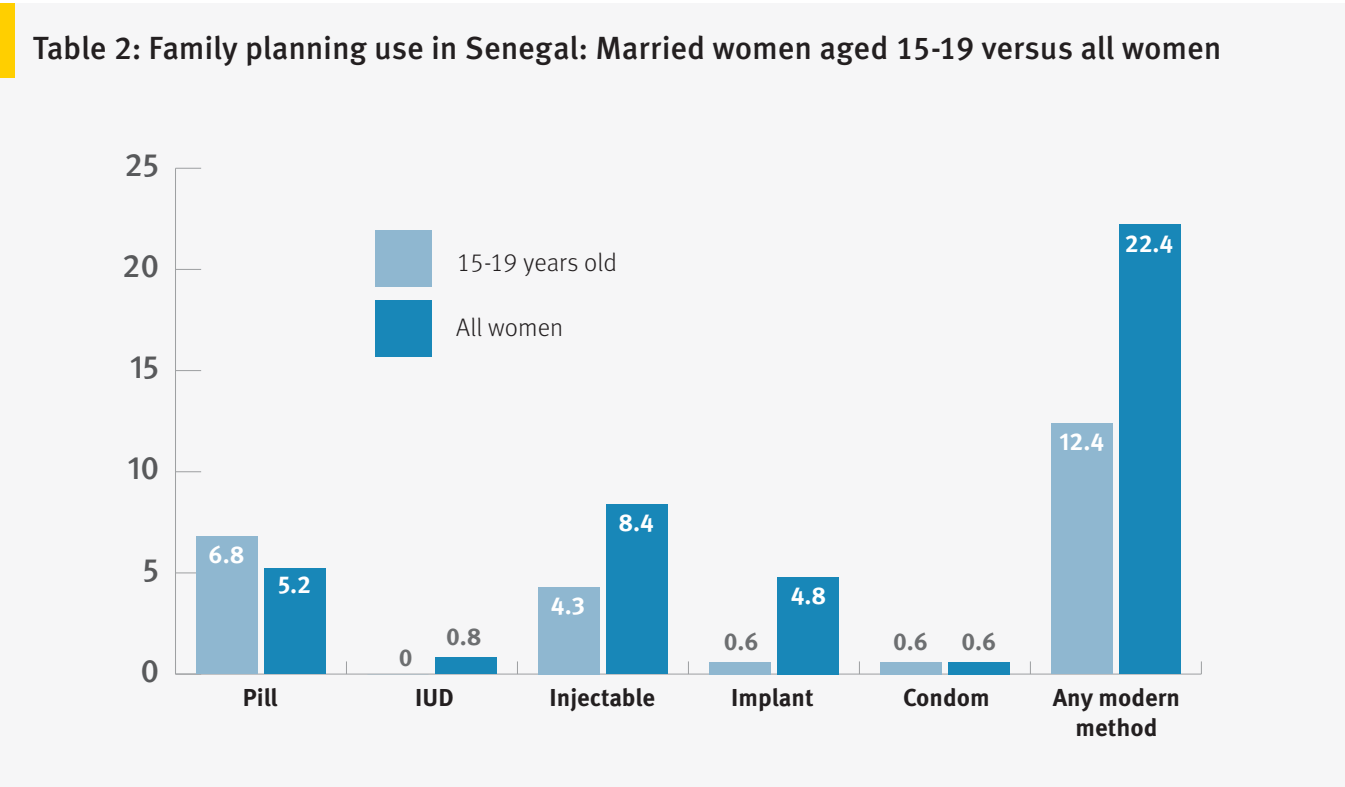
In recent multi-country DHS analyses of adolescents, 39.9% and 31.4% indicated injectables and pills as their preferred methods, respectively (McCurdy, Schnatz and Weinbaum et al 2014). As noted previously, however, DHS data do not always include unmarried women who may demonstrate different use patterns from their married counterparts. Table 2 uses DHS data from Senegal to show that married youth have different contraceptive use patterns than married women in general. Among the latter, implants and injectables are more popular methods whereas married youth preferred pills. This illustrates how LARCS may be seen as a more appropriate for women who have competed their families and who wish to stop childbearing rather than for women at the beginning of their reproductive careers who wish to space.

Qualitative evidence suggests that young people’s contraceptive decisions are often shaped by the views of

those in their social networks and therefore by the myths and rumours prevalent within them (Ankomah, Oladosu, and Anyant 2011). In such settings family planning programming must address rumours head-on by peer campaigns that engage the wider community. Commodities, therefore, cannot be viewed outside the social settings in which they are used; and providers and procurers must acknowledge this to increase access to young people.

Data also point to the popularity of pills among young women, although it can sometimes be difficult to ensure consistent adherence. Likewise, condoms are also preferred because they can be bought in non-health settings such as market or bars. But they require male compliance and effective negotiating skills which may be problematic in cultural settings where girls and women have low social status.

Implants are also both safe and suitable for young women. Indeed, young women are often ideal candidates for the method as they are less likely to exhibit the contraindications that prohibit their use such as deep vein thrombosis, liver



tumours and breast cancer (Jacobstein and Stanley 2013). In many settings, implant use has rapidly increased among young women, not least because it does not require frequent visits to the health centre and can be kept secret. In recent years, use of implants has doubled in Malawi, quadrupled in Tanzania and increased more than 15-fold in Rwanda and Ethiopia. Jacobstein and Stanley (2013) have identified three driving factors behind this increase: 1) an enabling environment with strong policy commitment to task shifting; 2) widespread training to increase providers' knowledge and skills; and 3) the procurement and availability of sufficient commodities. To ensure maximum uptake among young people, however, these three 'necessary conditions' must occur within the context of youth friendly service provision. Recently, DHS data from Ghana has revealed a high demand for implants (Population Council 2014)—a development which has encouraged government policy to support task-shifting among lower level of health care providers. Ghana's experience also underscores the need for governments to allocate a proportion of their health budget for the purchase of commodities instead of relying heavily on donor support.

(IUDs are also highly effective but rarely considered acceptable options for youth, especially for those who are unmarried or have not yet conceived. This may be due to provider biases (Robinson, Moshabele, Owusu-Ansah et al 2014). Although there is some evidence that younger women and women who have never given birth experience increased rates of IUD expulsion or removal (Allen et al, 2009, Alton et al, 2012), the method has proven itself to be appropriate for young women, providing there is adequate provider training and client counselling.

Overall, the successful expansion of LARC services, requires both provider training on youth-friendly services and effective product distribution strategies. In some settings, national distribution systems have resulted in uneven provision, even to regions where providers are not adequately trained. Meanwhile, in the larger cities where demand may be high, supplies often cannot be replenished in a timely manner, resulting in chronic stockouts (Population Reference Bureau/ Castle 2010 – see <http://www.prb.org/Multimedia/Video/2010/mali.aspx>). It is critical, therefore, that evidence-based research and reliable demand forecasts drive the choice and supply of commodities.

Finally, it is known that contraceptive discontinuation rates among young women are higher than among older women (Blanc, Tsui and Croft et al 2009). To ensure that those who discontinue one method do not cease family planning altogether, it is critical that there be a range of alternative contraceptives to choose from. Indeed, Jain, Obare and Ramarao et al (2013) have estimated that by adding one additional method or its equivalent to the number of methods available, there is an eight percentage point decrease in contraceptive discontinuation amongst all women. Supply chains need to ensure that there is a sufficient mix of commodities, and providers must be trained to minimize the risk of discontinuation, particularly through counselling on side effects.

7. Stockouts and young people

This section discusses how stockouts can be very problematic for young people, not only by depriving them of their preferred method, but also by undermining their trust in health services.

Stockouts resulting from supply chain problems may lead to method shortages or unavailability. Although these disruptions affect all users, many of the resupply methods favoured by young people, such as injectables, do require more frequent replenishment than longer acting methods. Thus, by the nature of what is being resupplied, stockouts may disproportionately affect younger users.

In addition, the absence of one's preferred method may undermine confidence in the health service and discourage further visits (Castle and Hardtman 2014). And if no alternative method is available or the alternatives (such as LARCs) are downplayed by providers, young people will find themselves at greater risk of pregnancy. Condom use, as a temporary measure, may also be problematic especially if young women lack the negotiating skills needed to ensure male compliance (Mash, Mash and de Villiers 2010).

Young people are also likely to lack the time, autonomy or financial means required to locate an alternative source of their preferred method. In Kenya, McClain, Burke and Ambasa-Shisanya (2011) found that when government clinics ran out of injectables, staff typically asked clients to buy them at the pharmacy and to return to the clinic for the injection. Because pharmacies often charge a higher price for the injectables, many women reported discontinuing the method. These obstacles are likely to affect young people more than other groups because of their lack of cash, autonomy and time.

Stockouts may occur because providers do not know how to reorder methods to predict stockouts before they occur (FP2020 2014). In Rwanda, providers were unfamiliar with the systems for replenishing supplies as these had not been addressed in either pre-service or in-service training. Addressing stockouts effectively may require the use of m-Health and new technologies. In Kenya, UNFPA partnered with Pharm Access Africa Ltd to enable providers to send text messages to reorder supplies in a timely fashion. In 80% of the participatory clinics, stockouts were eliminated (FP2020 Progress report 2013-14).

The Sayana Press self-administered injectable contraceptive could play an important role in resolving stockout issues. A recent study by Cover et al (2014) in Senegal and Uganda found that some providers felt that Sayana Press could facilitate supply management (5%), storage (11%) and waste disposal (22%). They saw the all-in-one packaging of Sayana Press as reducing the incidence of mismatched supplies (syringes and vials). And they saw its smaller size as easing space constraints and reducing the frequency of safety box incineration. The study concluded that providers of Sayana Press may see some modest improvements in service delivery logistics, including reductions in stockouts. These benefits, if realized, stand to impact younger family planning users who, as discussed above, tend to prefer injectables.

“In a rural Rwandan clinic staffed by newly qualified midwives, three weeks had passed since family planning services were operational. When assessed, the reason given for lapse in services was that no methods were available at the facility – ‘The cupboards are empty!’ None of the midwives or health centre staff knew how they could procure family planning methods. An additional group of eight midwives did not know how to replace commodities when stock ran out of the clinic and pharmacy. ‘If the hospital or health centre pharmacy does not have it, we just tell the women to come back’. When further questioned about obtaining commodities from the district pharmacy or central stores in the Ministry of Health, none of the providers was able to demonstrate an awareness of the steps required to restock the clinic”.

Pandora Hardtman, Nurse-Midwife trainer, Clinton Foundation/Ministry of Health, Rwanda.

8. Provider biases and young people's access to reproductive health supplies

Provider biases do not exist in a vacuum; they reflect the viewpoints of policy-makers' and community members' regarding the suitability of methods for young people.

Provider biases may manifest themselves at three levels. Firstly, some providers may approve of only certain methods as appropriate for young women who have never given birth mistakenly believing that others, such as LARCs, may threaten future fertility.

Secondly, some providers may lack the confidence or even training to insert LARCS. A study of the factors influencing contraceptive use among young people in rural Uganda (Nalwadda et al, 2011) showed that providers often did not feel competent providing IUDs or implants. There were significant differences in providers' self-rated competence by facility type. Private providers, for example, felt particularly unprepared at delivering all but a few methods. According to the study, therefore, a key factor limiting young people's access to LARCs was them providers themselves. This then sets in motion a vicious cycle in which young clients are discouraged from requesting LARCs; so unused products expire; which means providers have no opportunity to insert and build self-confidence.

Thirdly, providers may simply disapprove of premarital sexual activity and convey that disapproval to young clients. In South Africa, study participants described how providers scolded sexually active girls and treated them harshly. The providers' unwillingness to acknowledge a young girls' contraceptive needs undermined their ability to provide appropriate services. Many girls reported preferring to share oral contraceptives with friends rather than face unsympathetic providers (Wood and Jewkes 2006).

As a result of these biases, the contraceptive options typically available to young people are often limited. And what is considered appropriate, largely re-supply methods such as pills, require repeat visits to a health centre, where the risk always exists of confronting yet another unsympathetic provider.

In Senegal it was found that more than half (57%) of the public-sector providers surveyed applied age restrictions to provision of the pill and slightly fewer than half (44%) to provision of the injectable—the two methods most often used by young women in urban Senegal. In private facilities, those proportions were 49% and 41%, respectively (Sidze et al 2014).

9. Emergency contraception and young people

Emergency contraception (EC) is the only method that can be used after unprotected sex or when a barrier method has failed, and so it plays an important role preventing unwanted pregnancies. Unfortunately, it is not always part of the method mix, whether at local or national levels.

Levonorgestrel-only emergency contraceptive pills (ECP) are now registered in over 140 countries. They are particularly important for young people whose sexual activity is, as described previously, occasional and unplanned, and therefore at greater risk of resulting in pregnancy. And yet, for a variety of reasons, EC is not always available in either social marketing programmes or many public or private healthcare facilities. A 2011 survey by USAID | DELIVER found that only 26 of 40 countries included EC in their National Essential Medicines Lists (USAID | DELIVER 2011).

From a supply perspective, EC also has unique characteristics that make it difficult to accurately forecast to meet programme requirements. For well-established methods, forecasts are often based on consumption or even demographic data. Because EC is not intended for routine use, however, demand can be unpredictable, thereby making it more difficult to develop accurate supply forecasts.

Research indicates that some providers, especially those outside health facilities have reservations about the suitability of EC for young people. In South Africa, nearly all pharmacists sold at least one of the two types of dedicated emergency contraceptive pills available (Blanchard, Harrison and Sello 2005). Although most had accurate knowledge about the method's dosing schedule, side-effects and mechanism(s) of action, more than half erroneously believed that repeated use posed health risks. While most pharmacists believed the pills should be available to rape victims or to women irrespective of marital status or parity, almost half did not think they should be given to women under the age of 18. Similarly, in India, Dixit, Khan and Bhatnagar (2015) noted that while most doctors approved of the use of EC by married women, fewer agreed with its use by unmarried youth.

Importantly, in Ethiopia, Both and Samuel (2014) found that most young people had used ECs more than once and that it was becoming a 'go-to' contraceptive. Other anecdotal evidence from West Africa suggests that young men are increasingly procuring EC and encourage their partner to take it after intercourse, sometimes coercively (Rena Greifinger, PSI- personal communication 2015)

It is important to note that ECs should also be an integral part of comprehensive sexual violence services and for programmes targeting vulnerable populations. They should, therefore, be accessible via non-traditional outlets such as hospital emergency rooms, refugee and IDP camps, pharmacies, prisons, and schools. In Zambia, a study among sexual abuse survivors found that although 82% arrived at health facilities within EC's window of effectiveness, only 37% received EC from hospital staff (Amenu and Hiko 2014). This prompted the establishment of a successful pilot project that saw police officers trained to distribute ECP on the spot.

Given that many victims of sexual violence are young, it is crucial that training programmes take this fact into account and that ECP stocks be maintained outside formal healthcare settings. The International Consortium for Emergency Contraception (www.cecinfo.org/ec-issues/youth) recommends adoption of the following approaches to expand access to EC by young people:

- › Advancing legislation to make EC available over-the-counter (OTC) for people of all ages. Because EC is very safe and can be self-administered, there is no reason to require women to see a doctor first.
- › Training pharmacy and drug shop staff that EC is safe and suitable for all women, including young women, and that partner consent is not necessary.
- › Launching media campaigns and other marketing strategies to increase public awareness. These could include websites, social networking, text messaging services, hotlines, advertising in youth-oriented publications, and publicity at events).
- › Ensuring that EC is available at no cost to victims of sexual assault in emergency rooms and public health facilities.

10. Young people and choice of outlet

Understanding young people's preferences with regard to choice of supply outlet is extremely important in providing accessible and respectful care. The section below discusses the advantages and disadvantages of a variety of outlets where young people can acquire family planning.

Public versus private sector

Table 3 shows that across the developing world, around half of all family planning users age 15-19 obtain their method from the private sector. Public sector users constitute 32% in Sub-Saharan Africa, 37% in Asia and 41% in Latin America and the Caribbean. The rest use 'other' sources which may include the informal sector and pharmacies which are discussed below. The private sector is often preferred because it is perceived as being more discreet and offering a better quality of care. There is also a widespread sense that payment for services offers some sort of guarantee of respectful care.

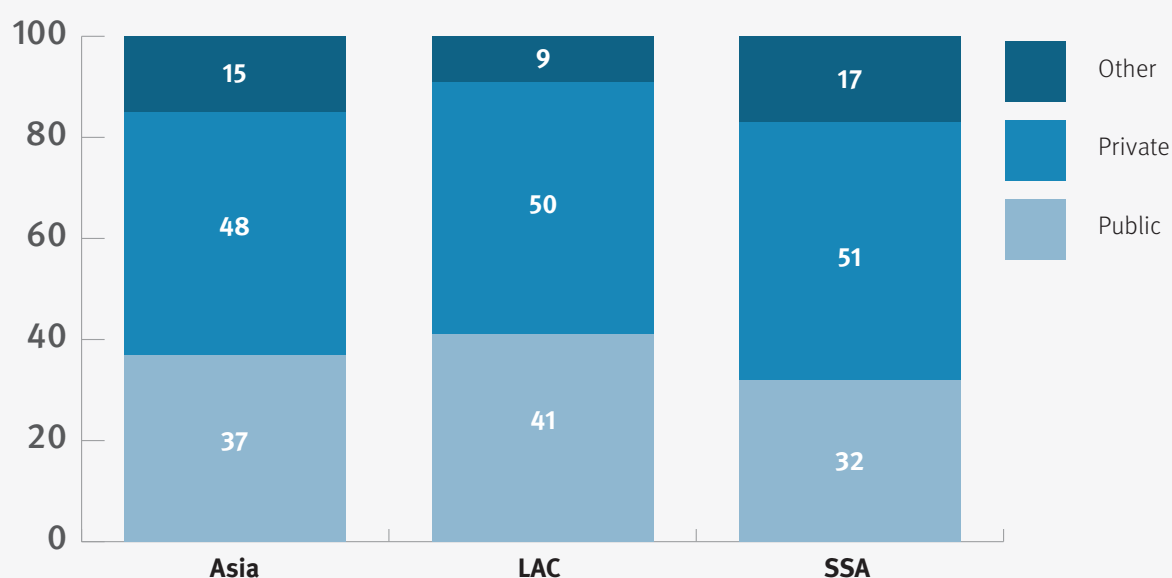
“I prefer the private clinic to the government owned hospital, because the way the nurses look at you and ask you questions, you will feel that you have committed the worst offence ever, but in the private hospital the nurses cannot really shout at you because it is business and they know that you are paying your money”

Out of school, 18, FG 6, 2004
Ndongo and Naidoo (2008)

Pharmacies

Drug shops and pharmacies, with their convenience, anonymity, and comparatively low costs (compared with the private sector) are an important source of health services, products, and information, particularly for young people. But

Table 3: Modern contraceptive users, aged 15-19, by source of family planning method



Source: USAID/SHOPS, July 2015

despite their popularity and potential, pharmacies and drug shops (or chemical shops as they are also known in parts of Africa) are not generally considered part of the larger health system. They are, therefore, largely missing out from countries' health strategies, policies and regulations and monitoring.

Studies show that young people view pharmacies as critical sources of contraceptive information and methods. Evidence from Africa and Latin America indicate that youth are more comfortable obtaining contraceptives from pharmacies than from clinics, which they consider more intimidating and judgmental (USAID 2013). In Bangladesh, most young women aged 18 and below use socially marketed contraceptives obtained through pharmacy outlets. This stands in sharp contrast to women 19 years and above, only a third of whom access socially marketed products (Karim, Sarley and Hudgins 2007).

In Ghana, a collaborative effort between Marie Stopes' BlueStar social franchise and the National Pharmacy Council has allowed contraceptives to be marketed in a quality-assured setting via chemical shops (The Global Health Group, 2009), thereby increasing access to young people.

Selected service delivery mechanisms for young people

According to Chandra-Mouli, Lane and Wong (2015), there remains much to learn about 'dosage', intensity and duration of approaches to improve young people's reproductive health. Contraceptive security must include these facets of programme delivery and include the acquisition of life skills if the intention is to maximise impact. The authors emphasise the need for improving knowledge in the field and for accelerating the expansion of proven approaches.

The term 'youth-friendly services' is today the subject of much debate with the result that there is a growing preference for the term 'youth-adapted services'. IPPF notes that services are only truly youth-friendly if young people themselves are involved in determining their content and in monitoring and evaluating them. (IPPF 2015). This may vary by context—for example, in Vanuatu, Kennedy et al (2013) note that the reliable supply of free products was a key element of 'youth-friendliness' as defined by the young people themselves. In Guatemala, young people at a local NGO, 'Wings', received free services but could make a monetary contribution if they

so desired (Dr. Rodrigo Barillas, Wings, Guatemala – personal communication – July 2015). At other centres young people can pay a nominal fee for commodities.

Attracting new clients may also entail the provision of innovative incentives. In Cameroon, for example, the 'Girls' Choice ice cream project' is a youth-led organization that aims to create a girl-friendly space—a mobile ice cream shop for girls ages 10 to 19. In the shop, girls can access quality, age-appropriate sexual and reproductive health information, services, and referrals free from stigma and coercion (<http://www.packard.org/what-we-fund/population-reproductive-health/making-quality-matter>).

There is also growing evidence, this time from Latin America, of the importance of tailoring service delivery by age group and/or market segment (Anabella Sanchez JSI 2015). Chandra-Mouli, Lane and Wong (2015) note that youth-friendly services often flounder because they take on more than can be reasonably handled. To maximize success, they recommend incorporating comprehensive sexuality education using participatory methods and experiential learning.

Multi-country peer-reviewed research shows that stand-alone youth centres that specifically target youth are not the most impactful nor cost-effective way of offering adolescent reproductive health services (Erulkar, Onoka and Phiri 2003). Far more successful are approaches that aim to integrate health services with life-skills approaches and opportunities for vocational training. In Mali, a local NGO ASDAP (www.asdapmali.org) has revolutionised the provision of sexual and reproductive healthcare for young people by launching Bamako's first cyber cafe—which also offers computer training. It also provides a number of sporting facilities including a basketball court. To date, ASDAP has trained thousands of peer educators who work with both school pupils and disadvantaged youth from all backgrounds including street children. ASDAP addresses a variety of reproductive health issues including family planning at its onsite clinic. It also carries out sensitization on female genital mutilation at both the centre and within the community.

Peer promotion programmes

Peer promotion programmes deliver information and services in the community and workplace through individuals similar in age and background to those they aim to reach. These programmes are especially successful in hard-to-reach

populations such as out-of-school youth, street children and commercial sex workers. Peer educators have an important role as referral points. They can ‘signpost’ their peers to services and, where appropriate, facilitate use of those services. They can, for example, make appointments or accompany potential users to sessions at family planning clinics (Save the Children 2004). As well as services, peer educators can offer insight into what young people want. For example, they can make recommendations regarding the layout of clinics, or familiarise health workers with the realities of children and young people.

Community outreach programmes

Community outreach programmes seek to reach those who, because of distance or other social barriers, have difficulty accessing family planning services themselves. Providing mobile services, for example, not only gets services to those in need, it also builds awareness of the barriers many young people face. Case comparisons of community outreach programmes in Zimbabwe and Kenya found that such programmes successfully reduced the numbers of sexual partners, delayed age at first intercourse, and increased condom use when compared to the control groups (Kalembo, Zgambo and Yukai 2013).

Some evidence suggests that uptake of family planning is improved if a holistic or rights-based approach is adopted. Young people’s access to services is often increased when interventions target their knowledge, skills, attitudes and behaviours (IPPF 2006). These may extend outside the health domain and include behaviour such as sexual violence and its prevention. In Guatemala, PSI/PASMO runs ‘Plan de Vida’ sensitization sessions that incorporate access to commodities in the context of rights-based sensitization (www.asociacionpasmo.org). By allowing young people to link their aspirations with employment or educational opportunities, this holistic approach motivates them to seek out their family planning method and use it correctly. Positioning family planning within this life-skills agenda which includes relevant legal information (for example, on age of consent), and guidance on reporting abuse, situates the issue in a rights-based framework that often leads to more effective uptake (Castle and Hardtman 2014).

IPPF recommendations in relation to commodities for peer education programmes (IPPF 2006):

- › If you have good materials, keep them in a designated location, and ensure that peer educators always have access to them.
- › Include condoms (both male and female, if possible) as an essential part of your peer education programmes on sexual health. However, they should not be the only method available. Remember to emphasize choice.
- › Decide whether to sell condoms and other commodities or to distribute them for free. If you choose to sell them, ensure that you first understand what implications this may have for young people’s access to these commodities.
- › Address issues of both quantity and quality of commodity supplies.
- › Establish a reliable source for commodities, and have alternative sources as back-up. If possible, stock male and female condoms.
- › Keep emergency contraceptive supplies for both demonstration and distribution.

In many cases, it is useful to compare different approaches to youth service provision and then scale-up. However scaling-up has considerable implications for supplies. Hainsworth et al (2014) noted that sustainable scale-up requires advocacy, together with intensive capacity building, appropriate work plans and budgets, and reliable age-disaggregated data to estimate the numbers of potential clients. To date, there is little disaggregated data on young people’s use of or attitudes towards family planning, and even less among unmarried youth or those under the age of 15. WHO recommends that health information systems gather, analyse and use age-disaggregated data on the need for, and use of, contraceptives so that provision can be better planned and tailored to their needs (WHO 2012).

11. Financing mechanisms for young people

Financing mechanisms for young people need to address both ‘supply’ and ‘demand’ issues and be underscored by equity, access and rights-based programming to optimise their use of services. This implies that regardless of young people’s economic status, they should be able to access family planning services. Financial barriers do not just include the cost of the method. They can also include the cost of transport and the opportunity costs (including lost days or hours of work or education) of obtaining the method.

According to Advocates for Youth, 238 million young people live on less than US \$1 a day; 462 million youth survive on less than US \$2 a day.⁸ These figures clearly show the important financial barriers many young people face when they need reproductive health supplies.

In many countries, public sector services are said to be free; however a youth-led survey in Sierra Leone found that many young people were still being charged, albeit illegally, for access to contraceptives and other reproductive maternal and child health services. They noted that “young people are vulnerable to these charges as they are not sufficiently aware of their rights or lack the skills and confidence to report illegal charges” (Restless Development 2012).

Financing mechanisms, such as vouchers or subsidies can assist young people to manage the costs of otherwise unaffordable services. But there are also other ways of facilitating access. In Guatemala, for example, the local NGO Wings finances the transport costs of those who miss the mobile clinics, thereby enabling them to attend the organisation’s youth-friendly clinics (Dr. Rodrigo Barillas, Wings, Guatemala – personal communication – July 2015). Creative ways of improving access and equity (financial, geographical and social) need to be at the heart of all youth service provision.

Total Market Approaches

Total Market Approaches aim to help governments achieve a more efficient and effective allocation of resources across the public-private divide, thereby ensuring greater coverage and access to family planning services (Barnes, Vail and Crosby 2012). Government clinics may serve poorer clients whilst the private sector supports often by social franchising systems, those who can pay. More effective market segmentation can also assist vulnerable groups such as youth, to access private sector services through subsidies.

Social Marketing

Social Marketing⁹ can be a powerful tool for improving access to contraception generally, and in particular among underserved populations such as youth. By offering products at a variety of prices, social marketing can also improve choice. It also has the potential to reduce the burden on the public sector by shifting those who can pay to the private sector. One of the world’s leading social marketing organizations, DKT, (www.dktinternational.org 2015) has identified the following benefits likely to make social marketed commodities especially appealing to young people:

- › It is fast. Because social marketing relies to a great extent on existing commercial and health service delivery networks, it can be scaled-up quickly, providing contraceptives to tens of thousands of outlets in just a year or two.
- › It is non-patronizing. Social marketing contraceptives are not perceived as a ‘programme’ by consumers. Rather, they are seen as normal commercial goods that offer consumers a benefit at an affordable price.
- › It is highly cost-effective. Because social marketing products and services are purchased, they are more likely

⁸ <http://www.advocatesforyouth.org/publications/publications-a-z/455-youth-and-the-state-of-the-world>

⁹ Social marketing uses marketing concepts — product design, appropriate pricing, sales and distribution, and communications — to influence behaviours that benefit individuals and communities for the greater good. Social marketing programmes sell subsidized products through commercial sector outlets like pharmacies, distribute products for free, deliver health services through social franchises, and promote behaviours not dependent upon a product or service, like hand washing (<http://www.psi.org/research/evidence/social-marketing-evidence-base/>)

to be used than those given away for free. <http://www.dktinternational.org/contraceptive-social-marketing/contraceptive-social-marketing/>

Social marketing often requires different strategies, depending on the market segment. Strategies to reach young people, for example, must recognize the potential barriers price may play and the importance of discretion and privacy. It should also be noted that social marketing of contraceptive commodities can take advantage of the advertising, information dissemination and feedback opportunities that derive from young people's wider use of new technologies such as mobile phones (USAID/FHI360 2012).

In various settings, voucher schemes have allowed young people to obtain their method of choice via the private sector. In Madagascar, for example, MSI has introduced a voucher scheme that provides access to LARCs at subsidized prices from private providers trained to offer youth-friendly services (Corby 2011). Another collaborative effort, this time with a national mobile phone company, is allowing providers to phone-in data on a select number of supply and service-delivery rated indicators, thereby reducing stockouts and ensuring greater user satisfaction.

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For young people, however, price points are critical and it is important to carry out 'willingness-to-pay' studies before fixing the prices of subsidized products. In Benin, an

BlueStar Healthcare Network Fianakaviana Mirindra	
Fanabeazana aizana	
• Pilina	300 Ar
• Kapaoty	50 Ar
• Tsindrona	1000 Ar
• Stérilet	5000 Ar
• Implant	4000 Ar
• Hafa	Ar

Figure 2: BlueStar price table, listing all contraceptives available at the health facility in Madagascar. © Sarah Castle

evaluation of mobile services found that commodity prices were often too high for poorer populations, including young people (Castle and Hardtman 2014). The cost of each method should always be visibly communicated to ensure that clients understand the final price and to avoid hidden provider surcharges (see Figure 2).

The fact remains, however, that providing services to youth can be more expensive per capita than for other groups because their needs may be best catered for outside mainstream health facilities. By contrast, a fixed youth centre may have high set-up costs but lower ongoing costs than an outreach setting (Jennifer Gassner- MSI personal communication – July 2015). Because of young people's preference for pills and other short-term methods, the cost per CYP tends to be higher. And so while lowering prices does typically increase method uptake, the subsidies required for this to happen figure-in as part of the overall programme cost. More research is needed on this topic as the differentiation between the running costs for youth and all clients by method and service delivery channel are not well understood.

12. Youth-led service provision

Sometimes young people are involved in the decision-making structures that shape the design and operation of family planning programmes. In Bujumbura, Burundi, the Réseau National des Jeunes Vivant avec le VIH/SIDA (RNJ+) runs a very successful youth centre under the auspices of the HIV/AIDS Alliance (<http://www.aidsalliance.org/our-priorities/current-projects/28-link-up>). The people who use its services are those most affected by HIV and include young sex workers as well as people from the LGBTI community. Unlike many other centres, this one has a non-judgemental philosophy and offers information, training, HIV counselling and testing, contraceptive advice, a helpline, and outreach to community and schools. RNJ+ also equips young people with the information they need to make their own decisions. With more than half of Burundi's population under the age of 17, the centre is much appreciated and a good example of youth-led integration of family planning and HIV services. Through its youth involvement and youth leadership, RNJ+ is successfully reaching out to young people and preventing both HIV transmission and unwanted pregnancies. (<http://www.aidsalliance.org/our-impact/making-it-happen/482-improving-sexual-health-one-table-football-match-at-a-time>).

Young people can also play critical roles with regard to commodity issues. In Uganda, the Leadership Development Programme (LDP+) supported a youth centre originally developed for recreational purposes, rather than family planning. During their LDP+ training (LMG for Health/USAID 2015), the team at the Mbarara clinic focused on increasing youth access to family planning services at their own facility. A subsequent evaluation of the effort found that the approach not only helped young people address their reproductive health needs, but also drew increased numbers of young clients to the clinic. Today, the Mbarara clinic serves well over 500 family planning clients monthly, an increase of over 350% from 2013.

“The team implemented a new strategy to involve youth in their decision-making and programme planning. We included young people from the community in our weekly meetings and hosted monthly health education talks at the youth center. We began to plan jointly for both the youth center and the clinic at the same time. We would now collaborate with each other.”

Health Worker, Mbarara clinic, Uganda

Young people's use of modern technologies has proven effective at allowing them to monitor the family planning programmes they use, thereby increasing transparency and accountability¹⁰. Marie Stopes Madagascar, for example, acquires client feedback through an SMS-based survey (Williamson 2013). By enabling young people to access and utilise this information, they are better equipped to locate providers who offer more youth-oriented services and avoid those characterized by stockouts, limited method choice or service quality. This transparency can create greater demand for youth-friendly services, but also encourage providers to improve their services and attitudes if they wish to attract younger clients. It also enables providers to better monitor youth preferences for specific methods and to adjust their supply chains accordingly.

¹⁰ In July 2015, young innovators participated in a Hackathon for Youth in Kampala, Uganda. They worked alongside UNFPA and expert coders from The Massachusetts Institute of Technology over a three day period to develop mobile app solutions to promote young people's access to sexual and reproductive health (<http://www.thecommunityagenda.com/index.php/youth-a-woman-voices/228-they-did-it-young-innovators-mobile-apps-to-boost-adolescents-access-to-health-services>)

13. Advocacy for improved access by young people

Advocacy is defined as a set of actions undertaken by a group of committed individuals or organisations to introduce, change, or obtain support for specific policies, programmes, legislation, issues, or causes (WHO 2008). With regard to young people, advocacy seeks to ensure not only their access to services, but their empowerment and acquisition of life skills that will enable them to use those services effectively. At a grassroots level this can be achieved by sensitising youth themselves, but also community stakeholders such as providers and decision-makers. At a national level, engagement with policymakers and political decision-makers is the most effective yet challenging way to establish youth-friendly services.

Organisations such as the Youth Coalition for Sexual and Reproductive Rights (www.youthcoalition.org) brings together youth advocates to lobby at high level meetings, such as those currently forging the Sustainable Development Goals, and to share best practices. In this way, youth remain at the forefront of decisions regarding the kinds of services they require and empowered to guide relevant policymakers and programmers.

Advocacy has often been very effective at improving young people's access to services. In Tanzania, for example, the inability of healthcare workers to develop accurate stock forecasts caused shortages and other supply disruptions. This led to declines in the number of women and girls attending affected facilities, thereby reducing contraceptive prevalence rates. Working together, the African Women Leaders' Network, Zanzibar Nurses Association, the Ministry of Women and Children of Zanzibar, the Zanzibar AIDS Commission, MSI Tanzania and the Youth Advisory Panel



Figure 3: Interactive session at a youth advocacy workshop in Latin America, sponsored by USAID | DELIVER. © John Snow, Inc. and JSI Research & Training Institute, Inc.

focussed their energies on addressing these supply challenges. After presenting their evidence, the Director of Tanzania's Central Medical Stores had all family planning staff undergo training in forecasting and ordering. As a result, stockouts have declined by 70% (Advance Family Planning 2015).

Also in Tanzania, Pathfinder used 'Citizen Report Cards' to persuade local government authorities to allocate funding for commodities during stockouts (Pathfinder 2013). The project encouraged action to address stockouts at the district level, while at the same time helping local organizations to use the Citizen Report Cards. An initial survey carried out by Pathfinder found that most of those who accessed family planning services from pharmacies and drug shops were in the age group of 13–24 years—an indication, perhaps, of the ongoing barriers young people face in accessing

contraceptives at public sector facilities. The project then engaged both young people and health workers to measure access to contraceptives, identify public sector inefficiencies and gaps, and develop appropriate solutions. Following the training of community-based organizations and extensive meetings with beneficiaries and key decision makers, a national stakeholders' forum produced a joint strategy for ensuring the availability of family planning supplies at all facilities, irrespective of the clients' age.

All too often, however, young advocates have limited access to relevant data because available data are not always disaggregated by age or marital status. JSI has documented how USAID | DELIVER has addressed this issue in Latin America and the Caribbean (JSI 2014). There, young people are learning how to use data to broaden advocacy efforts on behalf of improved contraceptive security. Between 2012 and 2014, USAID | DELIVER held a series of workshops in which youth from the Dominican Republic, Honduras, Belize, Guatemala, Nicaragua, El Salvador, Peru and Paraguay discussed the barriers to contraceptive security as it affected them. They learned how to carry out analyses of DHS and other data sets to illustrate how barriers to contraceptive access can result in high pregnancy rates and unmet need. They subsequently met with representatives from their countries' health ministries to make their case for improved service provision and raise concerns about policy barriers. They also issued data-driven advocacy statements and action plans to encourage their governments to increase family planning access for young people.

The impact of this advocacy training has been impressive:

- › In 2012, after returning from a regional workshop, youth participants created a Facebook page entitled 'Latinoamericana de Jóvenes por la DAIA' to share ideas and activities.
- › In 2014, in Guatemala, youth leaders ensured that newly-approved guidelines entitled 'Strengthening Youth-friendly Sites', included a chapter on dispensing contraceptives to youth and a summary of the tools necessary to monitor contraceptive security.
- › In 2014, in Nicaragua, two youth leaders actively participated in an assessment of ProFamilia youth-friendly sites to monitor the accessibility of contraceptives and reproductive health services for youth.

14. The way forward

National policies must be clear in ensuring that young people—especially those under the age of 16—have access to reproductive health services. They must also allocate funding for commodity procurement in order to improve sustainability and decrease reliance on external donors. There must be greater multi-sector collaboration among, for example, the Ministries of Health and of Education. Thirdly, task-shifting policies that authorise lower level cadres of health workers to carry out the new tasks should be implemented. And finally, emergency contraception must be included in all countries' Essential Medicines Lists.

With regard to service provision, programmes must recognise and respect the diversity of young people's needs. Nowhere is this diversity more evident than in the case of marital status. While unmarried women may often prefer resupply methods, increasing sensitisation efforts, especially towards providers, could improve their uptake of LARCs. At the same time, married women who may be more inclined to adopt LARCs, still remain at higher risk of method discontinuation and therefore stand to benefit from a broader mix of alternative options

Mobile technology can be used for everything from sensitising youth to addressing stockouts. It can also be used to address quality assurance and enable young people to access and monitor the services aimed at them. At the same time, rights-based services that empower youth are likely to improve youth engagement and lead to greater contraceptive use by them. This can help to eliminate stigma, discrimination and gender based violence as well as free and fair choice.

Finally, with regard to ensuring the long-term benefits of effective contraception, reproductive health services must go hand-in-hand with efforts to expand young people's life chances with regard to education and employment. Young people need to be actively involved in the development of reproductive health service provision at all stages (drafting, implementing, evaluating) to ensure their needs are represented, particularly with regard to supply preference and availability.

With regard to those who deliver services, there are a number of obstacles that have been identified in this report, the most notable of which include provider biases and the inability to

manage stock levels. The key to both of these is effective pre-service and in-service training during which the systems for reordering commodities can be clearly explained.

Young married women need to be better targeted, especially in settings where the median age at marriage is very low. In many cases they could benefit from using LARCS, whether to postpone their first birth or to space their second. Postpartum family planning initiatives, including postpartum IUD insertions and integration with childhood immunisation may be a way to support the use of longer-term methods. Other initiatives to increase the use of LARCS relate to mobile provision. The sporadic sexual encounters that characterize many unmarried youth mean that commodities must be available outside health centres. But sustaining such provision requires adequate programme budgets that can support supply chains and minimise the risk of stockouts (Anabella Sanchez, JSI 2015)

The integration of family planning services with other youth services or within general health facilities has been shown to be an effective approach. By contrast, stand-alone services that target youth with reproductive health information and services only have been found to be stigmatizing. The integration of family planning with HIV counselling, testing and management is to be welcomed.

Financial barriers often limit young people's access to commodities, so identifying the appropriate price points for different market segments is critical. Total Market Approaches can engage both the public and private sectors in a complementary fashion to provide youth-friendly services. In addition, social marketing programmes and innovative

financing schemes such as vouchers can help young people from poorer wealth quintiles access the commodities they need. In most settings, service delivery and finance systems can be piloted, tested and scaled-up to ensure an optimal fit between services, cost and access.

Lastly, it is crucial that young people be involved in national- and local-level advocacy to define, implement, monitor and

improve supply chains and to ensure that ‘youth-friendly’ services truly respond to their needs. Young people can be trained in data analyses and advocacy to engage with policymakers to demand better service provision. In addition, M-health and social media can enrich advocacy efforts and hold governments accountable for improving youth service provision.

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16. Annex 1: List of interviewees

Interviews were done by questionnaire or telephone/Skype.

Name	Email Address	Affiliation
Questionnaires returned		
Katie Chau	KChau@ezaproject.org	Pathfinder International
John Granda	JGranda@pathfinder.org	Pathfinder International – Angola
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Ashley Jackson	ajackson@psi.org	Population Services International
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Sarah Rich	srich@familycareintl.org	Family Care International
Katelyn Bryant Comstock	kbc@popact.org	Population Action International
Anabella Sanchez	annabella_sanchez@jsi.com	John Snow, Inc.
Telephone/skype conversation		
Dr Uwemedimo Esiet	u.esiet@actionhealthinc.org	Action Health Inc, Lagos, Nigeria
Chelsea Rocker	cricker@familyplanning2020.org	FP2020
Rena Greifinger	rgreifinger@psi.org	Population Services International
Dr Rodrigo Barillas	rodrigobarillas@wingsguate.org	Wings, Guatemala
John Skibiak	jskibiak@rhsupplies.org	Reproductive Health Supplies Coalition

With gratitude to, and in fond memory of, John Granda, who supported not just this report but the Coalition's ongoing work over the years to make reproductive health supplies accessible to the most disenfranchised people in the world.



The Reproductive Health Supplies Coalition

The Coalition is a global partnership of public, private, and non-governmental organizations dedicated to ensuring that everyone in low- and middle-income countries can access and use affordable, high-quality supplies for their better reproductive health. It brings together agencies and groups with critical roles in providing contraceptives and other reproductive health supplies. These include multilateral and bilateral organizations, private foundations, governments, civil society, and private sector representatives.

